The Defense Rests: Attorney Recognition of Symptoms of Brain Injury

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Abstract
Traumatic brain injury (TBI) has received increased attention in the practice of law. However, information regarding whether or not attorneys recognize symptoms of brain injury is extremely limited. In this study, attorneys responded to an Internet-based questionnaire regarding symptoms that would cause them to refer defendants for an evaluation of competency to stand trial as well as their confidence in recognizing various mental health disorders. Results indicated that many attorneys were not confident in recognizing psychotic disorders, brain injury, or cognitive disorders. The primary causes of referral were delusions, hallucinations, disorientation, and flight of ideas. Results also indicated that psychotic symptoms were significantly more likely to be the basis for a referral than were TBI symptoms.

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THE DEFENSE RESTS:
ATTORNEY RECOGNITION OF SYMPTOMS OF BRAIN INJURY

A THESIS

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY

HILLSBORO, OREGON

BY

ALISA NIEHUSER

IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE

OF

MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY

JULY 24, 2009

APPROVED: _______________________________

Genevieve L. Y. Arnaut, Psy.D., Ph.D.
ABSTRACT

Traumatic brain injury (TBI) has received increased attention in the practice of law. However, information regarding whether or not attorneys recognize symptoms of brain injury is extremely limited. In this study, attorneys responded to an Internet-based questionnaire regarding symptoms that would cause them to refer defendants for an evaluation of competency to stand trial as well as their confidence in recognizing various mental health disorders. Results indicated that many attorneys were not confident in recognizing psychotic disorders, brain injury, or cognitive disorders. The primary causes of referral were delusions, hallucinations, disorientation, and flight of ideas. Results also indicated that psychotic symptoms were significantly more likely to be the basis for a referral than were TBI symptoms.

Traumatic Brain Injury, Attorneys, Competency to Stand Trial
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INTRODUCTION

A traumatic brain injury (TBI) is defined by the Center for Disease Control as a blow or jolt to the head or a penetrating head injury that disrupts brain function (Center for Disease Control [CDC], 1999). The severity of TBI ranges from mild to traumatic. Although there is some disagreement about these definitions, mild TBI is often referred to as a brief change in consciousness, whereas traumatic TBI is a long period of unconsciousness often resulting in amnesia (CDC, 1999). TBI can result in various short- and long-term difficulties, including behavioral and emotional regulation problems. For example, TBI can result in irritability or aggressiveness, including explosive outbursts that can be set off by minimal provocation or occur without warning (Silver, Yudofsky, & Anderson, 2005).

According to the Brain Injury Association of America website (Brain Injury Association of America [BIAA], 2008), recent data show that, on average, approximately 1.4 million people sustain a TBI annually in the United States. The number of people with TBI who do not receive treatment is unknown. Furthermore, the number of people with TBI who are involved in the legal system in some way is also unknown. For individuals with TBI who are involved in the legal system, the question of competency may become important. Competency refers to multiple underlying constructs of mental or cognitive abilities required for a legal proceeding or venue; these constructs include abilities and skills such as IQ, memory, attention, problem-solving abilities or reasoning, and reading and verbal comprehension (Melton, Petrila, Poythress, &
Slobogin, 2007). Different constructs of competencies may be associated with specific legal issues or venues, such as agreeing to treatment, entering a plea in a case, making a confession, making a will or entering into a contractual agreement, being executed, and standing trial. The foundational standard of competency was established by the Supreme Court in 1960 (Dusky v. United States, 1960) as follows: “…whether he [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and “whether he has rational as well as factual understanding of the proceedings against him” (p. 402).

The standard for raising the question of competency to stand trial is somewhat liberal (Grisso, 2003). Most states have adopted the Dusky Standard; however, some states have required additional determinates (Grisso, 2003). Competency to stand trial is the most frequently raised competency issue (Grisso, 2003; Melton et al., 2007). Therefore, the construct of competency to stand trial will be the only competency discussed in this paper.

Generally, an individual’s competency is assumed to be intact unless the defense provides evidence to the contrary (Reid-Proctor, Galin, & Cummings, 2001). Thus, it is up to attorneys to be aware of both legal standards of competency as well as signs that a client may not be competent. Currently, no research is available to indicate whether attorneys are able to identify signs of TBI that may impair a client’s competency. Although mental state defenses (in which mental disease or defect is believed to have contributed to the defendant’s alleged criminal behavior) are beyond the scope of this study, it should also be noted that this subpopulation of defendants could potentially benefit from a mental state defense that is being ignored or missed by their attorneys.
Consequently, some defendants with TBI may be serving prison or jail time that they might not otherwise serve.

The purpose of this study was to assess attorneys’ knowledge of TBI symptoms and their likelihood of referring a client for a competency evaluation based on symptoms of TBI. As noted above, the focus was on competency to stand trial, but it is important to keep in mind that the research is equally limited in terms of using TBI as a basis for a mental state defense.
REVIEW OF THE LITERATURE

The following section includes an overview of the estimated prevalence, risk characteristics, and symptoms of TBI; information about the TBI defendant in the legal system; and a review of previous research on TBI and CST. Although many authors have focused on the competency of criminal defendants, few have addressed the specific issue of CST from the perspective of the attorneys’ reasoning. Because the issue of competency is often raised by the defense attorney based on his or her perception of the client’s abilities and mental well-being, it is important to understand how attorneys decide whether or not to raise the issue.

