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Psychological Expertise And Psychological Care For Offenders

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Abstract:

Human behaviour can sometimes be abnormal and deviant, leading individuals to commit acts of aggression or crime against others, property or even themselves. It is therefore important to explore the motivations behind such behaviour and to investigate how deviant behaviour can be treated using psychological approaches. This is the field of criminal psychology, which focuses on the study of the offender's personality and the factors that drive criminal behaviour. It also involves classifying offenders on the basis of their psychological, physical or social characteristics and categorising the crimes they commit in order to understand the underlying causes and provide appropriate psychological treatment.
Psychological expertise is recognised as a critical tool used by judges during judicial investigations in certain criminal cases. It is essential for assessing the psychological state of the offender at the time of the crime, which helps to determine their criminal responsibility.
Based on this, we aim to delve into this area to discuss psychological expertise and address its key elements, in order to outline a simple understanding of its nature, techniques and more.

Keywords: Psychological expertise, psychological care, offender.

INTRODUCTION

Every year, millions of people around the world are imprisoned as a result of actions considered criminal by the societies in which they live. In contrast, there are millions of victims who suffer harm as a result of these criminal acts, making crime a pressing concern for all communities. Psychology, the science that studies human behaviour, revolves around three main axes: the first is the accurate description of human behaviour, whether normal or abnormal. The second axis is to interpret this behaviour by understanding its causes and motivations. The third axis is the prediction of that behaviour, which involves anticipating how a person will behave in certain circumstances so that that behaviour can be controlled and modified.
While psychology studies human behaviour, it intersects with law, which codifies human behaviour. Law consists of a set of rules and regulations established by the state, which individuals are required to acknowledge and obey. It embodies principles established by the authorities that define acceptable behaviour - what is lawful and what is unlawful - thereby legitimising some actions and criminalising others. Thus, we can say that law is a framework for regulating human behaviour.
Since psychology studies human behaviour and law regulates it, these two disciplines share common ground and face similar challenges and concerns. Both occupy a common territory centred on 'human behaviour'.
The intersection of psychology and law is the field of criminal psychology, a branch of applied psychology that focuses on the study of human behaviour in the context of legal interactions. Criminal psychology applies psychological knowledge to criminal or legal situations, serving as a practical application of psychological principles in contexts where individuals interact with the law.
Based on this understanding, we aim to explore this field further by discussing psychological expertise and addressing its key elements.

1. Research Problem

Clinical psychology plays a crucial role in criminal cases, particularly in providing an accurate diagnosis of the offender's psychological state and the impact of psychological disorders on criminal behaviour. This includes clarifying whether the offender was aware of their actions and whether they acted with intent. Such assessments enable the judge to make informed decisions about the criminal responsibility of the offender - whether to absolve, mitigate or hold them fully accountable.
Psychology has a significant impact on criminal justice through the clinical role of psychologists, who have expertise gained from working with patients in a variety of therapeutic settings. This role typically involves assisting individuals suffering from mental or psychological disorders, and provides psychologists with knowledge of various forms of psychological and mental deviance. In addition, their interviewing and communication skills may exceed those of lawyers, enabling them to

2. Research questions

The following questions arise from the above:
1. What is psychological expertise and what are the conditions for the expert?
2. What is the psychological and pathological interpretation of criminal behaviour?
3. What psychological disorders are associated with crime?
4. What are the limitations of clinical psychology in criminal cases?
5. What are the legal rules for determining criminal responsibility?
6. What are the most common errors made by psychologists in assessing psychological competency?
7. What is the role of the psychiatrist in legislation and in the management of prisons?
8. What is the role of the psychiatrist in assessment, diagnosis and determination of criminal responsibility?
9. What is the role of the psychiatrist in predicting outcomes?
10. What is the psychiatrist's role in treatment?

3. Aims of the research

This research aims to achieve several objectives, which include:
1. To understand psychological expertise and the conditions required of the expert.
2. To explore the psychological and pathological interpretation of criminal behaviour.
3. Identify psychological disorders associated with crime.
4. To clarify the limitations of clinical psychology in criminal cases.
5. Understand the legal rules for determining criminal responsibility.
6. Recognise common errors made by psychologists in assessing psychological expertise.
7. Examine the role of the psychiatrist in legislation and in the management of prisons.
8. To examine the role of the psychiatrist in the assessment, diagnosis and determination of criminal responsibility.
9. Understand the psychiatrist's role in predicting outcomes.
10. Examine the psychiatrist's role in treatment.

4. Importance of research

Many defendants often resort to claiming mental illness in various cases in order to gain certain advantages and avoid legal responsibility. This tactic is not new; it is an old ploy used by criminals or suggested by their lawyers. However, with the advancement of science and the prevalence of claims of mental illness, it has become essential to involve psychological specialists to uncover the truth about the offender. Relying on the diagnosis and expertise of the psychologist, presented as psychological expertise in court, is crucial to resolving these cases.

Indeed, many offenders have psychological problems and complexes that drive them to commit crimes. However, psychological expertise can reveal whether the offender suffers from a mental disorder. For example, a person with schizophrenia may lack the capacity to make sound decisions because they cannot distinguish between reality and delusion. Committing an offence in such circumstances may warrant a reduced sentence or referral for treatment, as this illness affects the person's ability to control their decisions and actions and requires psychological care.

5. Definition of terms:

5.1 Definition of psychological expertise

Psychological expertise is a comprehensive assessment carried out by a clinical psychologist and formulated according to specific rules in an expertise report. It provides a scientific description of the current state of the individual being assessed, with the aim of identifying strengths and weaknesses in various personality dimensions through the use of psychological assessment tools such as observation, interviews and psychological tests (Jaber Nasr El-Din, n.d.).

5.2 Psychological care

The American Psychological Association defines psychological care as the services provided by specialists in counselling psychology based on principles and methods that study behaviour. This process aims to achieve adjustment for the client and equip them with new skills that will help them meet their developmental needs and adapt to life (Ahmed Abdul Latif Abu As'ad, 2009).

5.3 The offender and crime

Crime is an act or behaviour that is prohibited by criminal law. Each country has a limited number of prohibited acts (crimes) and those who commit these acts are punished by fines, imprisonment or other forms of punishment. In exceptional cases, failure to act can also be a crime, for example, failing to help a person in danger or failing to report child abuse.

