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Guidelines for Forensic Report Writing: Helping Trainees Understand Common Pitfalls to Improve Reports

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Running head: GUIDELINES FOR FORENSIC REPORT WRITING

Guidelines for Forensic Report Writing: Helping Trainees Understand Common Pitfalls to
Improve Reports

A DOCTORAL PAPER
PRESENTED TO THE FACULTY OF THE
GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY
OFFICE OF GRADUATE STUDIES
UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

BY
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Abstract

A forensic report is the primary work product of a forensic psychologist. The aim of a forensic report is to inform and influence the court. Unlike a clinical report, a forensic report influences the outcome of a legal conflict. This means that greater care must be taken in writing the report. The following errors (Grisso, 2010) were used to discuss best practices in forensic report writing: failure to answer the referral question, organization problems, language problems, mixed data and interpretation, inclusion of irrelevant data, over-reliance on a single source of data, improper psychological test use, failure to consider alternative hypotheses, and opinions without sufficient explanation. The purpose of this paper is to provide in one place all the information needed to improve forensic report writing, and to help the reader apply the literature using specific examples. Redacted report samples were collected from psychologists, graduate psychology trainees, teaching assistant experience, and clinical work. Identified errors in these samples were then corrected using the recommendations in the literature. Geared toward graduate psychology trainees, each section should serve both as a tutorial and as a brief checklist to help the reader avoid common pitfalls and assist in promoting better forensic report writing.

Introduction

As a psychology graduate student, I have had many different supervisors and many different types of supervision. Some supervisors, especially early in my training, taught me to produce written work that mimicked their own. More valuable were the supervisors who provided an understanding of what to do and why, and then allowed me to develop my own style. This approach promoted learning, because I was encouraged to question, “What do *I* think?” and “*Why* do I think this?” In my clinical work, this critical thinking ability has proved invaluable when completing written work. On paper, there is nowhere to hide. Each opinion is clearly expressed in black and white, with (hopefully) plenty of evidence to back it up. However, throughout my training, one problem I have noticed is that sometimes these written efforts fall short. In both clinical and forensic work, crafting a well-written report is important. However, in a forensic report, the stakes are higher. This makes forensic report writing a particularly daunting task.

A forensic report, unlike a clinical report, is written for the benefit of the court and is typically *about* the subject rather than *for* the subject. As the primary work product of forensic evaluations, forensic reports usually influence the court’s decision. Because of their importance, they require more care than an average report. The report should, therefore, be written with “clarity, precision, and artistry” (Griffith, Stankovic, & Baranoski, 2010, p. 33) to best assist the court. In reviewing the literature available on forensic report writing, there is a high level of agreement regarding the foundational aspects of this task. Broadly speaking, the writing should be clear, evidence driven, grammatically sound, and focused on the referral question. Yet, despite the agreement in the literature, many reports are substantially flawed.

In my opinion, the continued problems in forensic report writing, despite consistent recommendations otherwise, are related to the narrow nature of each source. While generally consistent across sources, most literature available provided information on forensic report writing from a singular perspective. Some authors chose to describe what should be done, some chose to describe what should never be done, and some described a bit of both. In writing, it seemed as though each author had a particular point he or she felt strongly about, and this point was described in more detail. Grisso (2010) provided the only empirical study on report writing, delineating the errors made across a sample of forensic reports. If given the opportunity to review all the literature available, the reader would have a clear idea of what to do and what not to do, but only a limited idea of how to apply this information to his or her own writing. For instance, although several sources have stated to “use clear language,” the reader might be left thinking, “I thought I *was* using clear language.” To improve report writing, readers need more information about what the errors really look like and specific recommendations regarding the correction of these errors.

The purpose of this paper is to provide in one place all the information needed to improve forensic report writing, and to help the reader apply the literature using specific examples. In order to provide real world examples, I collected redacted report samples from psychologists and graduate psychology trainees, in addition to using the reports I have reviewed as a teaching assistant or read during my own clinical work in hospitals, correctional facilities, and community mental health settings. Identified errors in these samples were then corrected using the recommendations in the literature. The specific errors identified in Grisso’s study (2010) were used as the lens to discuss each problem, its implications, and recommendations for how to correct (or avoid) the error. Geared toward graduate psychology trainees, this paper endeavors to

act as a particularly good supervisor: providing a thorough framework for what to do and why, elucidating key examples, and then allowing the trainee to develop his or her own style.

Ultimately, each section should serve both as a tutorial and as a brief checklist to help the reader avoid common pitfalls and assist in promoting better forensic report writing.

Purpose of Forensic Reports

All reports are written to provide information to the reader. To do this best, the writer must consider who requested the report, who might read the report, and what information the report should provide (Ackerman, 2006). The writer's task is to provide opinions supported by evidence that answer the referral question (Karson & Nadkarni, 2013). Both clinical and forensic reports require good writing, including "clarity, simplicity, brevity, and humanity" (Griffith et al., 2010, p. 36). Forensic reports, however, have a different purpose, impact, and style.

The purpose of forensic reports differs greatly from the purpose of clinical reports. When conducting a clinical evaluation, the client is likely the person being tested and the referral question probably relates to diagnostic clarification or treatment. The report is one small part of a larger treatment plan. Conversely, in a forensic evaluation, the client is usually the court and the referral question will be related to a psycho-legal issue. The forensic report is frequently the primary work product of a forensic evaluation (Gudjonsson & Haward, 1998; Karson & Nadkarni, 2013). A forensic report is intended to inform and influence the court about an assessment subject, specifically in reference to the subject's psychological functioning and behavior (Griffith et al., 2010; Gudjonsson & Haward, 1998; Reid, 2011). The forensic evaluator must be aware of the purpose of the report and direct the narrative accordingly.

Another key difference between forensic and clinical reports is the impact of the report. While clinical reports can provide additional insight and influence the outcome of treatment, forensic reports often have more lasting repercussions. The written report, either alone or with accompanying testimony, often significantly influences the outcome of a legal conflict (Griffith et al., 2010). If a psychologist determines that a defendant is incompetent to stand trial, for instance, the defendant's legal proceedings will likely be put on hold during the competency

restoration process. If a forensic evaluator determines that a child should be placed primarily with her father, rather than her mother, this may greatly impact the judge's opinion and the child's primary parent could change. In a defense mitigation evaluation, a defendant may get a lesser sentence because of a forensic report. In each of these examples, and so many more, the forensic report has an immediate and significant impact on the subject of the evaluation. Because of this impact, the "forensic clinician must take greater care in writing the report" (Karson & Nadkarni, 2013, p. 16).

The importance of the forensic report makes the task more demanding for clinicians. A forensic report is usually subjected to a high degree of scrutiny, from both attorneys and the judge. One person is always trying to discredit the evaluator or the report, and the evaluator must, therefore, write the report as though every word is meaningful (Wettstein, 2004). It is necessary for written findings to be presented in a manner that "anticipates critical analysis, disagreement, or even verbal confrontation on cross-examination" (Griffith et al., 2010, p. 32).

Forensic reports differ from clinical reports in both content and style to meet the demands of the legal system. The reports vary in content because they answer a forensic question that likely requires different data or a different method of acquiring data than a clinical report. The style is different because the report is provided to a different audience, or multiple audiences. By necessity, the report must be more detailed, precise, clearly written, and substantiated by evidence than a clinical report (Wettstein, 2004).

In a forensic report, the referral question is often very specific. The report should address the referral question completely, without addressing any additional issues (Grisso, 2010). Although clinicians might feel compelled to address clinical matters, the forensic report should focus only on the psycho-legal question before the court. A forensic report that offers excellent

clinical recommendations but fails to effectively address the psycho-legal question is “unhelpful at best and harmful at worst” (Gagliardi & Miller, 2008, p. 542).

An understanding of the purpose of forensic reports and the inherent differences of forensic work is important for clinical psychologists as well. Many clinical psychologists will work with children of divorce, divorced parents, victims of trauma, and people who abuse substances, to name a few. All of these areas, and several others, have a high degree of overlap with forensic work. In these cases, the psychologist might be required to write a report for the court. Forensic report writing skills are, therefore, applicable for both clinical and forensic psychologists.