Prevalence, Risk Characteristics, and Symptoms of TBI

According to Silver et al. (2005), the average rate of fatal and nonfatal brain injuries in the United States is 150 per 100,000 population per year. Nonfatal estimates for the United States are lower, ranging from 1.5 million head injuries per year to 5 million Americans living with TBI-related disabilities. However, these estimates may include self-reported injuries and often vary in terms of the definition of a brain injury. Additionally, it is unknown how many cases of injury go unreported, especially in cases of injury without loss of consciousness.

Some individuals are at higher risk for brain injury than others. As Silver et al. (2005) noted, “All studies of brain injury occurrence in the United States show that people ages 15-25 years are at the highest risk” (p. 8). Other characteristics of high-risk individuals identified by Silver et al. include gender (males are at higher risk than
females), ethnicity (non-White individuals are at higher risk than White individuals), and age (individuals aged 15-24 years and those older than 64 are at higher risk than individuals in other age groups). Blood alcohol concentration (BAC) was also found to be positively correlated with TBI. Additionally, low socioeconomic status has been associated with increased likelihood of TBI, as have lower levels of education and having fewer resources for prevention. Mode of frequent transportation also affects one’s chance of brain injury, with travel in motor vehicles being associated with increased likelihood of TBI. Finally, individuals who have sustained one TBI are at greater risk for future TBI.

TBI has been referred to as a “hidden” or “invisible injury” (Silver et al., 2005, p. 59) because the effects of TBI are not always obvious or physically visible. Furthermore, individuals with TBI are often unaware of the deficits or problems that have occurred as a result of the injury (Lippert-Grüner, Kuchta, Hellmich, & Klug, 2006). The signs and severity of symptoms of TBI can vary, depending on the severity and location of damage. However, some common signs and symptoms of TBI include the following (BIAA, 2008; CDC, 1999):

- headache or neck pain that does not go away
- difficulty remembering, concentrating, or making decisions
- slowness in thinking, speaking, acting, or reading
- getting lost or easily confused
- feeling tired all the time and having no energy or motivation
- mood changes (e.g., feeling sad or angry for no reason)
- changes in sleep patterns (e.g., sleeping more frequently or having difficulty sleeping)
- light-headedness
- dizziness, or loss of balance
- nausea
- increased sensitivity to lights, sounds, or distractions
- blurred vision or eyes that tire easily
- loss of sense of smell or taste
- ringing in the ears

Individuals with brain injury may experience or show one or more of these symptoms, in a variety of combinations. Thus, every TBI client will likely present with a relatively unique set of concerns, which may make attorney recognition of these signs more complicated.

The TBI Defendant in the Legal System

The Sixth Amendment guarantees two rights to those being tried in the justice system: the right to the presence of counsel and the right to effective assistance of counsel (Melton et al., 2007). The practical definition of “effective” is vague and arguable; however, related to the current investigation, it seems logical that if clients with TBI are not identified as such yet their injury causes a deficit in their legal capacities, there may be cause to argue for ineffective counsel. Conversely, recognition of potential impairment may lead to different sentencing, retribution, or restoration to competency.

One reason TBI is an important diagnosis for lawyers to be aware of is that, as Simon (2005) noted, there is evidence that a history of brain injury is often present among criminal defendants. Unfortunately, Simon did not report the source of this information, and little additional research is available about the prevalence of brain injury
and accompanying impairment in criminal defendants. In one of the few relevant studies available, Lewis, Pincus, Feldman, Jackson, and Bard (1986) found evidence of brain injury and neurological impairment in 15 condemned death row inmates who were examined for purposes of execution. Of the 15 subjects (13 men and 2 women), all had histories of severe head injury, 5 had major neurological impairment (e.g., seizures, paralysis, cortical atrophy, dizziness, and psychomotor epileptic symptoms), 7 others had less severe neurological problem (e.g., blackouts), and 3 subjects were episodically psychotic (loose illogical thought processes, delusions, and hallucinations). The authors concluded that many condemned individuals probably suffer unrecognized severe psychiatric, neurological, and cognitive disorders relevant to considerations of mitigation. Even this limited amount of research suggests that criminal defendants need lawyers who are competent in identifying and dealing with multiple clinical issues as well as legal issues in defendants with TBI.

Keeping in mind that competency is a legal term and is not governed by psychiatric or medical diagnosis, neither the presence of TBI nor the severity of symptoms alone directly affects a defendant’s competence. As defined in the landmark case of Dusky v. United States (1960), the competency of a defendant should be assessed in terms of “whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and “whether he has rational as well as factual understanding of the proceedings against him” (p. 402). However, if there is impairment in these abilities, statutes do require that the underlying cause be a mental disease or defect in order for a defendant to be found incompetent (Grisso, 2003). Thus, diagnoses are an important part of determining not only competency, but also treatment...
needed to resort competency, as well as the nature of a defendant’s care while serving
time in the justice system.

In the case of TBI, the symptoms discussed above may impair a defendant’s
competency in several ways. For example, cognitive symptoms may impair a defendant’s
ability to participate in the defense. More specifically, posttraumatic amnesia may
interfere with the ability to recall events, facts, and appointments. Disorganization,
distractibility, and forgetfulness may slow the judicial process. Disinhibition, mood
changes, and lack of expressed emotion may affect attorneys’ as well as jurors’
perceptions of defendants and their remorse or lack thereof. Because of such potential for
difficulties in terms of participating in the defense and the increased presence of TBI
among criminal defendants, Silver et al. (2005) recommended that the possibility of TBI
be thoroughly investigated in criminal defendants.

Competencies are dynamic and therefore must be assessed continually throughout
the judicial process. Such continued assessment is particularly important in defendants
with TBI; as noted by Simon (2005), “in TBI patients, fluctuations in mental capacity are
common, particularly in the days and even months after injury” (p. 584). Therefore,
knowledge of a defendant’s impairments resulting from TBI as well as the time of injury
could potentially impact the attorney’s perception of the defendant’s capacities.