The perpetrator of these prohibited acts (crimes) is called a criminal (Nirmala K., 2009).

6. Psychological expertise and requirements for the expert

Psychological experts are required to provide the courts with testimony that reveals the true nature of the offender, specifically whether he or she suffers from a mental or psychological disorder or is considered sane. This assessment is crucial in determining the appropriate legal process and punishment based on the expert's testimony.

This testimony is known as a psychological report, which is a contribution in which the expert gives a definitive opinion based on his or her assessment and diagnosis of the offender. It is a contribution by the expert who uses his or her psychological services and expertise to give professional opinions on matters for which he or she is qualified by virtue of his or her training, knowledge and experience. This opinion is based on a set of symptoms observed during the assessment.

An expert is essentially someone who has specialised knowledge or experience that would not be available to the tribunal without their input. Like any other witness, experts must give evidence in court and take an oath to comply with court procedures. However, their status as experts allows them to go beyond simply stating the facts as they know them. They can provide the court with evidence of which they are certain because of their expertise.

Experts are allowed to elevate their testimony by interpreting the facts as they perceive them, essentially giving an opinion. This elevated status can give the expert somewhat greater authority than a lay person who has merely witnessed an event. However, this process can be more subjective as it requires the use of judgement or insight. For this reason, there are restrictions on who can be accepted as an expert and the type of opinion they are allowed to give (Kanther, 2014).

7. The Psychological and Pathological Interpretation of Criminal Behaviour

Understanding criminal behaviour and the nature of crime is fundamental to forensic psychology. These interpretations form the basis for assessing offenders and determining whether they can be helped to avoid future criminal behaviour or how they can be "treated". If we assume that there is something inherent in being a criminal, then assessment, punishment, and treatment will focus directly on the characteristics of the offender. Conversely, if we assume that specific circumstances shape criminals, then crime reduction programmes will target those conditions rather than the individual offender. Consequently, debates about the causes of crime - which may seem somewhat theoretical - can, and do, have a direct impact on crime control policy and the treatment of offenders.

At the heart of these debates is the question of whether criminals are fundamentally different from people who have never committed a crime. Is there something about their make-up that makes them different? One way of exploring this is to consider what it takes to create a criminal.

The shortest route to identifying a potential criminal might be to look for someone who does not conform to prevailing social norms. Such a person might be expected to lack a vigilant conscience. One of the more specialised psychological descriptions might be that this person has not reached the adult stage of moral reasoning. Although this description may evoke the fascinating nineteenth-century idea that criminals are closer to "children and primitives", it at least provides a more detailed framework for studying the cognitive processes of offenders. It also opens up avenues for exploring the aspects of individuals labelled 'psychopathic' that contribute to their particular behaviour.

These interpretations are part of a family of psychological theories that see criminality as rooted in ways of perceiving the world. This encompasses a whole range of aspects of an individual's mental life, including:

- Lack of awareness: A failure to recognise the consequences of one's actions, particularly in terms of the suffering of others affected by those actions.
- Justification of criminal behaviour: Attempts to rationalise criminal behaviour and minimise its perceived impact.
- Low self-esteem: A diminished sense of self-worth that may lessen the burden of criminal success.
- Rational valuation: The belief that breaking the law provides a valuable return for minimal effort.
- Immediacy of gratification: A general reluctance to delay gratification or an inability to control desires.

These various theories can be organised into three psychological stages leading to criminal behaviour:

1. Interpretation of the situation: This initial stage may involve a misinterpretation of cues or comments from others. For example, before an act of violence, the phrase "What are you looking at?" may provoke a reaction. Alternatively, the understanding may be rationally correct, but the overall context is perceived as a situation that demands a criminal response.

2. Emotional and behavioural responses: In this second stage, a combination of emotions and habitual responses leads to the crime. An open window might be interpreted as an opportunity to steal, an insult in a bar might trigger a violent reaction, or a planned bank robbery might result from discussions about available opportunities.

3. Disregard for consequences: The final stage is characterised by a dangerous lack of genuine concern for the consequences of the act.

These stages illustrate how a complex interplay of cognitive distortions and emotional responses can culminate in criminal acts (Ma'nasr, 2021, pp. 13-14).

Cases of deviance:

Psychological deviance is closely linked to criminal behaviour, particularly in the case of psychopathy. Psychopaths are characterised by several key features, including:

1. Inability to control impulses: When a psychopath feels the need to satisfy an impulse, they pursue it with full force, without any resistance from their will.
2. Aberrant social behaviour: Psychopaths often engage in anti-social acts such as lying, cheating and breaking promises.
3. Innate selfishness: Psychopaths are inherently selfish to an extreme degree. This trait manifests itself in their behaviour from early childhood, and they do not abandon their selfishness even with family members.
4. Failure to function: In general, psychopaths find it difficult to hold down jobs; they frequently make mistakes and do not learn from their mistakes, repeating them without attempting to benefit from their experiences. They often commit crimes due to their inability to conform to societal norms and their lack of impulse control (Nasha'at, 2005, pp. 49-50).

Mental disorders and offending

The relationship between mental disorders and criminal behaviour remains unclear and lacks definitive objectivity. This ambiguity is largely due to significant methodological problems. The diagnostic framework for mental disorders continues to be influenced by the clinical biases of researchers, as well as problems of validity, reliability and sample representation. Below we discuss several primary and secondary disorders and their links to criminal behaviour.

- Neurotic disorders: These disorders are among the most common and are characterised by symptoms such as personality fragmentation, inner turmoil, anxiety, sadness, depression, obsessive-compulsive behaviour, heightened sensitivity and hysterical tendencies. The major neurotic disorders associated with criminal behaviour include dissociative and conversion disorders.
- Generalised anxiety disorder: This disorder involves a vague and unpleasant feeling accompanied by apprehension, fear, hyperarousal, tension and various physical sensations. It leads to increased activity of the autonomic nervous system which, if persistent, can manifest physically in the body. The clinical symptoms of anxiety fall into two categories:

Acute and chronic anxiety disorders

Acute anxiety can be divided into three forms:

1. Acute anxiety: characterised by intense tension, excessive movement, inability to sit still, rapid breathing and rapid, disorganised speech.
2. Acute terror: Characterised by immobility and prolonged stillness, muscle contractions, trembling, profuse sweating and loss of temporal and spatial orientation. This state of paralysis can sometimes lead to sudden impulsive behaviour, during which the person may commit a crime without clear awareness.
3. Acute anxiety fatigue: Occurs when anxiety persists for a prolonged period, leading to exhaustion and insomnia, with the individual experiencing numerous psychological changes.