Organizational Problems

Every good report starts with a solid foundation. Usually, this foundation is composed of good ideas and good organization of these ideas. Unfortunately, even the best ideas can be lost if they are not communicated clearly. Grisso (2010) determined that information was presented “in a disorganized manner” in 36% of reports submitted (p. 110). Usually, these errors occurred when information was presented in an illogical manner. There are several recommendations in the literature to help pinpoint how to format the report for readability, including suggestions for structure.

The first consideration when organizing a report is the purpose of the report. It should be formatted to best “fit the needs of the reader” (Resnick & Soliman, 2012, p. 414). Forensic reports likely have multiple audiences, including other mental health professionals, non-mental health professionals, and non-professionals (Ackerman, 2006). The report should be structured in a manner that is clear and easily understood by all parties. This means that reports will likely need to be written so that the layperson can understand the material presented. Technical language should be limited (See: *Language Problems*), and each section should be built on information in the preceding section. This also means that reports should be self-sufficient. The reader should not need to refer to other documents to understand how the conclusions were reached (Resnick & Soliman, 2012).

There are several different opinions on the structure of a report, and no one way is the correct way. Rather, the report “should be written in a manner that increases the likelihood that it will be read in its entirety” (Ackerman, 2006, p. 60). While brevity can improve the likelihood the report will be read from beginning to end, logical organization and a well-supported argument make the report an easier read. It may be helpful for the writer to ask the referring

party to provide a specific list of referral questions to guide the report and keep the writing on point (Reid, 2011). At a bare minimum, a well-organized report should include clearly articulated and supported opinions (Resnick & Soliman, 2012).

Most reports follow the general structure of presenting the information gathered, and then using that information to discuss the reasoning process that led to the opinion (Griffith et al., 2010). This type of report format is referred to as a Procedure-by-Procedure report. When using this format, all the information gathered is grouped by source. For instance, an interview with a collateral contact would be discussed in a single paragraph, as would the data from a particular test (Karson & Nadkarni, 2013). While this approach makes it clear where the information was obtained, it is less integrative than other approaches.

In Procedure-by-Procedure reports, the information gathered, or the findings, are usually broken into a few different categories, such as the introduction, the gathered history, behavioral observations, and/or mental status (Allnutt & Chapalow, 2000; Griffith et al., 2010). Headings can be particularly useful in differentiating data and making the report more reader friendly (Resnick & Soliman, 2012). The introduction typically includes information about the referring party and the purpose of the evaluation, identifying information about the subject, and the general procedures used. Sections involving data presentation would follow the introduction. This section often includes information from record review, clinical interview, or test data; essentially, anything that will later be used to support the clinical opinion (Griffith et al., 2010). This data section should report only data, not inferences (Grisso, 2010). Finally, the last section of the report should contain the final opinion supported by the gathered evidence. There should be no new information offered in this section (Grisso, 2010). This section should answer the referral questions posed in the introductory section of the report (Griffith et al., 2010).

Two more structures allow for more integrative approaches: issue-by-issue and point-by-point. An issue-by-issue format allows the writer to offer information in a structure based upon a particular theoretical orientation. For instance, all the information gathered might be grouped into categories such as intelligence, problem-solving skills, mental health functioning, etc. (Karson & Nadkarni, 2013). This structure allows for integration of the data in a manner that can be clinically, if not necessarily legally, relevant (Karson & Nadkarni, 2013). The final type of report structure is referred to as point-by-point organization. In this type of report, the data become evidence for a series of assertions that, collectively, generate an argument that answers the referral question (Karson & Nadkarni, 2013). This type of report tends to get to the heart of the matter as concisely as possible while remaining defensible in court, because there is sufficient evidence for each opinion and all data that are unnecessary for a particular assertion are excluded.

As a doctoral student, I frequently, if not always, write reports in the structure preferred by my supervisor. While there is more flexibility to write reports according to personal preference when not under supervision, many systems have a preference for the style of report used as well. The most common type of report structure I have seen, from collected reports, practicum work, supervision of other students as a teaching assistant, group supervision work, and internship, tends to be a variation of the procedure-by-procedure report. To some degree, most reports I have read followed the general structure of presentation of information by source, followed by a conclusion that answers the referral question. I think this occasionally leaves the reader surprised by the conclusion, especially if each piece of evidence was stated as strictly data during the data presentation portion of the report. My favorite style, when I have flexibility, is to use a modified version of a procedure-by-procedure and point-by-point. I like to integrate all the

data obtained from clinical interview and record review, attributing the source to the statements rendered. Then, I discuss all the tests administered individually so that the source of information is clear. Finally, I write my conclusion using a point-by-point format. I find that my argument is stronger, and the reader is familiar with the data obtained. It also allows me to craft a more convincing conclusion than simply reciting data from earlier in the report, and it guarantees that I will have answered the referral question thoroughly.

After the report style has been determined, there are several recommendations in the literature regarding brevity. In general, reports that are both concise and precise are best. They should include all relevant information, but no superfluous information, and they should encourage the reader to keep reading. In some cases, brevity can encourage a reader to start reading. If I am reviewing records, for instance, and I come upon a 60-page report, there is a part of me that wants to flip to the end. I am much more likely to read the text thoroughly if the report is less than 15 pages, and I am guaranteed to read it thoroughly if the report is 5 pages. That said, there are three generally acceptable report lengths, depending on the request of the referring party. Short reports are approximately three pages. These reports are essentially the conclusion section of a report, without the preceding data, along with recommendations. The standard report is typically somewhere between 2 and 10 pages, depending on the depth of testing conducted. This type of report would include a background history, test results, and conclusions. Finally, the third, and least used, type of report is a comprehensive report, which can be upwards of 30 pages (Ackerman, 2006). This type of report should typically not be used unless the referring party specifically requests it or it is mandated by statute. For instance, some sex offense specific reports and some custody evaluations tend to be quite lengthy to include numerous legal questions that must be answered by the evaluator. In general, keep the reader's "attention span,

motivation, and memory” in mind (Gagliardi & Miller, 2008, p. 546). The longer the report, the less likely it will be read in its entirety.

Regardless of the type of structure or length of the report, the conclusion is the most important part. It is the most relevant part of the report, and the reason the evaluation was conducted. While supporting evidence is important for each assertion made in the conclusion, the reader should not have to “wade through a lot of prose to get to the bottom line” (Reid, 2011, p. 357). Reid (2011) additionally recommends placing the opinions early in the report. Sometimes, writers, especially in forensic reports, will place a brief section immediately after the referral question stating a brief answer (i.e., “Mr. Jones is not competent to stand trial”). I think this can be helpful in certain types of reports. However, if the reason *why* Mr. Jones is incompetent matters, then I might save the final conclusion for the end. I would, in either case, present the conclusion as clearly and succinctly as possible, with sufficient evidence to support my assertions. Griffith et al. (2010) offer a final recommendation that the conclusion be “scientifically sound, truthful, respectful to a person, and understandable to the law” (p. 36).

Dos and Don'ts:

1. *Do* present the information in a logical sequence. The information presented in a report should build upon itself so the reader does not need to refer to later sections of the report.
2. *Do* determine what structure report is best for the particular case. Regardless of which is used, *do* answer the referral question clearly.
3. *Don't* overwhelm the reader with needless information.
4. *Do* consider length; ask the referring party for guidance.
5. *Do* make the conclusion the most important part of the report. Although it may be shorter than the data presentation section, it should be the most time consuming to write.

Language Problems

Forensic reports are the primary work product of forensic psychologists. While the content of the report *should* be the most important, the clarity and credibility of the report are often impeded by problems with language. In my review of reports, problems with language were pervasive, and, above all, distracting. At best, the error makes it look as though the writer did not put forth adequate effort. At worst, the reader concludes that the writer is not that smart, which affects the reader's interpretation of the content. Although an easily avoidable error, it nonetheless occurs frequently. Grisso (2010) determined that "multiple instances of jargon, biased phrases, pejorative terms, or gratuitous comments" occurred in 19% of all reports collected. Single instances of language errors likely occur with greater frequency.

The current literature identifies four primary problem areas related to language: use of jargon and technical language, poor grammar, lack of clarity, and poor writing style. Across these areas, there is a bevy of information instructing writers what *not* to do. Resnick and Soliman (2012) caution writers not to use overly formal language. They concluded that formal language "confounds the meaning of the report and communicates a lack of confidence" (p. 416). Technical language, especially when directed toward a legal or non-professional audience, can be confusing or distracting, and it lends itself to misconstrual. Alternatively, the reader may view overly informal language as less credible (Ackerman, 2006). Forensic writing, then, must strike a balance between writing in professional, but not technical, language. If a technical term must be used, then a clear, concise description of that term should follow (Karson & Nadkarni, 2013).

