

AAPL Newsletter

American Academy of Psychiatry and the Law



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**Forensic Psychiatry Review Course:
October 22-24, 2012
AAPL 43rd Annual Meeting:
October 25-28, 2012
Le Centre Sheraton, Montreal, PQ, Canada**



Montreal by night.

Traumatic Brain Injury, Amnesia, and Competency to Stand Trial

Steven J. Zuchowski MD, Susan Hatters Friedman MD, Renee M. Sorrentino MD, and Richard Bissett PhD

The holding of *Wilson v. United States* (1968) is well known. However, evaluating the competency to stand trial of a brain-injured individual who is allegedly amnesic for a crime is far from a straight forward endeavor. These individuals present with complex neuropsychiatric problems involving not only alleged amnesia for the time surrounding their alleged crime but also the potential for subtle deficits in current cognitive functioning. As in most forensic assessments, the possibility of partial malingering must also

be considered. These defendants may be accompanied by a plethora of conflicting and confusing neuropsychological reports. Here we provide a brief review of the current case law and literature related to the topic of amnesia and competency to stand trial. The role of psychological testing is discussed. We then focus on practical considerations in formulating a written opinion that incorporates elements of the *Wilson* case without straying too far into the judge's province. Finally, several

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2012 Guttmacher Award Announced

Michael R. Privitera, MD, MS will receive the prestigious Manfred S. Guttmacher Award at the Semiannual Meeting of the American Academy of Psychiatry and the Law in Philadelphia, in May 2012.

The award, which was established in 1967 and first awarded in 1972, is co-presented by the American Psychiatric Association and AAPL, honors outstanding contributions to the literature of forensic psychiatry.

Dr. Privitera is Associate Professor in the Department of Psychiatry at the University of Rochester School of Medicine and Dentistry. A consultant to hospital medical and surgical units in the areas of mood disorders and psychosomatic medicine, he co-chaired the University's Workplace Violence Committee for more than 6 years. He is the author of the award winning book "Workplace Violence in Mental and General Healthcare Setting", published by Bartlett.

The lecture "Workplace Violence in Mental and General Healthcare Settings: Development and Concepts" will take place at 2:30 p.m. Sunday, May 6 in Room 113A-C, Level 1 in the Pennsylvania Convention Center.



American Academy of Psychiatry and the Law

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COVER STORY

Traumatic Brain Injury

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counter arguments seen during cross examination will be discussed.

Wilson v. US (1968) was a D.C. Circuit Court of Appeals case in which Wilson contested that he had been competent to stand trial in light of his uncontested permanent retrograde amnesia. The court required an extensive judicial post-trial review of whether the defendant's amnesia had deprived him of a fair trial and effective assistance of counsel. Whether or not the government contests the amnesia appears critical.

In addition to *Wilson*, other cases shed light on this issue. In *Dusky v. US* (1960), the Supreme Court spelled out standards for competency to stand trial. Recall also that Dusky himself had denied memory of events surrounding the kidnapping. *Wilson* was a solitary Circuit Court ruling and most other courts have not taken this approach. No American court has found amnesia alone to be a bar to competency. (Thyssen, 2005) In *US v. Stevens* (1972), the 7th Circuit Court found that amnesia was not a bar to prosecuting a defendant who was otherwise competent. More recently, in *US v. Andrews* (2006), the 7th Circuit Court found that continuing the approach of being mindful about signs of incompetence other than amnesia during the trial were appropriate, rather than a post-trial *Wilson* type review.

Amnesia Claims: Offenders who claim partial or total amnesia for their crimes are not rare. 20 to 45 percent of individuals charged with a serious crime claim amnesia (Kopelman, 1995). The crimes most frequently associated with claims of amnesia are homicide and to a lesser extent domestic violence, sexual offenses and fraud (Bourget & Bradford, 1995; Swihart, Yuille & Porter, 1999; Kopleman et al, 1994). The psychiatric literature does not provide a consistent, generally accepted classification of amnesia. Most classification systems, however, include three basic categories of amnesia: dissociative, organic and feigned or malingered. Dissociative amnesia for criminal behavior is thought to origi-

nate from extreme emotions that accompany such behavior. Dissociative amnesia is more commonly reported with crimes that are unplanned, involve a significant other, and are committed in a state of agitation. (Kopelman, 1995)

Dissociative amnesia is theorized to arise from extreme levels of arousal during the commission of a crime, which interferes with the memory's subsequent retrieval. Individuals who claim memory loss consistent with dissociation are more likely to alert the police to their crimes and less likely to deny the offense than those who do not claim amnesia. Organic amnesia arises from a physical or structural defect such as brain trauma, stroke or drug intoxication (Kopelman, 1995). The memory loss in organic amnesia is thought to arise from storage problems rather than retrieval problems. Feigned or malingered amnesia refers to individuals who fake amnesia for a secondary gain such as avoiding conviction or punishment from a crime. Anti-social personality disorder, low intelligence and frontal executive dysfunction have been associated with feigned amnesia (Cima *et al*, 2003).