Chronic anxiety, when prolonged, can manifest as physical symptoms affecting the cardiovascular, digestive or respiratory systems, and may also present as psychological symptoms such as anxiety, tension, irritability, difficulty concentrating and substance abuse problems such as alcohol or drug addiction.

Obsessive Compulsive Disorder (OCD)

OCD is classified as a primary neurotic disorder characterised by obsessions that manifest as thoughts, fears or impulses, along with compulsive symptoms. People try to resist these compulsions, but over time this resistance weakens, leading to psychological and social breakdown. Some notable subtypes include:

- Kleptomania: An overwhelming urge to steal items of little value, where the individual experiences obsessive thoughts and may act despite fear of consequences, often leading to legal problems.
- Pyromania: Similar to kleptomania, individuals have an intense desire to start fires, leading to criminal activity.
- Alcoholism: An uncontrollable urge to consume alcohol.
- Sexual compulsions: Dominated by sexual thoughts that drive the individual to engage in sexual harassment or other criminal behaviour.

Dissociative and conversion disorders

These disorders are characterised by the emergence of unconscious symptoms, often motivated by a desire for attention, personal gain or escape from threatening situations.

- Conversion disorders: In these cases, psychological conflict or anxiety transforms into physical symptoms, such as limb paralysis.
- Dissociative disorders: Individuals may take on multiple personalities or lose their memories as a means of attracting attention or avoiding painful psychological experiences. Examples include amnesia and hysterical deviations, where the

person may engage in unusual behaviour and occasionally harm others, possibly committing crimes during such episodes (Nasha'at, 2005, pp. 149-152).

Psychotic disorders

Psychotic disorders can be divided into functional and organic psychoses:

1. Functional psychosis

Functional psychosis includes conditions such as:

- Schizophrenia: Characterised by disturbances in thought, emotion, perception, volition and behaviour that may lead individuals to commit crimes.
- Affective disorders: These include mania, depression, menopausal depression and bipolar disorder. A depressed person may contemplate suicide or commit homicide in the belief that they are saving themselves. Conversely, a person in a manic state may provoke sexual behaviour or assault.

2. Organic psychosis

Organic psychosis results primarily from brain dysfunction due to disease or injury. It can be classified as:

- Primary organic disorders: Directly related to neurological disease.
- Secondary organic disorders: Associated with systemic diseases that affect the brain.

The influence of mental disorder - both abstract and actual - on criminal responsibility varies according to the type, and a detailed examination of the effects of each type is warranted.

Hysterical conversion disorder

1. Hysterical fits: During episodes of convulsive hysteria, the individual's perception and control may be so impaired that they lose significant consciousness, leading to a lack of criminal responsibility if a crime is committed during the episode. Even outside these episodes, their emotional fragility may require a reduction of responsibility due to diminished self-control.
2. Sensory Loss Hysteria: In cases where a sense loses its function, such as hysterical blindness or pain, the individual's criminal responsibility remains intact because their perception and volition are not fundamentally affected.
3. Simple and walking hysterical sleep episodes: During these episodes, the person lacks consciousness and volition and is therefore not responsible for crimes committed during these episodes.
4. Dissociative personality episodes: In these cases, the individual loses their original identity and is unaware of their actions while in the alternate personality. Therefore, they cannot be held criminally responsible for crimes committed during these episodes.

Secondly: Anxiety Hysteria: The ongoing intrusive thoughts and vivid daydreams experienced by individuals with anxiety hysteria do not affect their perception but rather confuse and weaken their will, which can serve as a basis for reducing their criminal responsibility for any crimes they may commit.

Thirdly: Compulsive Hysteria: Individuals suffering from this condition lose their will without losing awareness. They are unable to resist the overpowering compulsive urge that drives them, leading them to commit crimes under the pressure of that driving force while still understanding the nature of those crimes and their severe consequences. It is unjust to hold someone accountable for an act committed against their will, as criminal responsibility ceases to exist with the loss of will.

Fourthly: Hysteria of Delusional Beliefs: The distorted delusions that dominate individuals with this type of hysteria impair their judgment, causing them to act according to these delusional beliefs that appear to them as factual realities. This condition indicates a partial breakdown of their perception, which necessitates a reduction in criminal responsibility (Nasha'at, 2005).

Fifthly: Hysterical Fears: The effects of hysterical fears are limited to provoking intense emotional reactions of fear towards specific situations or objects that do not warrant such fear. These acute emotional responses can disrupt the individual's judgment and will, justifying a reduction in responsibility if a crime is committed as a result of those fears.

Sixthly: Psychological Anxiety: Acute tension and troubling delusions experienced by the individual, combined with a pessimistic interpretation of transient symptoms and heightened sensitivity, cloud their perception and weaken their will. This may be sufficient to justify a reduction in criminal responsibility for offenses committed amid escalating anxiety.

Seventhly: Psychological Exhaustion: The intense mental strain that dominates a person suffering from psychological exhaustion leads to a false sense of incapacity and fatigue, along with obsessive thoughts that disrupt stability and weaken their ability to control actions. This condition renders them deserving of a reduction in criminal responsibility for crimes committed during such distressing episodes (Nasha'at, 2005, p. 180).

Statistics indicate that up to 90% of prisoners have some form of mental health issues, personality disorders, or substance abuse problems (Graham Durcan, 2016).

8. Limitations of Abnormal Psychology in Criminal Cases

Experts cannot express opinions on any aspect related to court procedures unless their opinions fall within their area of expertise, which is also constrained by legal limitations. One such limitation arises from what is known as the "deciding question," sometimes referred to as the "key issue." This is the question that the court itself must answer, which typically pertains to whether the defendant is guilty in a criminal case. Other related questions may arise, such as whether the defendant or a key witness is lying. However, in all cases, the idea is that trial procedures are designed to answer a specific question, although experts can assist in determining the answer.