An increasing number of personal injury lawyers specialize in civil litigation for TBI
issues. This subdiscipline is referred to as “neuro-law” (Hornstein, 2005, p. 578). Law
periodicals annually publish many articles about plaintiffs in civil cases with TBI. In fact,
the BIAA posts a directory on-line for lawyers who specialize in such cases. What is
lacking in this subspecialty is literature on recognizing signs of head injury based on
client presentation and linking these signs to issues related to criminal defense. Instead, the majority of the literature addresses worker compensation cases in which an individual has an established injury around which the case revolves.

Previous Research on CST and TBI

There is an incumbent responsibility on the legal system to prosecute only defendants who are competent and to refer for further evaluation those who may not be fit. Defendants must depend on legal officials such as judges and attorneys to initiate CST evaluations when they are appropriate. However, little guidance is available in the literature on this topic. Prior to the 1970s, few studies on CST could be found in the psychological literature. Although the numbers have grown, even fewer studies can be found that simultaneously address both CST and TBI. A recent PsycINFO search using several keywords (Brain Injury and Attorney, Brain Injury and CST, Brain Injury and Criminal Law, Brain Damage and Litigation, Brain Damage and Attorneys) yielded some articles specifically focused on TBI, some focused solely on CST, but none relating to both TBI and CST, with the exception of a few articles on how to litigate in cases in which a client with TBI is seeking compensation for injuries. Similar results were found in searches of other databases, including Criminal Justice Periodicals, Social Service Abstracts, and Medline. Such results from PsycINFO, which provides worldwide coverage of references within psychology and related disciplines, reveal a significant need for expansion in the study of TBI and its relationship to CST.

Looking first at CST, early researchers who explored attorneys’ perceptions of clients’ CST referenced attorneys’ familiarity with legal criteria upon which competency motions are generally based (Rosenberg & McGarry, 1972). Previous researchers have
also collected data in attempts to define differences between groups of defendants who were referred for CST evaluations compared with those who were not (Roesh & Golding, 1980; Rosenberg & McGarry, 1972). The focus of these studies is not directly related to attorneys’ perceptions of their client’s capacities based on client presentation and therefore, although they will be discussed here, they will not be reviewed in detail.

Berman and Osborne (1987) found no published studies in which researchers had directly evaluated the process by which attorneys decided which clients were appropriate for CST referrals. Berman and Osborne looked at variables that distinguished criminal defendants who were referred for CST evaluations from those who were not. Their study consisted of two groups of participants: defendants who were referred for CST evaluations (referred group) and defendants were not referred for evaluation (nonreferred group). Private defense attorneys and public defenders rated six clients based on demographic, behaviors, and certainty of incompetency. The results indicated no significant group difference for either age or race. However, results did indicate a significant difference between the defendants charged with a violent crime as compared to those with nonviolent crimes; the latter were more often found in the nonreferred group than the referred group. Behavioral descriptors for referred and nonreferred groups were analyzed using analysis of variance. Scales endorsed more frequently for the referred group of defendants were the following: “inappropriate behavior and mannerism, cognitive and perceptual disorganization, alternate legal strategies, self-destructive behavior, affective state, and substance abuse” (Berman & Osborne, 1987, p. 377). The only behavioral descriptor that correlated with certainty of the defendants’ incompetence was disorganized speech.
Hoge, Bonnie, Poythress, and Monahan (1992) utilized a structured interview to explore public defenders’ perceptions of their clients’ competency and participation in decision making. It should be noted the focus of interest was not on whether the client met the legal definition of incompetence, but rather attorneys’ perceptions of a defendant’s assistance in the defense effort, participation in the case, contribution to developmental or factual information, and participation in decision making. Of 122 randomly selected, non-dismissed felony cases, cases were identified for inclusion based on the basis of a positive reply to the question: “Did you ever have any doubts about your client’s mental capacity to participate in defense of the case?” (Hoge et al., 1992, p. 387). Hoge et al. found attorneys in their study doubted their clients’ competence in 14.8% of cases, yet they only referred 8.2% of their clients for an evaluation for competency. The authors believed this discrepancy was dependent on three factors. First, the seriousness of the crime was important in that the more serious the crime, the more likely the attorneys were to refer their client for evaluation. The second factor was whether or not attorneys involved families in the decision-making processes; that is, if attorneys involved families, they were less likely to refer. The third factor was peer consultation; attorneys were less likely to refer after consultation with another attorney.

A follow-up series of studies was conducted by Poythress, Bonnie, Hoge, Monahan, and Oberlander (1994). The purpose of the studies was to contribute to the limited literature of attorney-client interactions and the way they affect the defense. In Study 1, the researchers evaluated attorneys’ perception of a total of 200 felony and misdemeanor cases resolved by plea. In Study 2, they evaluated attorneys’ perceptions of 200 felony and misdemeanor cases that went to trial. In Study 3, they examined
perceptions of clients in 35 recently closed felony cases. All three studies utilized a public defender’s office (PDO) for samples. Each will be discussed separately.

In the first study, psychology graduate students and law students serving as research assistants conducted structured interviews similar to that in the Hoge et al. (1992) study. Results indicated attorneys doubted their clients’ competency in 5% of their cases. Specifically, attorneys doubted the competence of 8% of the clients charged with felonies and 3% of clients charged with misdemeanors. Attorneys also rated their clients on their assistance in developing facts, accepting advice of counsel, and their level of participation. Clients whose competency was doubted were commonly (60%) rated as not helpful. Additionally, 20% of these clients were described as rarely or never accepting advice, compared to 4% of those whose competency was not doubted. Clients whose competency was doubted were also perceived to be less involved, with 40% being rated extremely passive compared to 7.4% being rated that low in the group who appeared to be competent.