There are two types of technical language that I see most often in reports. The first type of technical language includes the overuse of acronyms. Often, psychologists working in forensic environments will encounter many different acronyms. These might include acronyms related to

the system or acronyms related to psychological tests. While reading forensic reports at a state hospital, I have read several reports with statements such as, “Mr. Johnson was placed in DSH after he was released from CDCR. While in CDCR-SQ, he was in CCCMS and EOP. In EOP, he was placed in a MHCB on four occasions. Mr. Johnson’s need for continued treatment is high.” This alphabet soup style of writing is particularly confusing for a layperson. Although I have the benefit of working in the field, I nonetheless found myself reading this sentence and thinking, “What does this mean?” It would be helpful to know, in this instance, that “DSH” is a state hospital system and “CDCR” is a state prison system. The other three acronyms (CCCMS, EOP, and MHCB) are all levels of mental health treatment within a prison. If several sentences of explanation are required, there is far too much technical language. In this instance, it would be much better to state, “Mr. Johnson has received mental health treatment for the duration of his prison sentence and within the state hospital system. His need for continued treatment is high.” If specific treatment program names are required, they should be identified and explained (Gagliardi & Miller, 2008). It is a mistake to assume that the reader will always understand an acronym.

The other type of error I see most often is the use of psychological jargon. This might include referencing psycho-legal standards or therapeutic modalities without explanation, or including highly technical descriptions of data and interpretation. In one report, the writer referenced a subject’s Rorschach Inkblot Test responses. The writer stated, “Her world is full of ‘majestic seals’ and ‘ominous’ butterflies; mere bats and bears are counterintuitively anxiety provoking in their simplicity.” While this sentence is confusing for a variety of reasons, one main problem is the assumption of the reader’s technical knowledge. To understand this statement, the reader must know (1) how the Rorschach is interpreted, (2) what people

commonly see on the Rorschach, (3) that “‘majestic seals’ and ‘ominous’ butterflies” are unusually elaborate, and (4) that “bats and bears” are common. If all this knowledge is assumed, the reader must still make an interpretative leap. This statement should be re-written without technical language, perhaps like this: “She finds complexity calming. For example, on the Rorschach Inkblot Test she tended to see items that are atypically elaborate. This suggests she managed the stress of the task by identifying only complex items.” If the sentence cannot be clarified, the example should be omitted and another example offered. As a good rule of thumb, the level of difficulty “should be no greater than that in an average newspaper. In fact, writing the report *as if* it were a newspaper article, not a clinical report, is close to an ideal frame of reference” (Gagliardi & Miller, 2008, p. 545).

Another language problem noted in the literature is poor grammar. According to Griffith et al. (2010), “bad grammar and typographical errors diminish the effectiveness of the report” (p. 37). In my experience, bad grammar, misspellings, word misuse, and a failure to proofread are evident in many reports. Unfortunately, no matter how seasoned the clinician or how excellent the conclusion, subpar writing detracts from the overall credibility. Most errors are avoidable with careful proofreading, and reading a report aloud a day or two after it is written can be helpful.

Fortunately, poor grammar is the easiest problem to fix. Several sources suggest review of general grammatical principles. Reid (2011) stresses that good grammar is a necessity and urges writers to “use a dictionary, thesaurus, and perhaps a grammar text such as *The Elements of Style* by Strunk & White” (p. 356). Proper word use should also be evaluated (e.g., affect versus effect; their, there, and they’re; or to, too, and two). One particular example in a recent report caused the writer to lose credibility with me. This report read as follows: “Mr. Thomas was

employed as a dishwasher and stalking shelves in a grocery store.” I assume that the writer does not mean that Mr. Thomas was providing the grocery store shelves with obsessive and unwanted attention, but rather that he was replenishing them (i.e., stocking). Another writer asserted, “She is not ‘wrong,’ per say, but this is a much more complicated image than most people see.” This should be corrected to “per se,” if the phrase is to be used at all. In addition to word misuse, misspellings, and general grammatical errors, care should be taken to re-read the document for typographical errors. This aids in the overall professional appearance of the document (Grisso, 2010).

Poor writing style and lack of clarity can additionally impede readability. Clarity is most easily achieved by writing in short sentences and avoiding overly complex words and phrasing. Resnick and Soliman (2012) recommend “simple, crisp English” (p. 415). Clarity is also aided by brevity. This can be achieved by eliminating needless introductions to sentences, avoiding sentences longer than 20 to 25 words, and avoiding repetition (Allnutt & Chaplow, 2000). Graduate school often teaches students to sound smart. Unfortunately, this smart-sounding writing can be overly complicated, unclear, and comprised of long words in long sentences. Clarity is better achieved by explaining something in a manner that could be understood by a sixth grader.

The following example includes both unnecessary phrasing and overly complex language: “In one of her earliest memories, Prudence recalls a night when the exciting, collaborative progress her sister was making on a school project all of a sudden splintered into violence.” In this instance, “splintered” refers to the “progress” earlier in the sentence. There are two problems with this sentence. First, progress cannot splinter. Second, “splintered” is an

example of an overly long and colorful word. It would be better to state this: “Prudence recalled collaborative work with her sister that ended in violence.”

Several report excerpts contained lengthy, flowery language. This language often contributed to the perception that the writer was unclear what point they were making. One such example can be seen below:

However, his compulsion to digress into a conversation of how this social interaction wronged him on such a drastic level demonstrates his need to organize himself through intellectualization as well as his discomfort with emotional stimuli and difficulty accepting events that he considers as outside of his control and defining of his self-image.

This is a good example of the complex language often adopted by graduate students. After several readings, it appears this sentence would be better written in the following way: “He intellectualizes events that are highly emotional or outside of his direct control.” This writer has combined several thoughts into one long sentence using only complex words. In doing so, the meaning of the sentence was lost. Griffith et al. (2010) caution that the writer “must write to protect against the corruption of translation, unintended bias of language, and unhelpful ambiguity” (p. 33). Before a report is submitted to the court, the writer should take care to format sentences clearly, utilize correct vocabulary, and provide adequate information (Reid, 2011; Resnick & Soliman, 2012; Wettstein, 2004). Each sentence should be written in clear, precise language and re-read to determine that the sentence says what the writer means to say.

There are several specific style suggestions offered in the literature. Factual and clinical data should be written in the past tense, as well as information reported by the subject that happened in the past. Opinion should be written in the present tense (Allnutt & Chaplow, 2000;

Karson & Nadkarni, 2013). When writing, double negatives, ambiguity, and over-use of qualifying statements should all be avoided. For instance, avoid stating, “Mr. Jones performed similarly to other men who may have the tendency to occasionally react with anger.” Instead, state, “Mr. Jones reacts with anger when confronted with opposition from those he believes are inferior [or whatever causes Mr. Jones to react with anger].” Then, provide the evidence for this assertion (Allnutt & Chaplow, 2000; Karson & Nadkarni, 2013).

Another excerpt is from an insanity evaluation submitted to the court, as follows: “Mr. Smith’s crime is a crime of force. He was psychotic at the time of the offense. Therefore, he was basically unable to determine right from wrong.” Although there are several apparent errors in these three sentences, including a failure to support an assertion or explain a psychological term, there are two problematic style errors in this passage: tense and poor use of qualifiers. The first phrase should read, “Mr. Smith’s crime was a crime of force.” The crime happened in the past and should therefore be reported in the past tense. Furthermore, the last phrase should not include the word “basically.” This word casts doubt on the writer’s assertion and the reader is left wondering if the subject was able to determine right from wrong. This assertion should also be followed with supporting evidence and explanation (see: *Opinions without Explanation*).

The importance of writing style and clear, readable language is emphasized throughout the literature. The writer must remain aware of the influence on the reader. Choice of words, paragraph, and sentence structure can all influence the reader’s interpretation and analysis of the evidence provided (Griffith et al., 2010). The writer, then, should choose language that “minimizes the potential for bias” (Grisso, 2010, p. 108). Weiner (2006) further warns that “murky” descriptions are often impersonal and fail to adequately describe the evaluatee (p. 645). Rather than vague, impersonal descriptions, quotations can be used to “animate the data,” along

with active rather than passive voice (Allnutt & Chaplow, 2000, p. 984). The style of the writing should include humanity by using quotations, descriptions, or metaphors offered by the subject of the report. This prevents the report from appearing generic and encourages the writer to paint a picture of the subject (Resnick & Soliman, 2012).