Another aspect of legal procedures that affects the testimony a psychologist can provide is the need to avoid what is termed "prejudicial information." This is a barrier that legal experts rarely have to confront. In family court cases and other legal situations where decisions are made solely by specialists, the expert is allowed to express their opinions based directly on their personal expertise. However, they must not stray into comments on the facts or the key decision that the court must render (Kanther, 2014).

The testimony provided by forensic psychologists, as legal experts, is largely derived from individual assessments using clinical interviews and diagnostic tools. This contrasts with the growing application of psychology to study and influence courtroom dynamics, which tends to rely more directly on social psychology rather than clinical psychology and psychological testing.

As is the case in many other fields of psychological applications, the United States holds a leading position in this area. A primary reason for this is that the American legal system is significantly more open to conducting assessments and allows for greater involvement of advocacy lawyers compared to what occurs in the United Kingdom. Specifically, in some states, it is possible to inquire directly about how juries actually make decisions. In contrast, in most countries that employ juries, the process by which juries operate remains confidential, although in France, judges are often present when juries reach decisions to ensure they fulfill their duties correctly. This prevailing confidentiality means that very little is known about how the randomly selected jurors actually handle the evidence presented in trials to arrive at a verdict.

Courts are, of course, aware of the challenges posed by these weak points, and psychologists are trying to find more effective ways for lawyers to interact with juries. This includes analyzing jury instructions to consider the educational levels imposed by these instructions and providing specific verdict models for jurors to complete, as well as flowcharts that can guide juries on how to evaluate the testimony and reach a decision.

Thus, the role played by the psychological expert in court is to provide advice that will assist the jury in reaching their conclusions. In family courts and other legal situations where decisions are made solely by specialists, the expert is allowed to express their opinions based directly on their personal expertise. However, they must not stray into comments on the facts or the key decision that the court must render (Kanther, 2014).

9. Judicial Rules for Determining Criminal Responsibility

It is evident from the above that there has been a historical evolution in defining insanity and its relationship to criminal responsibility. This evolution involves changes in the rules established by legislators and accepted by judges and jurors. This has crystallized in the multiplicity of laws, from the "McNaughton Rule" to the "Durham Rule," and then to the "Brawner Rule." The rules determining mental capacity in relation to criminal responsibility can be summarized as follows:

Understanding Rule:

This rule applies in contract cases, stating that a contract is not considered void due to insanity or mental incapacity if the individual has the ability to understand the nature of the contract they are entering into and the consequences that affect their rights and interests. Courts have differed in their application of this rule; in some cases, the court requires merely "understanding," while others require full understanding, and a third group requires understanding within reasonable limits. In 1941, Green reviewed the applications of this rule and concluded that an implicit standard was often used, which was not explicitly stated. The court would base its decision on a combination of evidence that supported each other, even though any single piece of evidence alone might not be sufficient.

It is clear that this rule faces difficulties due to disagreement over the extent of understanding required—whether it is complete or partial. Furthermore, the phrase "reasonable limits" inevitably leads to variability in judgments due to differences among judges in assessing what constitutes a reasonable limit, which detracts from the objectivity and completeness of this rule and makes it subject to criticism.

The Right and Wrong Rule

An individual is not considered responsible for a crime committed if, at the time of the offense, they are in a mental state that prevents them from knowing that the act they committed is wrong, and if they are in a condition that deprives them of the willpower to resist the impulse to commit the criminal act. The first part of this rule is known as the "Right and Wrong Rule," which serves as a cornerstone in both English and American law. In many U.S. states, it is the sole

rule for determining responsibility. This rule traces back to the "McNaughton Rule," as previously mentioned. The second part of this rule serves as a complement to the previous rule in some states, while representing an important rule in others.

The Irresistible Impulse Rule

This rule is used alongside the previously mentioned Right and Wrong Rule. An individual is not considered criminally responsible for actions taken under an irresistible impulse that they cannot control due to a mental disorder overwhelming their mind, feelings, and judgment. Some doctors support this rule concerning actions taken by individuals with schizophrenia, cyclical psychosis, and obsessive-compulsive disorder. However, most U.S. states have not accepted this rule, arguing that it is difficult to prove and use as a defense, as well as its potential danger to society, where individuals might commit serious offenses and justify them by claiming they were under an irresistible impulse.

The Delusional Belief Rule

Some Western courts have adopted this rule in certain cases. The prevailing practice in courts is that an individual under a delusional belief is considered responsible for the crime they committed unless they are unable to distinguish between right and wrong (Rule 2) concerning the act they performed. In the "McNaughton" case, the defendant was a victim of a false belief and delusions that the Prime Minister was conspiring against him. From this, the rule of "knowing the difference between right and wrong" was derived. However, like the previous rule, this one suffers from rejection by judges due to its ambiguity and the difficulty of proving it—that is, the challenge of verifying that the defendant was suffering from a delusional belief but was not insane (Shahata, 1994).

The penal code stipulates the absence of criminal responsibility due to insanity or mental defect. Article 62 states that there is no punishment for someone who is devoid of awareness or choice regarding their actions at the time of committing the act due to insanity or a mental defect. This provision entails three conditions for the negation of criminal responsibility:

1. Presence of Insanity or Mental Defect: The defendant must be suffering from insanity or a mental defect. The inclusion of "mental defect" appears to broaden the range of pathological cases included in this definition, as there are conditions that involve mental defects but do not constitute insanity, such as mental retardation or certain cases of neurosis and organic psychosis, among other categories that impair the ability to distinguish between right and wrong, or result in a loss of self-control, choice, and will.
2. Resulting in Loss of Awareness or Choice: Insanity negates criminal responsibility due to the resulting loss of awareness or choice regarding actions. Actions lacking will, choice, and freedom of action are not accountable. Will, choice, and freedom of action refer to the mind's ability to contemplate the consequences of actions and to make accurate judgments regarding those consequences, thus leading to either the performance of the act or its avoidance to evade negative outcomes. Consequently, acts performed under the influence of an irresistible impulse resulting from a loss of awareness or inability to judge may mitigate responsibility under certain laws.
3. Legal Precedents for Mitigation: Some legal systems have adopted this principle, as seen in Article 137 of the penal code, which reduces the death penalty to imprisonment in cases where a husband, provoked by the sudden discovery of his wife's infidelity, impulsively commits murder under the influence of rage for his honor. However, this does not negate criminal responsibility nor does it declare the defendant insane.
3. Contemporaneous Loss of Awareness or Choice in Committing the Act: We previously mentioned the fundamental issue in criminal responsibility, which is that insanity (or mental illness and other disorders) must be present at the time of committing the crime, not at the time of trial. The critical point is that the insanity that negates responsibility must be contemporaneous with the commission of the criminal act, not a temporary insanity that may occur afterward. It is well known how difficult it is for judges to determine the issue of the simultaneity between insanity and the occurrence of the crime; therefore, they rely on experts to establish this. Provisions have been introduced in the amended draft law of Law No. 141 of 1944 concerning the detention of individuals with mental illnesses. The third chapter of the mentioned amendment is dedicated to the examination and treatment of defendants suffering from mental illnesses and those suspected of such conditions who are placed under the authority of the judiciary. Article 21 states that the rules stipulated in this law do not apply to defendants in criminal cases who have mental disabilities or whose mental conditions are suspected, and who are detained in places designated for the custody and treatment of individuals with mental illnesses by order of judicial authorities, except as they pertain to their treatment and care within the designated hospitals. The rules specified in the Criminal Procedure Law apply concerning their detention, custody, and release. Article 22 states that "defendants shall be examined by a three-member committee formed by the director of the hospital in which the individual requiring examination is detained, consisting of specialists in psychiatry, one of whom does not work in the mentioned hospital, and none of whom shall be related to the hospital director by blood or marriage to the third degree" (Shahata, 1994).

10. Mistakes made by the psychologist in the evaluation of psychological experiences:
Psychologists or therapists often fall into numerous errors when assessing experiences related to emotional states, especially when they are new to practice. These errors include
- Haste in refutation or implementation:
One of the biggest mistakes a psychologist can make is to assume that an event or past experience is accurate and not the result of a distorted perception of reality. The psychologist must resist the urge to jump to disproof, especially in the early stages of their career. One of the biggest mistakes a therapist can make is to play down external or organic factors presented by the patient. Family conflicts, living with an aggressively controlling spouse, a critical mother, the use of mood-altering medication or the presence of a chronic illness may all be valid realities and not entirely the result of perceptual distortions. The clinician must therefore be wary of jumping to conclusions and being pressured to disprove them, as they may discover that the patient needs medical, social or family assessment rather than psychological treatment. In such situations, the patient may need, at the very least, collaboration with a treatment team or referral for further medical assessment or to a social worker or legal adviser, depending on the source of the complaint.
- Failure to prolong the process of exploring and delving into details of past events and experiences:
If the psychologist or therapist allows the patient to dwell excessively on past experiences, this may delay their therapeutic interventions and skills, which they are supposed to be well trained in. Consequently, this could affect their credibility as a competent psychologist or therapist.
- Jump between different theoretical frameworks:
Each theory has its own therapeutic methods and perspectives on the interpretation of mental disorders and the diagnostic techniques used by the psychologist. Perhaps the worst aspect of this is the jumping between different theoretical frameworks, which prolongs the treatment process and prevents the psychologist from forming a coherent understanding of their patient.
The psychologist must be honest and sincere with the patient:
In many cases, a patient may have a preference for certain therapeutic approaches over others (for example, a preference for medication over psychotherapy). In such situations, the psychologist must be honest and sincere and help the patient connect with specialists in their preferred field. (Shinaz, 2016)
- Avoid encouraging the patient to discuss multiple issues at the same time:
The psychologist should not encourage the patient to talk about more than one issue or source of a problem at the same time. Therefore, the focus should be on a specific cause or central issue that both the psychologist and the patient agree on, in the hope that the psychologist will allow additional time to discuss other issues. Often concentrating on a single problem allows other aspects or issues to be addressed indirectly.
- Encourage the patient to avoid confusing formulations of experiences:
The psychologist or therapist should help the patient to articulate experiences with precision and to avoid generalisations. For example, if a patient states that their spouse behaves in a foolish or negative way, the psychologist should help them to identify the specific behavioural aspects associated with this description and encourage them to provide examples of worrying or disturbing behaviour rather than accepting vague and confused formulations. Examples of vague statements are “I suffer from loneliness”, “My life is chaotic”, “No one loves me”, “I can’t stand this life”, etc. However, it is acceptable to articulate specific statements such as:
- Lack of parental support.
- The departure of a friend.
- Academic failure.
- Illness or death of a family member.
- Involvement in social or legal problems.
- Family conflicts.
(Shinaz, 2016, pp. 14-18)

11. The role of the psychiatrist in legislation and in the management of prisons:
The vast majority of people with mental illness lack insight into the reality of their condition; they do not feel or acknowledge that they are ill and in need of treatment. As a result, they see no reason for their admission to a psychiatric hospital and often refuse to go there, or even to a private clinic. However, in the interests of the patients themselves, their families and society as a whole, early diagnosis and treatment are needed whenever possible to reduce the likelihood of dependency and adverse outcomes for these patients. Many cases require inpatient treatment for a variety of reasons, including the inappropriateness of the social environment or its opposition to outpatient treatment, and the need to protect patients from potential harm to themselves or others.
In such cases, it becomes essential to admit patients to hospital on an involuntary basis. This involuntary admission, on the other hand, implies a restriction of the personal freedom guaranteed to all citizens by the Constitution and the laws governing life in society. There has long been an urgent need in all countries of the world to enact the necessary

legislation to regulate this restriction of personal freedom, ensuring that it does not deviate from its original purpose, which is the welfare of the patient and the safety of society.
Since the laws and regulations enacted in this regard contain technical aspects relating to the examination, involuntary admission, treatment and discharge of patients, as well as the facilities in which they should be treated, it is essential that psychiatric experts be consulted to prepare and present their recommendations and proposals on these matters. Their opinions should then be taken into account after they have been formulated and before they are ratified by the legislative authorities. This was evident in the formation of committees to study the drafting and amendment of Law 141 of 144 AH on the involuntary admission of persons with mental illness, as well as in the various contributions made by psychologists, psychiatrists, sociologists and others in the amendment of the provisions of Law 182 of 1960 on the control and regulation of drugs, which recently came into force under Law 122 of 1989.
The results of a study by Ann-Marie Bright, Agnes Higgins and Annmarie Grealish (20-21) indicate the need for greater support for mental health, including the need to improve communication between women and prison staff to promote positive mental health.