In Poythress et al.’s (1994) second study, the procedures were identical to those in the first study. However, the sample cases were ones that had been resolved by trial instead of plea. Attorneys reported doubts about competency in 11% of the total cases; breaking this down by criminal charge, they doubted competency in 14.7% of felony cases and 7.6% of misdemeanor cases. However, the relationship between offense and doubted competence did not reach statistical significance. Just as in Study 1, attorneys also rated their clients on assistance in developing facts, accepting advice of counsel, and participation. Results were similar to Study 1, with clients whose competence was in doubt being perceived as less helpful and accepting of advice and more passive in
participation.

In the third study, Poythress et al. (1994) attempted to address limitations in previous research by Hoge et al. (1992). Structured interviews were completed with both attorneys and clients to compare their perceptions of client participation. The random sample consisted of 35 closed felony cases, of which 21 were resolved by a plea agreement and 14 were adjudicated in court. Instrumentation and procedures for interviewing attorneys were identical to the previous two studies. The content of the client interview paralleled that of the attorneys. Discrepancy was found in client and attorney ratings in terms of helpfulness, willingness to accept advice, and level of participation. In 20% of cases in which attorneys reported about clients’ level of helpfulness, clients disagreed. In 6% of cases in which attorneys rated clients as not accepting advice, clients were in complete disagreement. In regard to client participation, there were only four cases in which there was complete disagreement (i.e., clients viewed themselves as extremely helpful while attorneys rated them as passive).

Poythress et al. (1994) summarized their results as follows:

In all three studies, the competence of felony defendants was doubted in approximately 1 of 10 cases: 7.9% in Study 1, 14.7% in Study 2, and 11% in Study 3. The rates of doubted competence in misdemeanor cases were lower (3% Study 1 and 7.6% Study 2). (p. 450)

The results suggested that attorneys doubted their clients’ competence more often in felony and tried cases. The authors suggested that there were a “…set of informal norms, similar to the norms applied by physicians in treatment settings, that may shape attorneys’ behavior in dealing with cases of doubted competence” (Poythress et al. 1994, p. 451).

Nicholson and Kugler (1991) reviewed 30 studies comparing competent and
incompetent defendants in an attempt to identify variables associated with judgments about defendants’ competency to stand trial, or lack thereof. Their results suggested a behavioral basis for attorneys’ doubt of clients’ competence, with symptoms of psychosis being the most common diagnosis for persons found incompetent to stand trial.

Reid-Proctor, Galin, and Cummings (2001) reviewed standards of competency with an emphasis on frontal lobe injuries. They noted the following:

…deficits in executive functioning are often more difficult to clearly and convincingly demonstrate than are the more overt deficits of perception, comprehension, memory functioning, or decision making. Thus, the relatively high standard of evidence set by the courts serves to directly underscore the importance of being able to accurately, clearly, and convincingly determine the strengths and weaknesses of the executive functioning in brain injured patients. (p. 379)

The authors noted that it is difficult to assess frontal lobe injuries because they are not easily measurable. According to the authors, symptoms such as loss of ability to analyze options, solve problems, and incorporate feedback, coupled with increased irritability, poor insight, and limited impulse control, may lead to involvement in the legal system. Although neurological evaluation can be helpful in assessing deficits, it is possible for patients to have severe deficits that are not identified using common screening tests. Thus, there is a possibility for frontal lobe deficits to be missed with respect to a client’s competency (Reid-Proctor et al., 2001). Consistent with Simon’s (2005) recommendations, the authors recommended continual assessment of competency throughout the legal process because of the potential for fluctuation during the recovery phase of TBI. The focus of Reid-Proctor et al.’s (2001) article was on outlining the neuropsychological assessment process of competencies in patients with frontal lobe injuries. Thus, the process by which attorneys evaluate client’s competency with frontal
lobe injuries was not discussed.

In sum, prior research has pointed to the existence of defendants with TBI in the legal system. Additionally, authors have addressed concerns for how competency is evaluated or perceived by attorneys as well as by mental health professionals. However, the literature is still limited in terms of understanding the process by which attorneys determine whether their clients are competent or incompetent to stand trial.

Purpose of the Present Study

As indicated by the limited research on TBI and CST, little is known about how attorneys conceptualize CST and perceive their client’s competency. Researchers have evaluated attorneys’ understanding and conceptualization of different competencies. Additionally, studies have indicated that certain behaviors are more likely to cause an attorney to refer for a CST evaluation, especially in criminal cases. However, the literature is lacking information about attorneys’ perceptions of CST based on certain client behaviors. The purpose of this study was therefore to assess attorneys’ knowledge of TBI symptoms and their likelihood of referring a client for a competency evaluation based on symptoms of TBI.
METHOD

The present study incorporated a survey methodology using an Internet-based questionnaire. In this section, I describe recruitment and data collection procedures, as well as the specific content of the questionnaire.

Recruitment Sources

Potential participants were recruited through postings on select listservs. An attorney at the Metropolitan Public Defenders office in Portland, Oregon, forwarded the survey to attorneys in that office (about 100 attorneys total) and to the Oregon Criminal Defense Lawyer’s Association (OCDLA) listserv (about 500 attorneys total). Many, if not all, of the attorneys in the Public Defender’s office were likely also on the OCDLA listserv, so it was not possible to determine the exact number of attorneys who read the request for participation beyond estimating that there were at least 500 potential participants. Of these, 69 completed the survey, providing an approximate response rate of 13.8%. The final sample consisted of 43 males (62%) and 26 females (38%).