These language errors are prevalent in a variety of forensic reports, whether written by graduate students or seasoned professionals. Clear language and good grammar are necessary to maintain credibility with the reader. These errors can be easily corrected. Clarity and writing style require practice and proofreading. Ultimately, the writer should take care to write in a manner that prevents bias and misinterpretation by the reader.

Dos and Don'ts:

1. *Don't* use overly technical language.
2. *Do* avoid grammatical errors, lack of clarity, and poor writing style.
3. *Do* remember that poor writing causes the writer, and therefore the opinion, to lose credibility with the reader.
4. *Do* write reports so they can be easily understood by all audiences.
5. *Don't* use lengthy, flowery language and long sentences.
6. *Do* proofread!

Mixed Data and Interpretation

Forensic psychologists who favor a procedure-by-procedure report structure often struggle to separate data from interpretation. The interpretive section of a report, usually titled “Discussion” or “Summary,” is typically structured in a manner that requires the writer to make an assertion, or state an opinion, and then support this assertion with data. The interpretive sections of a report will, therefore, likely contain both data and interpretation. However, the data sections should only include factual information. This prevents misattribution of opinion as fact and allows for greater clarity. Nevertheless, this error occurs with a high degree of regularity. Grisso (2010) indicated that this error occurred in approximately 26% of reports obtained.

According to Gagliardi and Miller (2008), information offered in a report falls “along a continuum of abstractness” (p. 544). Some information provided will be factual information. This often includes background information reported by the client and corroborated by several records. Karson and Nadkarni (2013) describe a *fact* as “an idea that no one of importance disputes” (p. 92). For example, if a young man generally performed about the same as his peers while he was still in school, received a score of 100 on the WAIS-IV, and his supervisor at work reported he generally completed typical work compared to his coworkers, it would be a fact to say, “Mr. Johnson is of average intelligence.” Another type of statement frequently found in report writing is referred to as an *inference*. An inference is a statement that occurs when the writer derives a logical conclusion given the presented data. In my experience, inferences are often mistakenly presented as factual. For instance, in the example with Mr. Johnson, the writer might add, “Mr. Johnson is of average intelligence and is able to complete the tasks required at work.” While the first part of the sentence is a fact, and the second is masquerading as fact, Mr. Johnson’s work abilities are inferred based on available information.

Other information contained in a report will be professional *opinion*, including some assertions made during the discussion. If a fact is information that is not disputed, professional opinion is considered “open to dispute” (Karson & Nadkarni, 2013, p. 92). Facts, inferences, and professional opinion should all be clearly distinguished from one another in a report. In the example above, for instance, the sentence might be better stated as follows: “Mr. Johnson is of average intelligence. In my opinion, he is able to complete the tasks required at work.” Failure to distinguish data from interpretation can result in “needless confusion, misunderstanding, and unproductive legal wrangling” (Gagliardi & Miller, 2008, p. 544). Yet another type of statement contained in reports is termed *speculation*. While opinion is typically an assertion that is well supported by evidence, speculation is “an idea that is useful but not well supported by evidence” (Karson & Nadkarni, 2013, p. 97). Sometimes, speculation is an educated guess about something that is unable to be known, such as the exact cause of the problem. For example, in Mr. Johnson’s case, the writer might speculate that he is able to complete tasks at work, but his current performance is suffering because he is overwhelmed, overworked, underpaid, experiencing emotional distress, or any myriad of potential causes. However, without evidence, these causes are only conjecture. Speculation should be clearly identified as such in a forensic report, or excluded from the report altogether.

Since it is not only acceptable but expected that data and interpretation be included together in the discussion or conclusion of a report, the failure to separate the two is most noticeable in reports that have a section reserved for data presentation. While I have read a handful of reports that are structured in the point-by-point format, most dedicate some part of the report to data presentation. This structure makes the error much more likely. In my own writing, I sometimes find this error difficult to avoid. One supervisor I had cautioned against the

interchangeable use of “indicate” and “suggest.” He used “suggest” for an inference and “indicate” when reporting factual data. Increased awareness of the distinction in terminology helped me to distinguish data from interferences, opinions, and speculation. In doing so, I was better able to keep data-only sections free from interpretation that masquerades as fact. For instance, when reporting cognitive scores, I might say, “On the WAIS-IV, Mr. Appleseed received a Full Scale IQ score of 100, placing him in the 50th percentile, meaning he scored better than 50% of same-aged people. This indicates his score falls in the average range.” It would be very easy to then state, “This suggests Mr. Appleseed is able to complete the tasks required of him in the workplace.” However, this sentence should not appear in a data-only section. Rather, should there be sufficient evidence for this assertion, it should be supported by data in the discussion section of the report. Furthermore, it is better practice to support assertions, such as the one above, with data, rather than present the data and then make a guess as to what each data point means (see: *Opinions without Sufficient Explanation*).

In one report sample I reviewed, the writer combined behavioral observation data with interpretation. This segment reads, “On the vocabulary section of the WAIS-IV, her answers started off base and were longwinded, but eventually circled back to the correct definition. This suggests that her vocabulary remains intact, yet her ability to problem solve may be impaired.” The second sentence here is an inference based upon the subject’s behavior, rather than scores obtained, during the WAIS-IV. Rather than including this information in a data-only section of the report, it will have more impact during the discussion. Then, it might read something like this, “Her ability to problem solve is impaired. For example, on the vocabulary section of the WAIS-IV, she was able to determine the correct answer only after initially longwinded, circular

attempts.” This then allows for additional data to be incorporated that supports the same point (see: *Opinions without Explanation*).

Avoidance of mixed data and interpretation in a section that should report only data requires careful writing. Allnutt and Chaplow (2000) agree that information in sections reporting data should be reported objectively, and all inferences or conclusions should be left to the opinion section of the report (p. 985). This separation allows for the opinion section to tie the findings and inference together as they relate to the psycho-legal issue and the forensic referral question (Allnutt & Chaplow, 2000).

Dos and Don'ts:

1. *Don't* include inference, opinion, and speculation in sections that only report data.
2. *Do* make sure the type and source of information are clear to the reader (i.e., facts should read as facts and opinion should read as opinion).

Inclusion of Irrelevant Data

Forensic reports can significantly impact the outcome of a court case. Given the weight placed on each evaluation, some forensic psychologists have a tendency to include every bit of data collected in the report. In this way, they make sure to demonstrate that the evaluation was exhaustive. They also create a large foundation for their opinions to rest upon later. However, the tendency to include all the information obtained can hint at the writer's uncertainty. The writer may not be sure which facts are or are not important, and so he or she includes all the data. Occasionally, the writer might find it easier to mechanically report everything rather than sorting through to find only the most relevant information. This tendency creates cumbersome reports that are bogged down by far too much data. Grisso (2010) determined that 31% of forensic reports included data or opinions that were not relevant for the referral question. He concluded that not all data should be reported, but "only those data that will be relevant for addressing the clinical or forensic questions in the case" (p. 108).

While this seems fairly self-explanatory, it can be difficult to determine which data to report and which to exclude. The psychologist is likely faced with an enormous amount of data that varies in value. Some of this data will be crucial in answering the referral question. Other data will be less relevant, but still warrant inclusion in the background of the report to aid understanding. Finally, some data will be biased, untrustworthy, or simply irrelevant. Information that falls in this last category should be discarded (Gagliardi & Miller, 2008). Karson and Nadkarni (2013) outlined two primary criteria that serve as a decision tree of sorts. First, any data that might be included should be reliable. This includes repeatable test scores and information obtained from reliable sources. Unreliable data should never be included, and reliable data should only be included if it helps tell the story. Second, some data are "so

compelling...that they *must* be included in the story” (p. 12). The remaining reliable data may or may not be included, depending on the psychologist’s judgment of relevance.