The pathologic conditions associated with claims of amnesia include psychiatric disorders, such as dissociative identity disorder, psychosis, parasomnias, or substance abuse and neurologic conditions, such as traumatic brain injury and stroke. Traumatic brain injury may include a retrograde amnesia for the criminal act and prior events and/or anterograde amnesia.

Profile of amnesic defendants: Some studies of psychiatric prison inmates who claim amnesia for their crimes have found lower IQ, poor performance on executive function tests, and heightened scores on malingering (Cima *et al* 2003). Other studies have shown that defendants who claim amnesia are on average older than non-amnesic offenders and have more prior convictions. Hakkanen et al. (2008) examined offender characteristics in female and male homicide offenders claiming no, partial and complete homicide-related amnesia. Females (61%) claimed amnesia more

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Collaborating with Medical and Mental Health Colleagues

Charles C. Dike MD, MPH, MRCPsych



Too many cooks spoil the stew.

With increasing splitting of medicine into sub- and super specialties, the need for collaboration

between practitioners has never been stronger. In psychiatry, however, collaboration is increasingly difficult and perilous.

Once upon a time, in an era long gone and forgotten, a psychiatrist was considered the sole captain steering the ship of treatment for an individual with mental health needs. The psychiatrist did the initial assessment, generated diagnosis and planned treatment, which could be a referral to other mental health colleagues for therapy, if the psychiatrist did not have enough time for (or interest in) providing psychotherapy. Did this ever happen or was it all in my imagination?

These days, the landscape could not be more muddled. A new title known as ‘Clinician’ has emerged and has subsumed the psychiatrist as only one of many mental health professionals including psychologists, social workers, advanced practice nurses (APRNs) and therapist (Licensed Practical Counselors, Marriage and Family Therapists, etc.). Another title, ‘Prescriber,’ is generic for anyone who could prescribe medications, and may include psychiatrist, APRN, neurologist, and primary care physicians (PCP), to mention a few. All of these ‘Providers’ (yet another equalizing title) could be involved in providing care for our patients, a confusing picture that leaves some unsuspecting patients with the wrong impression that expertise, training and qualification are the same across these different groups.

Take the case of one patient who insisted she needed stimulant medication for ADHD because her therapist (a Marriage and Family Counselor) had

diagnosed her with ADHD. When the psychiatrist later informed her that she (psychiatrist) did not believe the patient had ADHD but major depression with severe anxiety that had impaired the patient’s attention/concentration, the patient replied, “That’s your opinion. My therapist feels strongly that I have ADHD. Which of you two doctors should I believe?” Unsurprisingly, the patient wrongly believed her therapist was a doctor. When the psychiatrist later called the therapist, she got the same response; “that’s your opinion, doctor, I know what I know. My questionnaire has confirmed it.”

What about the case of a PCP who knows he shares a patient with complicated psychiatric disability with a psychiatrist, but who proceeds to change one of the patient’s psychotropic medications without consulting the psychiatrist? The patient who is on treatment for resistant mood disorder, often comes for follow up appointment with the psychiatrist on yet another new psychotropic medication added by the PCP, which unbeknownst to the psychiatrist, he had been taking for a couple of weeks? Apart from questions of liability, a major question is who is in charge of the patient’s psychiatric care? Does it make sense for the psychiatrist to remain involved?

In a related case, a primary care physician argued with a psychiatrist about side effects of an antidepressant; the psychiatrist had informed the PCP that the patient appeared to be in early stages of a movement disorder, possibly Parkinson’s Disease, and asked the PCP to refer the patient to a neurologist for evaluation. The PCP smugly told the psychiatrist, “I have seen many patients on this antidepressant with this type of side effect.” When the movement disorder got progressively worse despite discontinuation of the medication, the PCP finally referred the patient to a neurologist who promptly diagnosed the patient with Parkinson’s Disease.