Data Collection

Before beginning data collection, approval was obtained from the Pacific University Institutional Review Board. Subsequently, the general data collection procedure was as follows: In early December 2008, a link to the survey was forwarded to the listservs described above. The survey, which was developed and posted online through the Internet-based survey program Survey Monkey, included informed consent on its opening page (see Appendix A). After reading this information and giving their
consent to participate in the survey, participants were instructed to click on the survey link to continue. The survey (described below and included in Appendix B) took approximately 20 min to complete. By early March 2009, approximately 69 responses had been received. My e-mail address was included at the end of the on-line survey so that interested participants could request a copy of the results once they were completed. Only one individual contacted me and/or expressed enthusiasm for the study.

Instrumentation

The survey used for this study was comprised of four categories, described below: demographic information, common reasons to refer for CST evaluation, symptoms that may be a cause for referral, and confidence levels in recognizing types of psychological disorders and TBI. The majority of the items were closed-ended questions with designated response options. Several open-ended questions were also included in order to gain qualitative data from respondents regarding details of their practice and reasons they would refer for a CST evaluation. Finally, in some cases participants used a rating scale to indicate frequencies or confidence in recognizing psychological disorders and brain injury symptoms. Participants were required to answer each question in order to continue to participate in the survey.

Demographic Information

This section consisted of seven questions regarding age, gender, type of law practiced, work venue, annual number of clients, annual number of clients referred for CST evaluations, and specialty of practice or client population.

Common Reasons for CST Evaluation

Participants responded to an open-ended question asking for the most common
reasons underlying their referrals of clients for CST evaluations.

Symptoms Leading to CST Referral

This section included a list of symptoms of several disorders in addition to TBI, including psychosis, depression, and anxiety symptoms as listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*; American Psychological Association, 2000). The symptoms of TBI and mild brain injury (MBI) were generated from information on the National Institute of Neurological Disorders and Stroke (NINDS) website (http://www.ninds.nih.gov/disorders/tbi/tbi.htm). These symptoms included headache, lightheadedness, dizziness, blurred vision, ringing in the ears, bad taste in the mouth, fatigue or lethargy, a change in sleep patterns, and behavioral or mood changes. The attorneys were asked to rate whether each symptom would cause them to refer a client for a CST evaluation.

Confidence in Recognizing Disorders

Participants rated how confident they felt in recognizing the following disorders: psychosis, cognitive deficits, TBI, and MBI. Participants rated themselves on a scale with three anchors: *not confident, confident enough, and extremely confident.*
RESULTS

A total of 69 participants completed the survey. However, some survey questionnaires were incomplete, missing one or more responses to survey items. This occurred despite efforts to design the survey to prompt respondents for required responses on a select group of survey items. Therefore, results from survey items are discussed in terms of the number of total respondents answering each item.

Descriptive statistics are provided for the survey data. Qualitative data from individual responses were reviewed to identify common themes. A nonparametric test was completed for the results from one question (common reasons for referral for CST evaluation). Statistical tests were not completed on the other questions due to the nature of the sample distribution and limited sample size. In some cases, however, noteworthy trends are briefly discussed because they suggested possible differences in respondents’ answers when referring for symptoms of psychosis as compared to symptoms of TBI.

Participant Characteristics

Demographic Information

Of the 69 respondents who completed the survey, most (84%) were between 25-55 years of age, with a mean age of 43 years ($SD = 10.7$; see Table 1). The breakdown of gender in the sample was 62.3% male and 37.6% female, which is not dissimilar to the demographics of lawyers in the United States: The most recent gender demographics available on the American Bar Association website are for the year 2000, and they indicated a gender distribution of 73% percent male and 27% female.
Table 1

*Age of Participants (N = 69)*

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<td>25-35</td>
<td>19</td>
<td>27.5</td>
</tr>
<tr>
<td>36-45</td>
<td>20</td>
<td>28.9</td>
</tr>
<tr>
<td>46-55</td>
<td>19</td>
<td>27.5</td>
</tr>
<tr>
<td>56-65</td>
<td>9</td>
<td>13.0</td>
</tr>
<tr>
<td>65+</td>
<td>2</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Respondents practiced several types of law, though most (56 respondents, or 89.9%) indicated they practiced criminal law. Other areas included juvenile law (6 respondents; 5.4%), capital defense (1 respondent; 1.7%), civil law (2 respondents; 3.6%), and civil commitment of Alleged Mentally Ill Person (AMIP; 1 respondent, 1.7%). When asked to specify their work venue, 45 respondents (65.2%) indicated they worked at a public defender’s office, with the second largest group (19 respondents, 27.5%) choosing private practice, and 5 respondents (7.2%) choosing a combination of both.

The most common response regarding specialty area of law or specialty population was indigent defense, which was written in by 25% ($n = 16$) of the 64 respondents who answered this item. Another 15% ($n = 10$) indicated they worked on felony cases.

With respect to number of annual clients, 53% of the 65 respondents indicated an annual client case load ranging from 1 to 199, with a mean across all respondents of 184 clients ($SD = 155.4$; see Table 2).
Table 2

Annual Number of Clients (n = 65)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-99</td>
<td>15</td>
<td>23.1</td>
</tr>
<tr>
<td>100-199</td>
<td>20</td>
<td>30.8</td>
</tr>
<tr>
<td>200-299</td>
<td>11</td>
<td>16.9</td>
</tr>
<tr>
<td>300-399</td>
<td>9</td>
<td>13.8</td>
</tr>
<tr>
<td>400-499</td>
<td>4</td>
<td>6.2</td>
</tr>
<tr>
<td>500+</td>
<td>2</td>
<td>3.1</td>
</tr>
</tbody>
</table>

The number of yearly referrals for CST evaluations ranged from 0-75, with a mean of 7 (SD = 7.43; see Table 3).