Determining which data to include or exclude can be difficult and can carry significant consequences for the subject (Griffith et al., 2010). When struggling to determine which data should be included and which data eliminated, it can be helpful to remember that the goal of the report is to answer the psycho-legal question. While more information may be uncovered during the course of the evaluation, it should be excluded unless it directly pertains to the referral question. If, for instance, a psychologist is evaluating a defendant for competence to stand trial, only material related to (1) understanding of legal proceedings and (2) ability to assist counsel should be included. If the psychologist learns that the defendant was physically abused as a child and it has no bearing on either of the two criteria noted above, it should be briefly mentioned in the background information only or eliminated. However, if the defendant were experiencing Posttraumatic Stress Disorder (PTSD) symptoms as a result of the abuse that interfered with his ability to assist counsel, the information would be relevant and should be provided in detail.

Some factual data should also be eliminated if unnecessary to the referral question. One report regarding a recently admitted patient at a psychiatric hospital stated, “Mr. Baker reported he has six younger siblings named Fiona, Phillip, Ian, Debbie, Carl, and Liam.” The names of Mr. Baker’s siblings are generally unnecessary. If a psychosocial history must be included, this sentence would be better framed as, “Mr. Baker reported he is the oldest of seven children.” However, if Mr. Baker were being evaluated for malingering or psychopathy and he had provided several different accounts of his social history, then the inconsistency warrants inclusion. Even so, this is likely best stated as, “During this interview, Mr. Baker reported he is the oldest of seven children. In three previous interviews, Mr. Baker has alternately stated he has

no siblings, three step-siblings, or that he is adopted. His self-report is highly inconsistent and unreliable.” The referral question, then, guides the inclusion or exclusion of data.

There is considerable literature dedicated to discerning what type of information is relevant. Relevance, essentially, requires omitting a significant portion of the information received and “instead providing a distillate of those features to the individual that bear directly on the issues in the case” (Weiner, 2006, p. 646). While it may be difficult to determine what information to include or discard, certain types of data should never be included. Incriminating or embarrassing data should either be omitted, or, if absolutely necessary to answer the referral question, should be rephrased (Appelbaum, 2010). Avoidance of self-incriminating information is especially important in pre-trial reports involving defendants with unresolved criminal charges (Grisso, 2010). Every attempt should be made to demonstrate respect toward the evaluatee and avoid invading the person’s privacy more than is necessary (Appelbaum, 2010; Karson & Nadkarni, 2013). All “data and speculations that are prejudicial” should be omitted (Karson & Nadkarni, 2013, p. 27). For instance, in one report often used as a teaching sample, the first opening line reads, “Ms. Doe is an attractive, 26-year-old woman.” It should go without saying that the description of Ms. Doe as “attractive” is unnecessary, equally so as a description of someone as “homely,” “unattractive,” or “unfortunate-looking.” Physical attractiveness has no bearing in answering a referral question, and is, therefore, irrelevant data.

Allnutt and Chaplow (2000) offered some final guidance regarding the inclusion of information. They opined that psycho-legal questions require understanding of psychological phenomena, rather than diagnosis. For instance, when completing an insanity evaluation, “the nature of the individual’s delusions at the time of the offense and their impact on the offending

behavior has more relevance than saying ‘this person has schizophrenia and is therefore insane’”

(Allnutt & Chaplow, 2000, p. 985).

Dos and Don'ts:

1. *Do* sift through all data collected to determine its relevance. Only data relevant to the referral question should be included.
2. *Don't* include embarrassing or incriminating data.
3. *Do* practice meticulous writing to ensure that pertinent information is not lost in a cumbersome report.

Over-reliance on a Single Source of Data

In an effort to produce concise reports and avoid the inclusion of irrelevant data, some psychologists err in the other direction and fail to include sufficient data. Often one source of data will be particularly salient. This piece of data may warrant inclusion as evidence for more than one assertion. However, over-reliance on a single source of data can generate a biased report that lacks sufficient evidence. Grisso (2010) determined that 28% of forensic reports reviewed “required additional types of data that were not obtained or were not reported” (p. 110). When data are not accessible for a valid reason (e.g., a collateral contact refused to participate in an interview or the subject refused to sign a release for additional records to be obtained), an explanation of its absence should be provided in the report.

The inclusion of multiple data sources is important for two main reasons. First, multiple data sources provide a check-and-balance, so to speak, of the data collected. Data sources can be compared to one another to determine bias, highlight errors, or illuminate contradictions in the data that need further explanation. Second, multiple data sources allow the writer to talk about the subject, rather than simply talking about the data. Multiple sources provide the writer with enough information to support the assertions offered in the conclusion (Karson & Nadkarni, 2013).

While it may seem obvious to include more than one source of data, this error occurred frequently in the reports I reviewed. I have seen this error commonly occur in two different ways: over-reliance on self-report data and over-reliance on a single assessment measure. The former occurs when the writer relies exclusively on the subject’s self-report. The writer may make several different assertions and provide evidence for each assertion. However, with careful reading, it is clear that all evidence was obtained from the clinical interview. For instance, a

competency report might state that Mr. Anderson is unable to work with his attorney because he said he does not like his attorney. While this is certainly one piece of evidence, other information is necessary to make the determination that he is incompetent because he cannot assist his attorney. Other sources of data in this instance might include collateral information from the attorney, information from the referral source, or a review of the defendant's history working with attorneys and the court. While the subject's self-reported data are frequently the most readily available information, an opinion based on self-report should only be proffered when other "reasonably reliable sources of data offer corroborative or logically consistent support" (Grisso, 2010, p. 109).

Over-reliance on self-report data may be less noticeable, although still problematic, when the writer's style implies the information is factual. When self-report information is presented as fact, the writer gives the impression that he or she has used more than one source of data. Self-report information stated as fact might read like this: "Mr. Taylor was born in New Jersey. He has three brothers. He and his brothers were sexually abused as children." Instead, self-report information should be identified as self-report. In some cases, a disclaimer might be made before beginning the section, stating that all information was obtained from the subject and has not been verified by collateral information. Otherwise, the report should read more like this: "Mr. Taylor said he was born in New Jersey. He stated he has three brothers. He reported that he and his brothers were sexually abused as children." As a rule, sources of data should be clearly identified as each is described (Grisso, 2010).

Over-reliance on a single assessment measure occurs with a high degree of regularity. Most often, the evaluator will have conducted a clinical interview as well, providing an additional source of data. However, in some reports, the writer may fail to adequately integrate

the two, instead choosing to focus heavily on the assessment data. This is especially problematic in cases involving effort testing or risk assessment, as the predictive validity improves with additional measures. I read a report on malingering for a man who had been committed to a state psychiatric hospital for competency restoration. The writer included minimal data about contradictory self-report, no information regarding behavioral observation, and one malingering assessment screen (in this case, the Miller Forensic Assessment of Symptoms Test, or MFAST). This man's MFAST score exceeded the cutoff score typically associated with a high probability of feigning. Based exclusively on this information, the writer had concluded that the man was malingering and should be returned to jail to await trial. There was no explanation regarding the limited information contained in the report.

While this is a very poor example of report writing, it is an excellent example of over-reliance on a single source of data. To improve the report and the findings, this evaluation should have included "multiple sources of data to seek support for a hypotheses," including a thorough clinical interview, extensive record review, behavioral observation, collateral information, at least three effort measures, and determination of external gain (Grisso, 2010, p. 108). A variety of data sources would have allowed for increased accuracy and a well-supported, defensible opinion.

Dos and Don'ts:

1. *Do* include all data relevant to the referral question.
2. *Don't* rely on only one source of data.
3. *Do* incorporate a variety of data sources when conducting an evaluation, when possible. The most common sources include clinical interview, collateral interview, record review, behavioral observations, and nomothetic test data.
4. *Do* explain the absence of additional information if only one source of data is available to support a particular assertion.

Improper Psychological Test Use

Another error noted in forensic reports is the improper use of psychological tests. Grisso (2010) determined that psychological test data was used incorrectly in 15% of reports reviewed. This included the use of tests that were unnecessary to answer the forensic referral question, as well as tests that were used incorrectly given the subject's age or race. Additionally, some tests were appropriate for the circumstances, but were interpreted or applied to the case incorrectly.

There are several ways to avoid this error. For instance, according to Grisso (2010), each test should be relevant and necessary to address the forensic and clinical referral questions. Once the test is deemed necessary, the evaluator should ensure that the test is appropriate for the subject in terms of age, cultural, and language norms. It is also beneficial if the test has been normed on a forensic population, but, at a minimum, there should be some indication of validity in a forensic context, such as admissibility in court. Finally, these tests should be scored and interpreted "accurately and consistent with their empirical limits and values" (Grisso, 2010, p. 109).