12. The psychiatrist's role in examination and diagnosis and in determining criminal responsibility

Assessment and diagnosis is one of the main tasks assigned to psychiatrists by the judicial authorities, and it is a challenging and complex responsibility. Typically, they are asked to determine not whether the defendant is currently disturbed, but whether they were disturbed at the time of the offence, which may have been some time ago. To make matters worse, they are expected to give a definitive answer (yes or no) that will affect the individual's fate.
The legislation has organised the way, method and purpose of consulting psychiatrists as experts, but many have criticised the process of examination and diagnosis, and its theoretical, methodological and practical implications. In response to some of these criticisms, mental health experts have sought to improve the psychometric properties of the interview-derived data that underpin many forensic assessments, and to address sources of error and disagreement among mental health professionals. These issues include:
(a) Individual differences among professionals in their ability to select appropriate information, recognise appropriate cues, and assign appropriate weights to these cues.
(b) Differences between professionals in behavioural cues or referrals for forms of mental disorder classification.
(c) Differences in diagnostic criteria used to determine the most accurate diagnostic categories.
It is noteworthy that with the explicit adoption of the third edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association (DSM-III), diagnostic agreement on major categories has increased significantly, especially when these criteria are combined with the selection of semi-structured diagnostic methods such as the diagnostic interview, the schizophrenia and mood disorder checklist, and the current state examination. (Shahata, 1994)
Rogers attempted to contribute to the assessment of insanity through a set of measures called the Rogers Criminal Responsibility Assessment Scale. These measures were designed to translate the legal concept of insanity into a set of quantifiable variables consistent with accepted scientific standards. The expert is required to assess the defendant on 25 measures divided into five domains:
1. Stability of reports
2. Presence of organic impairment
3. Psychopathology
4. Cognitive control
5. Behavioural control
In addition to these assessments, the specialist makes further assessments as to whether the controllable behaviour (both cognitive and behavioural) is due to organic or psychological conditions, and a general assessment of 'insanity' as defined by the law.
Rogers and colleagues have shown that the reliability of these five categories is acceptably high and that there is a strong consensus on the final assessment, i.e. the determination of insanity.
Undoubtedly, linking organic or mental disorders to the potential for ethical control in terms of a quantitative scale is a step forward. However, challenges remain in cases that fall into grey areas - those that are unclear or clinically ambiguous.
In 1984, Slobogin, Melton and Showalter attempted to present a strategy for improving the examination and assessment of insanity. The Institute of Law at the University of Virginia, specifically the Department of Psychiatry and Public Policy, sought to provide better training for criminal justice professionals and developed a method to make the examination of the mental state at the time of the criminal act more legally sound. This method differs fundamentally from structured clinical interviews in that it was designed as an assessment approach heavily influenced by legal and psychopathic standards within a legal context. This is referred to as the Mental State of Offender (MSO).
The data available to date on the MSO approach indicate its effectiveness as a screening and classification tool, particularly in isolating defendants who do not fall within the insanity mechanism.

This classification method is divided into several stages:
(a) The clinical-legal examination of the previous case.
(b) Exploration.
(c) Detailed examination of current mental state.
(d) Detailed examination of the mental state at the time of the offence.
(e) Co-ordination with other data sources.
(f) Extraction or final stage.
(Shahata, 1994)

The following is a brief explanation of these stages:
(a) The beginning:
The beginning involves establishing a rapport with the accused and providing a clear explanation of the role of the specialist, highlighting the reason for the examination and evaluation, the entity to which the report will be sent, and the limits imposed on the confidentiality of the information. Since confidentiality rules vary widely from one jurisdiction to another and are heavily influenced by the specifics and circumstances of each case, the auditor should act formally and be aware of these limits as part of his or her professional competence.
(b) Exploration:
This phase consists of a focused and purposeful review of the defendant's history, focusing on the defendant's life history in terms of disorders, types of treatment received, and fluctuations in mental status. Of particular importance at this stage are previous episodes, including the presence or absence of criminal offences, previous competency assessments, civil commitment and other circumstances. Other important factors include the pattern of mental disorder and its relationship to pharmacological and psychological treatment, medical conditions, situational stressors, substance abuse, etc.
(c) Detailed investigation of the current mental state and the mental state at the time of the offence:
It is difficult to separate the two conditions, as a severely disturbed defendant may have undergone rapid medical treatment. It is therefore advisable to use structured and semi-structured interviews to comprehensively and convincingly cover the pathological aspects and to demonstrate consistency between examiners in testing and coding information. Psychological tests can also be used, as Andreasen's studies of thought disorders and Bellak, Hurvich and Gediman's methods of assessing ego functioning, together with Pfohl, Stangl and Zimmerman's efforts to uncover personality disorders, are very useful in this regard.
The detailed examination of the mental state at the time of the offence should focus on the relationship between psychological pathological elements and the offence committed by the defendant. The defendant should be asked to reconstruct his or her thoughts, perceptions, experiences, attitudes and behaviour during the examination and at the time of the offence. The process of retrospective assessment is challenging for non-specialists such as judges and jurors. Therefore, mental health experts should take great care to obtain detailed information about the defendant, covering all aspects of his or her life, while avoiding errors that may arise from the confusion that may affect the defendant's memory during recall. (Shahata, 1994)

13. A model for the clinical examination of the psychological state (of the offender):
This model is commonly used by many psychiatrists in various hospitals and clinics for patients, whether they are accused of crimes or not:
- Demographic data: This includes name, age, marital status, current or former occupation, and address.
- Complaint: This can be obtained from the patient, a relative or other source if the patient is a minor or incapable of understanding their condition.
- Medical history: The evolution of symptoms and signs since the onset of the illness should be detailed, with a chronological timeline, including different stages of treatment.
- Family history:
  - Father: Age, occupation, personality, relationship to children, whether deceased or alive, causes and circumstances of death (if applicable), history of mental illness, etc.
  - Mother: A detailed study of her life, similar to that of the father.
  - Siblings: Number, relationships between them, occupations, social status and medical history.
- Social situation of the family:
  - Housing situation, degree of crowding, adequacy of conditions, financial resources, relationship between parents, influence of the general environment, divorce, polygamy, etc.
- Diseases in the family:
  Inquiry should be made about any neuroses, psychoses, neurological disorders, addictions, epilepsy or personality disorders among family members. Careful and sensitive questioning about these conditions is essential to avoid causing the patient to doubt his or her mental capacity or to avoid misrepresentation.