Table 3

Number of Yearly Referrals for CST Evaluations (n = 67)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>49</td>
<td>73.1</td>
</tr>
<tr>
<td>6-10</td>
<td>15</td>
<td>22.4</td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>16-20</td>
<td>5</td>
<td>7.5</td>
</tr>
<tr>
<td>21-30</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>31+</td>
<td>3</td>
<td>9.0</td>
</tr>
</tbody>
</table>

As shown in Table 4, the most common reasons for CST evaluation referral were issues understanding the court process (19.4%; n = 13), mental illness and mental health problems (13.4%; n = 9), ineffective communication (12%; n = 8), and client presentation (12%; n = 8).
Table 4

*Common Reasons for CST Evaluation (n = 67)*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues understanding court process</td>
<td>13</td>
<td>19.4</td>
</tr>
<tr>
<td>Mental Illness/Mental Health Problems</td>
<td>9</td>
<td>13.4</td>
</tr>
<tr>
<td>Inability/ineffective communication</td>
<td>8</td>
<td>12.0</td>
</tr>
<tr>
<td>Client’s presentation (in interview)</td>
<td>8</td>
<td>12.0</td>
</tr>
<tr>
<td>Inability to assist defense</td>
<td>7</td>
<td>10.4</td>
</tr>
<tr>
<td>Psychosis</td>
<td>6</td>
<td>9.0</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Delusions/Paranoia</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>TBI</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>IQ/DD</td>
<td>1</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Symptoms that may be of concern for CST referral were rated on a scale with the following values and corresponding anchors: 0 (*never*), 1 (*rarely*), 2 (*sometimes*), 3 (*frequently*), and 4 (*always*). Based on frequency, the majority of TBI symptoms were rated lower than were other symptoms as reasons for referral for a CST evaluation (see Table 5).

As shown in the table, TBI symptoms had an average rating of 1.0, and symptoms of psychosis had an average rating of 2.5. A Mann-Whitney U test indicated that this difference was significant, $z = 3.79, p < .001$. That is, symptoms of psychosis were significantly more likely to prompt attorneys to refer clients for a CST evaluation than were symptoms of TBI. In line with this finding, attorneys felt more confident recognizing psychotic disorders and least confident recognizing brain injury (see Table 6).
### Table 5

**Symptoms That May Prompt Referral for CST Evaluation**

<table>
<thead>
<tr>
<th>Symptoms of Psychosis</th>
<th>Mean rating</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusions</td>
<td>3.0</td>
<td>55</td>
</tr>
<tr>
<td>Hallucinations – auditory</td>
<td>3.0</td>
<td>56</td>
</tr>
<tr>
<td>Hallucinations – somatic</td>
<td>2.8</td>
<td>55</td>
</tr>
<tr>
<td>Hallucinations – visual</td>
<td>2.8</td>
<td>54</td>
</tr>
<tr>
<td>Hallucinations – tactile</td>
<td>2.6</td>
<td>55</td>
</tr>
<tr>
<td>Flight of ideas</td>
<td>2.4</td>
<td>56</td>
</tr>
<tr>
<td>Hallucinations – olfactory</td>
<td>1.9</td>
<td>53</td>
</tr>
<tr>
<td>Hallucinations – gustatory</td>
<td>1.7</td>
<td>53</td>
</tr>
<tr>
<td>Average across psychotic symptoms</td>
<td>2.5</td>
<td>54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms of TBI</th>
<th>Mean rating</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory loss</td>
<td>2.0</td>
<td>55</td>
</tr>
<tr>
<td>Disinhibition</td>
<td>1.6</td>
<td>54</td>
</tr>
<tr>
<td>Slowness in thinking</td>
<td>1.8</td>
<td>56</td>
</tr>
<tr>
<td>Change in behavioral or mood</td>
<td>1.5</td>
<td>56</td>
</tr>
<tr>
<td>Getting lost</td>
<td>1.2</td>
<td>54</td>
</tr>
<tr>
<td>Difficulty writing</td>
<td>1.1</td>
<td>54</td>
</tr>
<tr>
<td>Difficulty reading</td>
<td>1.0</td>
<td>55</td>
</tr>
<tr>
<td>Sensitivity to lights or sounds</td>
<td>0.9</td>
<td>55</td>
</tr>
<tr>
<td>Lightheadedness</td>
<td>0.8</td>
<td>56</td>
</tr>
<tr>
<td>Dizziness</td>
<td>0.8</td>
<td>56</td>
</tr>
<tr>
<td>Complaints of physical pain</td>
<td>0.8</td>
<td>56</td>
</tr>
<tr>
<td>Change in sleep patterns</td>
<td>0.8</td>
<td>55</td>
</tr>
<tr>
<td>Headaches</td>
<td>0.7</td>
<td>54</td>
</tr>
<tr>
<td>Blurred vision or tired eyes</td>
<td>0.7</td>
<td>56</td>
</tr>
<tr>
<td>Fatigue or lethargy</td>
<td>0.7</td>
<td>55</td>
</tr>
<tr>
<td>Ringing in the ears</td>
<td>0.7</td>
<td>55</td>
</tr>
<tr>
<td>Bad taste in the mouth</td>
<td>0.6</td>
<td>56</td>
</tr>
<tr>
<td>Average across TBI symptoms</td>
<td>1.0</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other psychological symptoms</th>
<th>Mean rating</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorientation</td>
<td>3.0</td>
<td>54</td>
</tr>
<tr>
<td>Pressured speech</td>
<td>2.0</td>
<td>55</td>
</tr>
<tr>
<td>Psychomotor retardation</td>
<td>1.9</td>
<td>55</td>
</tr>
<tr>
<td>Denial or lack of awareness</td>
<td>1.9</td>
<td>55</td>
</tr>
<tr>
<td>Distractibility</td>
<td>1.8</td>
<td>54</td>
</tr>
<tr>
<td>Impulsiveness</td>
<td>1.5</td>
<td>55</td>
</tr>
<tr>
<td>Slurred Speech</td>
<td>1.5</td>
<td>53</td>
</tr>
<tr>
<td>Irritability – emotional disturbance</td>
<td>1.4</td>
<td>55</td>
</tr>
<tr>
<td>Depression</td>
<td>1.2</td>
<td>55</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.2</td>
<td>56</td>
</tr>
<tr>
<td>Average across other symptoms</td>
<td>1.7</td>
<td>54</td>
</tr>
</tbody>
</table>