Kalmbach and Lyons (2006) take a firmer stand on these guidelines, stating, "Testing should not proceed unless a determination is made that a psycholegal issue can be directly addressed by the use of a particular test" (p. 273). They further caution that indiscriminate and inaccurate test administration can be "time consuming and unnecessary" or "expose prejudicial information" (p. 273). When trying to determine if a particular instrument should be used, they offered the following considerations:

- Is the test *directly* relevant to the psycholegal issue at hand? (e.g., competency to stand trial)

- Does the instrument match, *exactly*, the factor being measured? (e.g., a test normed on persons with malingered psychosis should not be used to assess for malingered Post-Traumatic Stress Disorder)
- Is the measure culturally appropriate, valid, and reliable?
- Are the tests, and/or results of the test, easily *understandable*? (i.e., will the court find the information useful?) (Kalmbach & Lyons, 2006, p. 274).

The central issue in determining a test's usefulness should be one of relevance. The only exception to this rule occurs when a particular test is mandated by the state (Kalmbach & Lyons, 2006). For instance, in Colorado, sexual offense specific evaluations require at least two actuarial risk assessment measures, including the STATIC-99 and the STABLE. In Texas, Sexually Violent Predator evaluations require administration of the Hare Psychopathy Checklist, Revised. Each state likely has particular legal requirements for certain evaluations, and the evaluator should be aware of these prior to completing an evaluation.

In my review of reports I have come across several examples of improper test use. Some evaluations conducted at a psychiatric hospital contained testing administered when the subjects were too unstable or psychotic for testing to be accurate. Similarly, some tests were conducted on individuals who needed, but did not have access to, hearing aids or glasses. In both these instances, the test may have been suitable for the referral question, but it was not suitable for the subjects who were being evaluated. Care should be taken to make sure that the tests used will assist in answering the referral question and will also be valid for a particular subject.

Frequently, forensic evaluation involves a subject with lower-than-average cognitive functioning or a poor academic history. In these cases, tests should be used that will be accurate given an examinee's abilities. For instance, the MMPI-2 requires approximately an eighth grade

reading level. Even if it would be helpful, it should not be administered to individuals who are unable to read and understand the material, unless it is administered in the audio format. In this case, the change to standardized administration should be noted in the report. In a competency evaluation, a MMPI-2 is unlikely to be helpful or relevant to the referral questions. Although it may be interesting or allow insight into treatment, the scope of the evaluation should preclude administration of the MMPI-2 in this instance. The test measure used should be directly relevant to answering the psycho-legal question (Grisso, 2010; Kalmbach & Lyons, 2006).

If a test meets all the above criteria, there are still several considerations regarding the incorporation of data into the report. In several reports I have seen, psychologists have used the right tests in the right way, but still discussed the data badly. There are several recommendations in the literature regarding the discussion of data. Grisso (2010) advises writers to identify specific scores and the normative meaning of said scores. Ackerman (2006) further states that comments should be made about the validity scales in the measure if they exist. For example, when discussing the MMPI-2, a statement should be made about the validity scale profile as well as the normative scale. Karson and Nadkarni (2013) indicated their preference that numeric scores (such as the standard scores on the WAIS-IV or the T-scores on the MMPI-2) be reported with the percentile rank. They also suggested avoiding the use of the confidence interval, as it tends to be confusing for most readers and can make the writing less clear.

Although there is some disagreement regarding the use of specific scores, actual scores are necessary in reports in order for psychologists to evaluate one another's work (Gudjonsson & Haward, 1998). If a report states, for instance, "Mr. Swift's score on the Schizophrenia scale was elevated," this does not offer the psychologist reader much information. While the layperson may not know that a T-score of 84 on the Schizophrenia scale on the MMPI-2 is elevated, a

psychologist will know that the score is significantly elevated. Therefore, for both specificity and readability, the statement should read more like this: “Mr. Swift’s score on the Schizophrenia scale was significantly elevated (T=84, where a T-score greater than 65 is significant).” Further explanation could then be given regarding the percentiles or other scale scores to paint a more accurate picture of the subject. It additionally allows the professional reader to discern if the evidence provided by the writer is strong or weak.

Finally, under no circumstances should the computer-generated interpretative report be used in place of the psychologist’s interpretation (Ackerman, 2006). A psychologist’s use of the verbatim interpretive report might imply that he or she does not have an adequate understanding of the measure. When faced with a significant amount of work, it can be tempting to simply cut and paste large sections of an interpretive report. However, this is problematic for a few reasons. First, the interpretive report is only a suggested interpretation; the psychologist can then choose to proffer this interpretation in his or her report. Second, in some interpretive reports, the standardized sentences conflict with one another. This occurs when the written interpretation is generated based upon one data point only, not a cohesive picture of the results. While it may save time, the information could be inaccurate for the particular subject. In some cases, this can also violate copyright laws, and the segments used from computer-generated text are often bulky or full of technical information. In general, the practice of copying computerized reports diminishes the role of the psychologist and eliminates the need for clinical skill. Better writing requires careful interpretation by the psychologist, and decision-making regarding the inclusion and subsequent explanation of data.

Dos and Don’ts:

1. *Do* choose a test that is relevant and necessary to answer the psycho-legal question.
2. *Do* use a test that is valid given the subject’s age, race, language, and general ability level.

3. *Don't* use a test that will not be understandable to the court.
4. *Don't* use a test that is not valid and reliable.
5. *Do* report scores in the report, including validity, normative data, and percentiles.
6. *Don't* talk about confidence intervals.
7. *Don't* use the computer-generated interpretive report as your own unless explicitly allowed by the publisher.

Failure to Consider Alternative Hypotheses

In court, an attorney presents information about his or her case in such a way that the narrative is convincing to the judge and jury. Typically, the attorney will present information to support his or her client's case, and refute information that damages his or her client's case. If they cannot refute the information, the attorney might find a way to cast doubt on the information presented by the opposing attorney. In forensic writing, some psychologists take this same approach. However, in attempting to provide a convincing case for the reader (i.e., the court), some writers fail to consider alternative hypotheses. Grisso (2010) determined that, in 30% of reports reviewed, the data allowed for alternative interpretations, but the writer did not address these alternative explanations or discuss why they were ruled out.

One significant problem with this approach, aside from a potentially biased report, is that the report is less defensible in court (Weiner, 2006). In order to defend a particular opinion in court, it is necessary to understand why one opinion has more credibility than another. If some evidence, especially salient evidence, is ignored, it presents the reader, in this case the court, with a false sense of certainty (Karson & Nadkarni, 2013). Therefore, once data are collected, the best practice is to include all relevant information, even if information obtained does not support the writer's hypothesis. If the writer considers only the information that fits with his or her initial hypothesis, the writer has fallen prey to confirmation bias (Ackerman, 2006).

One mistake that contributes to this error is the assumption of causality. For instance, if I am completing a defense mitigation evaluation for Mr. Smith, and I learn that he sustained a significant head injury prior to committing his first offense, I cannot then state that the head injury caused his dangerous behavior. Rather, I would discuss the potential correlation between the head injury and his behavior, and then discuss the relevance for continued risk. I would also

discuss any inconsistencies or contradictions to account for alternative hypotheses (Karson & Nadkarni, 2013). For instance, I might state that Mr. Smith's dangerous behavior was preceded by a head injury, as well as an increase in substance use and the onset of symptoms of depression. Even if I believed the head injury was the root cause of all behavioral problems and mental health symptoms, I would not determine causality or eliminate other plausible explanations from my report. The reader would likely trust my opinion more and gain more "confidence in the credibility of the report" (Allnutt & Chaplow, 2000, p. 985). I would also be able to think critically about the data I provided, allowing me to provide better recommendations for the court.

Like all errors, this error falls on a spectrum from hardly noticeable to egregious and unethical. One notably poor Child and Family Investigation report (often referred to as a custody evaluation) provided a dramatic example of this error. Upon one reading, the general tenor of the report was, "I don't like the mother." Nearly every paragraph in the 30 page report presented a biased view of the case, with substantial information offered against the mother but no information offered in favor of the mother. Similarly, the father was painted as the obviously superior parent who had no faults. Although I am not a parent myself, I think it is safe to say that no parent is perfect and both parents likely had strengths and weaknesses. In this particular case, the mother had a seizure disorder and both children had chronic medical conditions. The mother, at the time the primary parent, was often late to her appointments with the evaluator. The evaluator determined that the lateness was caused by indifference to her children and a lack of respect toward the evaluator and the court. In the evaluator's mind, the mother simply was not taking the process seriously and therefore likely would not take motherhood seriously. While this alone is a huge leap, the report also failed to address any alternative explanations for the

mother's tardiness and assumed a negative reason was the cause. The evaluator unequivocally recommended that the father become the primary parent and the mother have only supervised parenting time.