- Personal history:
  - (a) Place of birth, mother's condition during pregnancy, type and complications of delivery, use of drugs and medication during pregnancy, type of feeding, child's developmental milestones (e.g. smiling, sitting, walking, teething, beginning to speak, toilet training and interest in cleanliness).
  - (b) Neurotic symptoms in childhood such as night terrors, sleepwalking, emotional state, bedwetting, thumb sucking, nail biting, stuttering and motor rituals, or a child who is overly obedient, idealistic and withdrawn.
  - (c) The child's physical health, infectious diseases such as fever, seizures, diarrhoea, respiratory diseases, etc.
  - (d) Educational history: Age at school entry, academic performance, educational level attained, reasons for leaving school, hobbies and relationships with peers at school or university.
  - (e) Employment: Age at start of employment, types of jobs and reasons for changing or leaving, job satisfaction, career aspirations, financial status and relationships with colleagues.
  - (f) Sexual history: Age of puberty or onset of menstruation and related pain, information and sexual education, experience of masturbation and related feelings of guilt, other sexual activities, relationships with the opposite sex and their success, other sexual experiences, taking into account social and cultural contexts when discussing sexual matters. It is acceptable to defer discussion of sensitive topics to later sessions to avoid discomfort.
  - (g) Marriage: Duration, premarital courtship, length of engagement, age of husband and wife, emotional and sexual compatibility, frequency of intercourse, level of satisfaction, sexual dysfunction, number of living children, deaths and causes of death.
  - (h) Habits: Smoking, use of medication or drugs, or use of alcohol.
- Medical history: Any previous physical or mental illnesses and their treatment.
- Personality before the illness: Social relationships with friends and at work, intellectual activities, hobbies, preferred types of books, films and plays, mood, optimism and pessimism, anxiety, emotional instability, jealousy, suspicion, selfishness, stubbornness, rigidity, shyness, etc. Values and ethical/religious standards, daydreaming, eating and sleeping habits. A sudden or significant change in personality may indicate the presence of a disorder.

Physical examination:

This includes the different systems of the body: the nervous system, the digestive system, the chest, the heart, etc.

Psychological and mental examination:

- (a) Behaviour: Description of behaviour, self-neglect, shyness, anxiety, agitation, depression, involuntary movements, relationships with other patients and medical staff, stubbornness, etc.
- (b) Speech: whether the patient talks little or a lot, gives short answers or talks continuously, coherence of speech or jumping from one topic to another, speed or slowness of speech.
- (c) Mood: whether the mood is anxious, depressed, cheerful, flat, frozen or inappropriate.
- (d) Thinking: Content, expression, flow of thoughts, control of thoughts, ability to describe symptoms, organisation and coordination of thoughts, ability to think abstractly, to think in fragments or coherently, to broadcast or share thoughts.
- (e) Delusions: False beliefs, such as persecutory, grandiose or somatic delusions.
- (f) Hallucinations and illusions: Visual, auditory or sensory perceptions in the absence of external stimuli.
- (g) Obsessions: Thoughts, images, urges, fears, and motor rituals that the patient recognises as trivial but tries unsuccessfully to resist.
- h) Orientation: Awareness of time, place and people.
- (i) Memory: Concerning recent events indicating possible organic brain disease, as well as distant events and auditory or visual memory.
- (j) Intelligence: A general estimate of intelligence may be approximated by clinical case study.
- (k) Attention and concentration: In particular, issues such as distractibility and daydreaming.
- (l) Insight: The patient's awareness of their illness and willingness to seek treatment, or belief that they are not ill.

It is noteworthy that section nine (psychological and mental examination) contains elements common to both psychiatrists and clinical psychologists, although each uses their own methods to assess these aspects. After the examination, the information and data obtained by both parties should be cross-checked for greater accuracy and consistency, leading to reliance on this information in the diagnostic process. The psychological methods for assessing these functions were discussed in a previous chapter.

Data matching and extraction:

In this context, it is important to note that the role of the expert (psychiatrist) is not to provide legal conclusions (guilty or not guilty) or official and definitive psychological diagnoses (e.g., schizophrenia or organic psychosis), but rather to confirm scientific knowledge about the existence of certain mental disorders and the resulting disturbances or impairments in behavioural, cognitive and judgmental capacities. At this final stage, the psychiatrist should be prepared to make a kind of synthesis of the available information and to reassure all parties involved (defendant, defence, judges) of the usefulness of the examination process, allowing each of them to provide additional information or raise clarifying

questions. Disagreements among experts should not distort the psychological examination process, and efforts should be made to resolve disputes regarding grey areas, thereby assisting the relevant authorities in making informed decisions.
(Shahata, 1994)

14. Predicting outcomes:

The law allows for two methods of admitting or committing mentally ill patients to hospitals. The first is involuntary admission, whereby any relative of the patient, a carer, the police or the attending physician can admit the patient to hospital if there is a desire for treatment or if it is believed that the patient is a danger to public safety or individuals.

A person suffering from a mental illness may not be detained unless the illness threatens public safety or order and there is concern for the safety of the patient or others in accordance with legal provisions.

The second type of commitment is by court order. This applies to accused persons who have one of the following conditions

- They are a danger to themselves or others.
- They are likely to harm themselves or others.
- They are unable to meet their basic needs.
- They lack the capacity to make responsible decisions about their stay in hospital.
- They require care and treatment in hospital.

