Capacity Concerns and Fetal Alcohol Syndrome

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Arnie G. was a 12 year-old male who was referred for testing by his attorney, a public defender. Arnie had been picked up on several burglary charges and his attorney was concerned about his capacity to understand the reasons his behavior was considered wrong.

Arnie was the youngest of six children born to a woman who was reported to have used alcohol, cocaine, and other drugs during her pregnancy. Arnie's mother was unable to care for any of her children and they had all been placed into foster care. Arnie had run from his latest foster home several times and was, for the most part, living on the streets. He had not attended school on a regular basis for two years. He was described as having serious learning difficulties and had been in Special Education classes.

Arnie was given a complete psychological evaluation while he was in the juvenile detention center. His IQ scores were in the 60s and his achievement scores were below the first grade. His adaptive behavior scores were around the age of five to six years. Arnie's verbal skills were poor and he was not able to articulate any understanding as to why his behavior had been inappropriate.

Arnie was short and slight with microcephaly and facial features consistent with Fetal Alcohol Syndrome (FAS). Because of his behavior, history of prenatal alcohol exposure, and physical attributes, Arnie was referred to a clinic to be evaluated for Fetal Alcohol Syndrome. His diagnosis for FAS was positive.

Due to his low scores, poor verbal skills, and lack of abstracting abilities and understanding, Arnie was found to not have capacity. Arnie, however, did not fare well. He did not remain in the therapeutic foster home where he was placed, he continued to be involved in criminal activity, and, at age 16, was finally placed into long-term custodial care.

CAPACITY AND DIMINISHED CAPACITY: DEFINITIONS

Capacity and diminished capacity are legal terms and common reasons why people are referred for psychological evaluations. The definitions from the Washington Advisory Code are presented below:

Capacity: In many states, children under the age of eight are presumed to be incapable of committing a crime. Children between the ages of eight and twelve are also presumed to be incapable of criminal activity. However, if evidence exists that removes this presumption, they may be tried on assigned charges (1).

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Diminished Capacity: Diminished capacity has to do with a person being able to establish criminal intent or the motivation to engage in criminal behavior and to understand it as such. Determination of both capacity and diminished capacity are dependent upon examination by an expert qualified to testify on the subject (2). Diminished capacity is not based on age. Rather, there are several factors that come into play to establish a defendant having diminished capacity. These include:

- the defendant lacks the ability to form a specific intent due to a mental disorder not amounting to insanity;
- the cause of the inability to form a specific intent must be a mental disorder, not emotions like jealousy, fear, anger, and hatred;
- the mental disorder must be causally connected to a lack of specific intent, not just reduced perception, overreaction or other irrelevant mental states;
- the inability to form a specific intent must occur at a time relevant to the offense;
- the mental disorder must substantially reduce the probability that the defendant formed the alleged intent; and
- the lack of specific intent may not be inferred from evidence of the mental disorder. The opinion from the evaluator must contain an explanation of how the mental disorder had this effect.

FAS, CAPACITY, AND DIMINISHED CAPACITY

Fetal Alcohol Syndrome (FAS) is a birth defect that results from prenatal alcohol exposure. Brain damage, most noticeably in behavior problems associated with the frontal lobes, is a hallmark of alcohol-related birth defects. Impulsivity, abstracting and memory deficits, a lack of understanding between cause and effect, and learning difficulties are all connected with FAS (3).

In terms of capacity, particularly for children between the ages of eight and twelve, FAS and its sequelae should be considered as an influencing factor. Children with FAS often appear chatty and more capable than is actually the case. This can lead evaluators to assume that a child with FAS had the capacity to understand right and wrong when, in actuality, they are simply

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guessing and giving an answer they think the evaluator wants.