Later in this same case, I learned that the father had been in prison for the last nine years (the children were 12 and 10 years old at the time), and he had been reported to Child Protective Services for child abuse and neglect three separate times during the three years of his children's lives that he was partially responsible for their care. This information, although known at the time of the evaluation, was not discussed. This evaluator's failure to include alternative hypotheses about the mother and failure to incorporate all available data was a shocking example of biased reporting. The evaluator had determined the father should be the primary parent, and so only evidence that aligned with this view was presented. This substantially damaged the credibility of the report, and I imagine that the report was easily discredited by opposing counsel. While most people, including myself, can make judgments based on nothing more than intuition, it is exceptionally important to maintain awareness of potential bias, explain all the data, and support opinions with evidence. I find it useful to continually ask myself, "What else could be happening?" I find that this generally helps me to organize my thoughts about a particular case and discuss all the data. If I do not think a piece of data fits, I explain why in the report, rather than eliminating that particular piece of data. Karson and Narkarni (2013) specifically recommend that "an alternative hypothesis for which there is a good deal of evidence should be presented and rebutted rather than ignored" (p. 99). When in doubt, I seek consultation with trusted colleagues or supervisors.

Avoiding this error requires a fairly high degree of self-awareness and attention to the process. In some ways, it is a bit like the teacher's instruction to "show your work" (Dvoskin &

Guy, 2008) in a high school math class. This is important in report writing because it makes the writer credible to the reader. The reader wants to be able to follow the writer's process to see why certain conclusions were adopted and others discarded. Karson and Nadkarni (2013) recommend looking at all the pieces of data and asking "What is the best way to account for these data that answers the referral question?" and not "Do the data support or refute the specific hypothesis I am gathering data to test?" (p. 75). Once a conclusion is generated, the writer should address both consistencies and inconsistencies in the data (Gudjonsson & Haward, 1998). Any alternative explanations should then be discussed, and the writer should offer a reason about why this data did not fit as well with the overall opinion (Grisso, 2010).

Dos and Don'ts:

1. *Do* look for other explanations for the data and discuss these in the report.
2. *Don't* fall prey to confirmation bias. Make sure the opinions support the data, rather than the other way around.
3. *Don't* attribute causality.
4. *Do* present other hypotheses and talk about why they were refuted.
5. *Do* note consistencies and inconsistencies in the data.
6. *Do* make sure the report will be defensible in court by offering explanations for all possible hypotheses, and evidence for why the hypothesis you are proposing is the most plausible. This will lend credibility to the report.

Opinions without Sufficient Explanation

Psychology requires knowledge of people and behavior. In forensic reports, this knowledge, along with acquired information about the subject, is used to offer an opinion. The more experienced the psychologist is, the more accurate this opinion. However, even the most accurate opinion loses some validity if its origin is not explained. By far, the most common and most problematic error noted in the literature was the tendency to provide opinions without explanation. Grisso (2010) stated that reports failed to identify the connection between the data and the offered opinion in 56% of reports reviewed. In more than half the reports, major interpretations, opinions, or conclusions were offered without explaining how they were derived (Grisso, 2010).

The opinion is arguably the most important section of any report. While the sections on data presentation lay the foundation, the opinion is the purpose of the paper. Without the opinion, the referral question cannot be answered. Because of this, the writer may spend half of his or her time writing the opinion, even when it only accounts for 20% of the total report (Resnick & Soliman, 2012). This is the section that is of the most interest to the court and the most pertinent to the legal question. On occasion, this may be the only section the judge reads. Because of this, the reasoning process should be clear and evidence should be presented to support each assertion. The report will likely be given more credibility if the writer crafts a strong argument in the conclusion (Allnutt & Chaplow, 2000).

Even if the writer knows that opinions should be supported by evidence, he or she may not know how to create a strong argument. One goal in creating a better conclusion should be to write as a *clinician* and not a *technician* (Karson & Nadkarni, 2013). By clinician, I mean someone who uses clinical judgment to apply a technical skill. While a technician may be able to

accurately administer an actuarial measure and state a person's scores, a clinician would be able to take these scores and integrate information about base rates, incorporate other data, and exercise clinical judgment to develop an opinion. Writing as a clinician rather than a technician requires a different level of skill.

One way to strengthen and clarify the opinion section of the report is to begin by “mapping” the opinion (Resnick & Soliman, 2012). This process is similar to outlining. Resnick and Soliman (2012) recommend listing all the opinions that will be offered in the report, followed by a list of all the evidence underlying each opinion. Then, the evidence underlying the opinion can be grouped into similar categories for clarity. For instance, if I offer the opinion that Mr. Richards cannot assist his attorney in court, I might want to include information about his auditory hallucinations, past disruption of court proceedings by talking aloud, statements that he is trying to fire his attorney, disorganized and incoherent speech, a history of leaving his seat during court, and observed agitation when discussing his relationship with his attorney. Rather than speaking about each of these individually, I would group this information into three categories: psychiatric instability (i.e., auditory hallucination, disorganization), erratic behavior (history of disrupting court proceedings, inability to stay seated in court), and a poor relationship with his attorney (statements that he would like to fire his attorney, agitation when discussing his attorney's role). This will help streamline the writing and make the argument clear, while also offering sufficient evidence for the opinion. The evidence should be discussed in order from strongest to weakest. In some cases, there might be so much evidence available that the weakest points can be eliminated (Resnick & Soliman, 2012).

Karson and Nadkarni (2013) recommend a similar approach to the opinion section. However, this approach requires that the writer work backward in mapping out the opinions

offered in the report. Using this method, the writer would state the opinion about the referral question, ideally in one sentence. Then, the writer would work backward to determine the foundation for this opinion (Karson & Nadkarni, 2013). Each assertion that the final opinion rests on should become a topic sentence in the conclusion section, followed by the evidence supporting each assertion (Karson & Nadkarni, 2013). In this way, when the reader reaches the final conclusion, he or she should not be surprised by the opinion offered.

I read one malingering evaluation where the conclusion consisted of only one paragraph, beginning with the sentence, “Based on the available data, Mr. Baker is malingering psychiatric symptoms.” The writer then briefly recounted the scores from two symptom validity tests. A better, more defensible way to approach this would be to use the backward mapping suggested by Karson and Nadkarni. For instance, the writer might establish, as the topic sentence of the final paragraph, that Mr. Baker is malingering psychiatric symptoms. The foundations for this assertion might be: (1) Mr. Baker is exaggerating psychiatric symptoms, (2) he is doing so intentionally, and (3) he is exaggerating these symptoms for secondary gain. Each of these sentences would then become topic sentences of previous paragraphs in the opinion.

After the writer has mapped out the assertions necessary to provide the foundation for the final opinion, each assertion should be supported by evidence. This evidence should be based on the data obtained during the evaluation (Gudjonsson & Haward, 1998). While at one point, psychologists may have been able to say, “This is my opinion, because I am a doctor,” the current literature recommends explicitly addressing the link between the data, observations, and the conclusions drawn (Witt, 2010).

Good writers continually ask, “How do I know that?” (Karson & Nadkarni, 2013). In the previous example, for instance, the writer should critically examine how she knows that Mr.

Baker is exaggerating symptoms (perhaps from symptom validity testing and incongruence between reported and observed behavior), and then use this evidence to support the assertion.

After identifying the relevant evidence for each assertion, the evidence should be explained to the reader. In one report reviewed, the writer made an assertion that the client enjoys attention from her therapist. One piece of evidence provided read as follows, “Ms. Baudelaire scored in the elevated range on many scales of the MMPI-2, which is a self-report measure.” No other information was offered. While this might be evidence that Ms. Baudelaire over-reports symptoms to gain attention, the connection between the evidence and the assertion should be explicitly discussed (Resnick & Soliman, 2012).