*Symptoms that may be of concern for CST Referral were rated as 0 (never), 1 (rarely), 2 (sometimes), 3 (frequently), and 4 (always).
Table 6

Confidence in Recognizing Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Mean*</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic disorders</td>
<td>1.05</td>
<td>0.59</td>
</tr>
<tr>
<td>Cognitive disorders</td>
<td>0.85</td>
<td>0.62</td>
</tr>
<tr>
<td>Traumatic brain injury</td>
<td>0.70</td>
<td>0.69</td>
</tr>
<tr>
<td>Mild brain injury</td>
<td>0.27</td>
<td>0.45</td>
</tr>
</tbody>
</table>

* Confidence was rated as 0 (*not confident*), 1 (*confident enough*), or 2 (*extremely confident*)
DISCUSSION

This study was designed to assess attorneys’ knowledge of TBI symptoms as well as attorneys’ likelihood of referring a client for a competency evaluation based on symptoms of TBI. As noted earlier, the focus of this study was on CST, but it is important to keep in mind that prior research is equally limited in terms of providing any guidelines for using TBI as a basis for a mental state defense.

Summary of Results

The majority of respondents practiced criminal law, working as public defenders or in a private practice with a public defender contract. Most specialized in indigent defense. The mean annual case load was 184 clients, with a mean annual rate of referral for CST of 7 clients (3.8%). In terms of factors most likely to lead to a referral for a CST evaluation, the majority of attorneys were concerned with the client’s understanding of the court process, followed by previous mental health issues and the client’s presentation during interview. A sizeable percentage of attorneys felt confident recognizing psychotic symptoms or signs but less confident recognizing signs or symptoms of brain injury. The majority of TBI symptoms were rated as never being a cause for concern with respect to CST, whereas psychotic symptoms were rated as frequently to always being a cause for concern.

Comparison to Prior Research

Overall, the findings from this study suggest that psychotic symptoms were more commonly recognized by attorneys than were other symptoms. In regard to concerns related to CST, symptoms of TBI were rarely a concern. These findings are similar to
those in the Nicholson and Kugler (1991) study in which psychosis was the most common reason for questioning a client’s CST.

The mean annual referral for CST was 3.8% in the current study, which was quite a bit lower than the referral rate of 8.2% found by Hoge et al. (1992). This finding is similar to Poythress et al.’s (1994) findings that attorneys doubted clients’ competency in about 3%-8% of misdemeanor cases; however, in the current study I did not differentiate between felony and misdemeanor cases.

The results of this investigation are also similar to the findings of Berman and Osborne (1987) that specific defendant behaviors (e.g., delusions and hallucinations) were correlated with attorney’s decisions to request CST evaluations. As the current results indicate (see Tables 5 and 6), attorneys were most likely to questions clients’ CST when the client presented with signs of delusions, disorientation, and/or hallucinations.

Strengths and Limitations of the Study

This study provides a useful step in looking at attorneys’ decision-making process with respect to CST referrals. To date, few researchers have looked at factors that prompt attorneys to make referrals for CST evaluations, and no prior research looking specifically at symptoms of TBI in this context could be found. The results confirmed findings from previous studies in regard to attorneys’ perceptions of competency being based at least in part on clients’ presentation of specific behaviors. They also shed light on which behaviors are perceived as contributing to a client’s doubted competence as well as which behaviors do not raise concern about CST.

The study also had certain limitations. The sample of 69 attorneys may not be entirely representative of the general population of attorneys. The attorneys were all
contacted through one of two listservs of defense attorneys in Oregon. One of the listservs was in the Portland metropolitan area, and thus many of the respondents may not be comparable to attorneys working in more rural regions or other areas of the country. Most of the attorneys worked in indigent defense. Therefore, the findings may not be applicable to attorneys in different types of practice (e.g., private or contract) or attorneys practicing in different specialties (e.g., juvenile, disabilities, capital defense).

The survey design itself suffered from several limitations. First, interpretation of the results was sometimes difficult because of the vague wording of several survey items. For example, participants were asked: “How confident do you feel in recognizing the following disorders?” The possible response options were very confident, confident enough, and not confident. However, no behavioral anchors were provided for the respondents.

In addition, the survey was originally designed to require responses on all items; if respondents failed to answer these, they were not allowed to progress with the survey. However, it appeared that some respondents inserted blank spaces or characters (e.g., “.,” “N/A”) into the survey item text boxes in order to skip the item and progress further through the survey. Additionally, open-ended questions (such as “What type of law do you practice?”) made for difficulty in summarizing responses.