Danger is the primary, and perhaps the only, basis for involuntary admission to hospital. If the court suspects that a person has a mental illness, it will require a psychiatric examination to assess the level of danger.

The concept of dangerousness is ambiguous and raises several issues. Defining danger as imminent or imminent has improved the situation, but some problems remain. Danger includes emotional, cognitive and economic harm as well as physical harm. But what about property damage? What level, severity or frequency of harm is sufficient to persuade the police to intervene? Some experts have attempted to mitigate the problems arising from such questions by limiting the danger to acts that cause physical harm to self or others. However, many courts do not typically accept this limitation, leaving variability from place to place.

There is a belief among people that all mentally ill patients are dangerous, while the American Psychiatric Association estimates that only about 10% of patients are actually dangerous. In Arizona, for example, a 19-year-old woman was hospitalised for being dangerous and remained there for 59 years, even though her main symptoms on admission were laughing, singing and wanting to talk to someone.

The problem does not seem to be one of agreeing on a definition of dangerousness; finding such a definition may only solve part of the problem. The real need that needs to be addressed is the accuracy of predicting danger.

Psychiatrists and other mental health professionals have certain tools on which they rely to assess risk, and they are better equipped to do so than untrained or unqualified individuals. However, they face significant challenges, including exaggerated expectations from the public, judges and the justice system, and scepticism from law enforcement about their ability to make these assessments.

The Tarasoff case reignited the debate in 1967. A psychologist at the University of California Mental Health Clinic assessed a patient as dangerous, specifically stating “he intends to kill a woman”, and reported this to the police, requesting that the patient be transferred for further examination. The police visited the patient’s home, spoke to him and found that there was no problem, so he was released. The patient then killed the woman, Tatiana Tarasoff, the very psychologist who had assessed him.

This incident shows that mental health professionals did not fail to identify the danger and fulfilled their responsibility by informing the police to take appropriate action. The intention was not to detain the patient, but to carry out further assessment to resolve the issue of danger. However, the police acted on the basis of their own assessment rather than the psychiatric assessment, possibly because of a lack of clarity in law enforcement about the meaning of dangerousness or a lack of confidence in the assessments of mental health professionals. Tragedy eventually struck.

The California court affirmed the clinic’s role in warning the intended victim of the danger and held it responsible for that duty. This opened the door for judges to have inflated expectations of psychiatrists and to impose liability on them. As a result, the task of accurately predicting danger went from being a very difficult responsibility to one that was almost impossible.

In response, mental health professionals have clarified their capabilities and limitations in assessing risk, stating that these are not certain assessments and outlining the difficulties they face in doing so. For example, US states differ on the extent of “expert responsibility for dangerousness, whether general or specific”.

A related issue is predicting the likelihood of aggressive behaviour, which is undoubtedly part of the previous task. Monahan identified eight demographic variables that are typically considered indicators of aggression:

- Being male.
- Being of low socio-economic status.
- Belonging to a minority group.

- Having a low intellectual level.
- Having an unstable educational or employment history.
- A history of alcohol or drug abuse.
- Being young or adolescent (especially between the ages of 30 and 35).
- Having a low level of education.

Other studies have added additional variables, including a history of violent behaviour, previous suicide attempts, a history of domestic violence, antisocial personality traits, cruelty to animals, recent stress exposure, especially when associated with low serotonin levels. In cases of aggression towards other residents, this is particularly associated with hallucinations, emotional instability and a high level of activity. In addition, data from psychological tests can help experts make predictions with greater accuracy than anecdotal data.

If someone manages to escape death, they will be prosecuted and punished. If the investigating authorities suspect that the person has a serious mental illness, they refer the case to experts to determine their mental fitness and establish criminal responsibility. If the patient remains depressed, they may attempt suicide repeatedly, and in such cases it is essential to predict the persistence or cessation of suicidal ideation and the associated risk to themselves or others.

In summary, one of the critical roles of the psychiatrist in the criminal domain is to predict the level of danger that the defendant or patient poses to themselves and others. This is a challenging and difficult task and requires the development of additional criteria on which experts can base their risk assessments.

15. The psychiatrist's role in treatment:

When a psychiatrist is called upon to give expert testimony in determining the extent of a person's responsibility for an act committed, or the absence of such responsibility due to the defendant's mental illness or cognitive impairment, the situation results in a recommendation to the judicial authority, followed by several possible outcomes:

- The law takes its natural course (i.e. the imposition of a sentence).
- The defendant is released with or without conditions, with a recommendation for psychiatric treatment.
- The defendant is released under supervision, with a psychiatrist assigned to monitor the patient's condition, either in an inpatient or outpatient setting.
- Offenders under the age of majority are placed in care facilities.

In the last four cases, the role of the psychiatrist is extended to provide therapeutic services to these patients.

The treatments offered by psychiatrists vary widely, ranging from pharmacotherapy (chemical treatment) to electroconvulsive therapy (ECT). In some special cases, they may use surgical interventions or participate in certain types of psychotherapy.

If the alternative outcome is a court decision that finds the accused guilty and responsible for the criminal acts committed, resulting in a sentence of imprisonment, this means that the accused will serve their sentence in prison. It is often the case that some convicted persons, or those awaiting trial, experience psychological and mental disorders that require the intervention of psychiatrists for treatment. Studies have shown that between 20% and 40% of prisoners are mentally disturbed (2% with psychosis, 11% with substance abuse problems and 14% with mental retardation). Their suicide rate is three times higher than that of the general population. Therefore, the therapeutic role of psychiatrists may extend beyond hospitals and health care institutions to correctional facilities. (Shahata, 1994)

Psychological programmes implemented in the legal field play a role in cognitive restructuring (correction of faulty thought patterns) of offenders, which involves psychological intervention in criminal cases. (Fitri Yani et al., 2021)

Conclusion:

In conclusion, specialists, including psychiatrists and lawyers, agree that there are two categories of human beings: the sane and the insane (mentally ill). Those in the first category are responsible for their actions, while those in the second category are not. Based on this distinction, criminal proceedings are conducted with special considerations.

Perhaps the most important aspect is the psychological examination of the accused before the trial and during the investigation in order to determine their psychological suitability for prosecution. The psychological dimension is given its due attention and effective time, which we call psychological expertise.

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