In crafting a well-reasoned and well-supported opinion, there are several things to avoid. The writer should be careful to support his or her assertions with good evidence. For instance, tautological explanations, or those that tell “the reader nothing that was not already contained in the behavior that the writer is explaining” (Karson & Nadkarni, 2013, p. 103) should be staunchly avoided. The statement, “He was malingering because he was faking his symptoms” is a tautology, as is the statement, “He was reactive because he was angry.” Additionally, it is good practice to make relative rather than absolute statements and to describe rather than categorize the subjects of evaluations (Weiner, 2006). It would be better to state, “Mr. Johnson had a limited ability to cope with stress” rather than, “Mr. Johnson had an inability to cope with stress.” Similarly, describing Ms. Brown as “tangential, disorganized, and responding to internal stimuli” would be more beneficial for the reader than stating “Ms. Brown is schizophrenic.” Description, as evidence, is more straightforward for the reader and tends to be more factual and less disputed. Therefore, it provides better evidence of a particular assertion than naming a category to which the subject belongs.

Opinions should not be offered if they are outside the evaluator's area of competence (Grisso, 2010). For instance, a psychologist should not make claims about the side effects of a particular medication. This is also applicable in the discussion of the ultimate opinion. The ultimate opinion is the question that the court is attempting to answer (Ackerman, 2006). While the psychologist may contribute information used in deciding the ultimate opinion, determination of the outcome of the case crosses into legal territory, placing this opinion outside of the psychologist's area of competence. The majority of literature agrees that this final legal determination is the court's responsibility, and the psychologist's role is to provide the judge and jury with an adequate description of the person's mental state as it pertains to this issue, but nothing more (Allnutt & Chaplow, 2000; Resnick & Soliman, 2012). However, there is some contradicting evidence. Ackerman (2006) referenced several surveys concluding that "75% of psychologists believe that psychologists should address the ultimate issue" (p. 69). In some cases, referencing the ultimate issue may be inherent in the referral question and will therefore require discussion. For instance, in a competency evaluation, the court is attempting to determine if an individual is competent to stand trial. The evaluator has the same goal. In this instance, the evaluator must address the ultimate issue to have satisfactorily answered the referral question. As a rule of thumb, legal issues that fall outside the question posed in the referral should not be addressed in the opinion of the report.

Dos and Don'ts:

1. *Do* spend the most time on the opinion section of the report.
2. *Don't* provide opinions without articulating the basis for the opinion explicitly.
3. *Do* begin writing the opinion section by mapping all the assertions necessary to provide a foundation for the final opinion.
4. *Do* support each assertion with evidence gathered from the data, and *do* describe why this information is evidence for the assertion.
5. *Don't* use tautologies as evidence.
6. *Don't* write in absolutes.

7. *Do* describe subjects rather than categorize them to provide additional explanation for the opinion and increase defensibility.
8. *Don't* answer questions outside your area of competence or stray from the referral question.
9. In general, *don't* provide the ultimate opinion unless directly specified by the nature of the referral.

Conclusion

Good writing is a skill. Like any other skill, writing can be improved with practice, dedication, and good guidance. Forensic report writing requires a particular skill set because the impact of the work is greater than in most psychological writing. If a psychologist offers an accurate opinion, but does not sufficiently support this opinion in the report, it may lack credibility in court. To improve forensic report writing and better inform the court, this is a skill worth practicing.

Each identified error is framed to provide recommendations and promote better writing. A good report must adequately address the referral question, demonstrate good organization and clear writing, use test measures correctly, include all necessary data but nothing more, address all hypotheses, and provide evidence for the proffered opinions. In doing so, the forensic report will tell a story to the court, provide a clear picture of the specific subject, and help to inform the court's decision. A report that adheres to these criteria will also serve as a guide for subsequent testimony. If the report writer does not follow these guidelines the report will, at best, fail to inform the court, and, at worst, cause harm to the subject of the report or the community.

While many of the errors identified may seem easily avoidable, good writing requires constant dedication. This is true regardless of experience. Trainees may make these errors because of limited knowledge, skill, or practice. More seasoned clinicians may make these same errors because of lack of familiarity with forensic writing or complacency. To improve forensic reports, I think a two-pronged approach is most effective. First, the information about the most common errors and the recommendations for good reports should be used to develop a foundational understanding of the task. This serves to help the writer prevent some of these

errors altogether. Second, the information should be used as a checklist to review the completed report. Each section is formatted for use as a quick reference for this purpose.

This paper serves to gather all available information about the most common errors in forensic report writing in one place, and then to provide specific guidance for correcting these errors using real world examples. While this is intended as a guide for trainees, anyone looking to begin or improve forensic report writing might benefit. Future research might focus on gathering empirical data on forensic reports. A larger sample of forensic report writing would provide more accurate prevalence statistics or highlight other areas for improvement. Additionally, a review of errors from multiple disciplines, including psychologists, psychiatrists, attorneys, and judges, may provide additional insight into report writing. An alternate perspective may highlight new areas for improvement or provide new recommendations for errors that have already been identified.

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Appendix

Dos and Don'ts: Quick Reference

- ✓ **Do** present the information in a logical sequence. The information presented in a report should build upon itself so the reader does not need to refer to later sections of the report.
- ✓ **Do** determine what structure report is best for the particular case.
- ✓ **Don't** overwhelm the reader with needless information.
- ✓ **Do** consider length; ask the referring party for guidance.
- ✓ **Do** make the conclusion the most important part of the report. Although it may be shorter than the data presentation section, it should be the most time consuming to write.
- ✓ **Don't** use overly technical language.
- ✓ **Do** avoid grammatical errors, lack of clarity, and poor writing style.
- ✓ **Do** remember that poor writing causes the writer, and therefore the opinion, to lose credibility with the reader.
- ✓ **Do** write reports so they can be easily understood by all audiences.
- ✓ **Don't** use lengthy, flowery language and long sentences.
- ✓ **Do** proofread!
- ✓ **Don't** include inference, opinion, and speculation in sections that only report data.
- ✓ **Do** make sure the type and source of information are clear to the reader (i.e., facts should read as facts and opinion should read as opinion).
- ✓ **Do** sift through all data collected to determine its relevance. Only data relevant to the referral question should be included.
- ✓ **Don't** include embarrassing or incriminating data.
- ✓ **Do** practice meticulous writing to ensure that pertinent information is not lost in a cumbersome report.
- ✓ **Do** include all data relevant to the referral question.
- ✓ **Don't** rely on only one source of data.
- ✓ **Do** incorporate a variety of data sources when conducting an evaluation, when possible. The most common sources include clinical interview, collateral interview, record review, behavioral observations, and nomothetic test data.
- ✓ **Do** explain the absence of additional information if only one source of data is available to support a particular assertion.

- ✓ **Do** choose a test that is relevant and necessary to answer the psycho-legal question.
- ✓ **Do** use a test that is valid given the subject's age, race, language, and general ability level.
- ✓ **Don't** use a test that will not be understandable to the court.
- ✓ **Don't** use a test that is not valid and reliable.
- ✓ **Do** report scores in the report, including validity, normative data, and percentiles.
- ✓ **Don't** talk about confidence intervals.
- ✓ **Don't** use the computer-generated interpretive report as your own unless explicitly allowed by the publisher.
- ✓ **Do** look for other explanations for the data and discuss these in the report.
- ✓ **Don't** fall prey to confirmation bias. Make sure the opinions support the data, rather than the other way around.
- ✓ **Don't** attribute causality.
- ✓ **Do** present other hypotheses and talk about why they were refuted.
- ✓ **Do** note consistencies and inconsistencies in the data.
- ✓ **Do** make sure the report will be defensible in court by offering explanations for all possible hypotheses, and evidence for why the hypothesis you are proposing is the most plausible. This will lend credibility to the report.
- ✓ **Do** spend the most time on the opinion section of the report.
- ✓ **Don't** provide opinions without articulating the basis for the opinion explicitly.
- ✓ **Do** begin writing the opinion section by mapping all the assertions necessary to provide a foundation for the final opinion.
- ✓ **Do** support each assertion with evidence gathered from the data, and **do** describe why this information is evidence for the assertion.
- ✓ **Don't** use tautologies as evidence.
- ✓ **Don't** write in absolutes.
- ✓ **Do** describe subjects rather than categorize them to provide additional explanation for the opinion and increase defensibility.
- ✓ **Don't** answer questions outside your area of competence or stray from the referral question.
- ✓ In general, **don't** provide the ultimate opinion unless directly specified by the nature of the referral.