While the presence of a mental disorder is NOT part of the criteria for diagnosing FAS, secondary disabilities frequently occur. Common psychiatric diagnoses associated with FAS include: high functioning autism; borderline personality disorder; depression; attention deficit hyperactivity disorder; and antisocial personality disorder. Periodic episodes of psychosis have been less frequently noted. With the exception of psychosis and autism, these diagnoses are unlikely to fit the criteria for diminished capacity (4).

Fetal Alcohol Syndrome has had an odd place in this area of criminal law. Often, people with FAS are not appropriately identified and diagnosed and so their cognitive difficulties are misunderstood. Their behavior problems are often misinterpreted without their etiology being understood. On the other hand, people who do receive the proper FAS diagnosis have their possible psychiatric secondary disabilities overlooked or minimized. Several suggestions are offered in the next section to help clarify the connection between FAS and capacity and diminished capacity.

EVALUATION FOR FAS, CAPACITY, AND DIMINISHED CAPACITY

Determination of both capacity and diminished capacity requires an evaluation by a qualified expert. The diagnosis of Fetal Alcohol Syndrome is made by a specially trained physician. It is very rare that the expert who can make the diagnosis of FAS is also qualified to make the determination of capacity and/or diminished capacity. However, both of these procedures need to be coordinated and done in conjunction with each other.

If a child under the age of twelve (or slightly older) is referred for a capacity evaluation, a preliminary question must be asked: Was the child exposed to prenatal alcohol? If the answer to this question is "Yes," the next step should be for a referral to a physician qualified to make a diagnosis. In addition, the psychological/capacity evaluation should focus on the child's ability to understand cause and effect, to understand the outcome of his own behavior, and to be able to articulate abstract concepts.

In the case of diminished capacity, the issue is one of "intent, of motivation." While many people with FAS have IQ scores indicating the apparent ability to understand cause and effect, this needs to be carefully examined and detailed in any evaluation. Many people with

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FAS do not have such understanding and do not have the ability to form intent. However, the cognitive deficits often present in people with FAS are frequently misunderstood and these people are found to NOT have diminished capacity.

Another difficulty with FAS is that it is not recognized as a mental disorder. Little knowledge of the demonstrated organic damage and deficits associated with FAS has made it into the legal system. However, the frontal lobe damage does limit a person's ability to form intent and understand behavioral consequences. It is this reality that needs to be detailed in the evaluation and clearly communicated to the court.

Evaluations for people with FAS to determine capacity and diminished capacity need to include an IQ test focusing on abstracting abilities, verbal skills, and the ability to connect cause and effect. Personality tests and clinical interviews focusing on psychiatric functioning should be coupled with intellectual and past behavior to fully determine intent. Again, given that many people with FAS look more functional than is the case, care should be taken to review enough records, gain collateral information, and to administer enough tests to provide validation of all deficits. A diagnosis of FAS, in and of itself, is not enough to provide this.

In summation, a diagnosis of FAS does not either rule out or necessarily confirm a child not having capacity or an adult having diminished capacity. There is a wide range of ability among people with FAS. In addition, evaluations of people with confirmed prenatal alcohol exposure must be evaluated for both FAS and capacity/diminished capacity. One does not confirm the other. Finally, FAS has not been accepted as a mental disorder. However, people with FAS have frequently been diagnosed a having a wide variety of secondary disabilities, including psychiatric disorders. Therefore, any evaluation for someone with FAS coming through the legal system must include intellectual functioning, adaptive behavior, academic achievement, and personality/psychiatric functioning.

REFERENCES

1. Washington Criminal Code; 9A.04.050
2. Washington Criminal Code; Diminished Capacity.
3. Jones, K.L. & Smith, D.W. (1973) Recognition of the fetal alcohol syndrome in early infancy. Lancet, 2, 999-1001.
4. Olson, H.C., Streissguth, A.P., Bookstein, F.L., Barr, H.M., & Sampson, P.D. (1994) Developmental research in behavioral teratology: Effects of prenatal alcohol exposure on child development. Developmental Follow-up. New York: Academic Press.