Furthermore, it would have been more useful to ask attorneys to estimate the annual percentage of clients about whom they had doubts about CST as well the percentage of these clients that they referred for a CST evaluation. It would also have been helpful to have identified whether the attorneys were more likely to refer in felony or misdemeanor cases. Such inquiries would have allowed for a better comparison to
Hoge et al.’s (1992) findings.

Recommendations for Future Research

This study represents a first step towards addressing the lack of knowledge regarding actual and needed data about whether or not TBI symptoms go unnoticed by attorneys. Future studies should involve a broader sample of defense attorneys in both the public and private sector. In addition, it would be ideal to compare attorneys who advertise as experienced or specialized in TBI with those who do not. Better information needs to be elicited from attorneys about both psychiatric symptoms and perceived legal abilities that cause them to refer for CST.

Attorneys were asked to rate symptoms independently of other symptoms. It is very likely that clients present with multiple symptoms that shape attorney opinions of their competence. Thus, the impact of a client presenting with a combination of symptoms should be explored in future studies. Other studies should also account for the how the seriousness of the charges affect the perception of CST. Additionally, future researchers should also try to account for the role a referral for CST evaluation plays in the strategy of the defense and the legal process. Specifically, the role of TBI in mental state defenses should be considered.

Conclusions

Based on the prevalence of TBI in the general population as well as the estimated rates in the prison population, it is likely that attorneys will at some point encounter a client with TBI. The presence of TBI does not equate with incompetence; however, the results of this study clearly indicate both a lack of ability on the part of attorneys to recognize these symptoms and a feeling of inadequacy in doing so. Thus, more research
is needed to understand how client’s presentations affect attorneys’ perceptions of CST.
References


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APPENDIX A

Informed Consent*

The purpose of this research study is to assess what symptoms generate cause for mental health evaluations. Only attorneys/lawyers are eligible to participate. If you chose to participate you will be asked to fill out a short on-line survey about symptoms that generate concern for mental health evaluations as well as demographic information.

Your decision whether or not to participate will not affect your current or future relations with Pacific University. If you decide to participate, you are free to withdraw at any time without prejudice or negative consequences. The only foreseeable risks for participants is the lack of a guarantee that the internet is secure; however, we will not be collecting any personally identifying information, and all data will be aggregated across participants for analysis. There are no financial or other benefits for your participation.

The information collected will be kept anonymous. The data will be kept for a minimum of five years. For further information about the study, or for a summary of results contact Alisa Niehuser at Pacific University. For further concerns contact the Faculty Advisor, Dr. Arnaut. For further information about participants’ rights in the event of research-related harm contact Pacific University’s Institutional Review Board.

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By clicking “Next,” you are indicating that you have read the Informed Consent above and are agreeing to participate in this survey.

*This version of the questionnaire differs slightly from the survey posted on-line in font and formatting (e.g., the on-line version had drop-down menus), but not in content.
APPENDIX B

Survey*

Demographic Questions

1. Gender:
   Male
   Female

2. How long have you been in practice?

3. What type of law you are practicing?

4. In which venue do you work? (e.g., public defender office, private practice

5. Please provide the specialty area or specialty population you serve.

6. Please provide an estimate of yearly number of clients.

7. Number of yearly requests for Competency to Stand Trial evaluations (CST).

8. What are the most common reasons for referral for a CST evaluation?

Symptom Checklist

How often would the following symptoms cause you to refer for a Competency to Stand Trial Evaluation?

0 = Never  1 = Rarely  2 = Sometimes  3 = Frequently  4 = Always

9. Getting lost

10. Ringing in the ears

11. Blurred vision or tired eyes

12. Hallucinations - auditory (perception of sound, most commonly voices)

13. Complaints of Physical pain

14. Irritability - emotional disturbance
15. Headaches
16. Denial or lack of awareness
17. Slowness in thinking
18. Disorientation (confusion about time of day, date, season, where one is, or who one is)
19. Lightheadedness
20. Fatigue or lethargy
21. Sensitivity to lights or sounds
22. Hallucinations - gustatory (involving the perception of taste)
23. Anxiety
24. Difficulty writing
25. Difficulty reading
26. Hallucinations - tactile (perception of being touched or something under the skin)
27. Delusions (a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone believes)
28. Psychomotor retardation (visible generalized slowing of movements and speech)
29. Hallucinations - visual (consist of formed or unformed images such as persons or flashes of light)
30. Depression
31. Slurred speech
32. Hallucinations - somatic (perception of physical experience within the body such as a feeling of electricity)
33. Pressured speech (accelerated, difficult to interrupt, increased in amount)
34. Dizziness
35. Change in sleep patterns
36. Change in behavioral or mood changes
37. Impulsiveness
38. Distractibility (inability to maintain attention)
39. Memory loss
40. Bad taste in the mouth
41. Hallucinations - olfactory (perception of odor, such as burning rubber)
42. Disinhibition
43. Flight of ideas (nearly continuous flow of accelerated speech with abrupt changes form topic to topic)

**Comfort level with recognizing symptoms**

How confident are you in recognizing the following disorders?

0 = Not confident 1 = Confident enough 2 = Extremely confident

44. Traumatic brain injury (sustained from more severe injury & included loss of consciousness)
45. Mild brain injury (incurred with no or short loss of consciousness)
46. Cognitive Disorders (e.g., dementia, loss of memory)
47. Psychotic Disorders

*This version of the questionnaire differs slightly from the survey posted on-line in font and formatting (e.g., the on-line version had drop-down menus), but not in content.*