Perhaps it is in collaborating with a

neurologist that the distinctions are most unclear. Of course it is easier if, for example, the neurologist prescribes an anticonvulsant medication for seizure treatment or prophylaxis in an individual with Bipolar Disorder, but even in such situations, careful and purposeful collaboration is indicated for prescribing medications that would optimally target both problems. However, there are other situations where neurologists encroach on the turf of psychiatrists. An example includes a case in which the neurologist started a patient on antipsychotic medication despite being aware that the patient is also seeing a psychiatrist, and then asks the patient to have the psychiatrist continue the medication. How would one define this relationship? If the neurologist respected the expertise and training of the psychiatrist, would he not have deferred to the psychiatrist for possible treatment with antipsychotic? As it ultimately turned out, the patient did not need antipsychotics; the symptoms he described did not hang together in a way that would support a psychotic process. It was later determined the patient was malingering.

This issue of disrespect for psychiatrists’ expertise appears to be at the core of these problematic collaborations. An MD who graduated from a combined internal medicine and psychiatry residency program, who later practiced medicine until retirement before deciding to work in psychiatry, remarked during an interview for a job, that “psychiatry is easy; everyone has depression, bipolar disorder or schizophrenia.” No practicing psychiatrist grappling with the difficulties of treating patients would ever utter such a statement.

So, how should a psychiatrist collaborate with other medical colleagues or mental health professionals? Should psychiatrists just “grin and bear it” when they encounter disrespectful colleagues? The difficulty, of course, is the patient caught in the middle of these contrary opinions. There is an African proverb which states that when two elephants fight, the grass suffers. Whatever the solutions to these wrinkles of collaboration, we must strive to ensure the patient does not become the grass that suffers. ☪

Traumatic Brain Injury

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frequently than males (42%). IQ and psychopathy indicated no significant relationship with claims of amnesia in either gender. Evans *et al.*, (2009) examined the prevalence and phenomenological qualities of amnesia in convicted violent young offenders. Results suggest a lower rate of amnesia found for violent offenders than previously reported. This study also described an association between amnesia and a perceived lack of control during the offense. This finding, although not replicated, suggests impairment in cognitive processing when individuals perceive an event is “out of their control” (Evans *et al.*, 2009).

Potential pitfalls in evaluations:

The potential pitfalls in evaluating defendants reporting amnesia include the following: disregard of other potential mitigating/legal considerations, missing the diagnosis, inadequate knowledge of the neuropsychiatric literature, and bias or skepticism of defendants claiming amnesia. The legal considerations in a competency to stand trial evaluation include evaluation of other potentially impaired criminal competencies and possible mitigating factors such as diminished capacity. Psychiatric comorbidity is common in individuals with claims of amnesia. For example in studies of individuals with traumatic brain injury, PTSD (14%), acute stress disorder (24%), and major depression (19-30%) were common (Bryant *et al.*, 1998; Schwarzbald, 2008). A complete evaluation should include examination for psychiatric disorders which are comorbid with TBI and/or mimic TBI. Skepticism of a defendant’s claim of amnesia should be balanced by a competent knowledge of the science of amnesia. Experts who evaluate amnesic defendants must familiarize themselves with the biologic and neurologic characteristics of amnesia. In cases of traumatic brain injury and claims of amnesia, neurologic consultation is often necessary in order to determine the scientific feasibility of such claims.

Psychological Testing: Both neuropsychologists and psychologists are

often tasked with evaluating individuals with traumatic brain injury (TBI) and alleged amnesia of events surrounding the crime. The main goals for the neuropsychologist/psychologist are to assess both current cognitive functioning (especially the ability to learn new information) and response bias (however this is articulated – lack of effort, feigning, malingering, suspect performance, etc.). Neuropsychologists are preferable for this task in that they are trained to give both a more comprehensive assessment of current functioning and a wider range of effort tests (especially those embedded in standard cognitive tests). It is recommended the neuropsychologist utilize a sufficient quantity of dedicated (free-standing) and embedded measures dispersed throughout the evaluation. Increasing the number of these measures dramatically reduces the number of false positives – the number of credible individuals classified by the measures as suspect.

Neuropsychologists also employ other means to assess response bias, including 1) comparing inconsistent scores within the present evaluation and across time (an example of this would be recall memory performance better than recognition memory); 2) noting test scores inconsistent with activities of daily living (ADLs); and 3) documenting inconsistencies between test scores and the nature of the injury. An example of the latter would be low test scores not matching those expected for mild TBI. Given ambiguous results from effort testing of memory, one can utilize evidence of feigning in other cognitive domains (e.g., motor/sensory), if available, to generalize that feigning of memory is also likely. Given strong results on feigning of current memory, one can generalize that feigning of memory of past events (surrounding crime) is also likely.

Wilson v. U.S.: To Reference or Not: Although the guidance of the Wilson case with regard to amnesic defendants is quite clear, many forensic practitioners are not comfortable with the idea of explicitly referencing case law within their reports. One member’s audience comment during

the authors’ recent presentation likely summed up the feelings of many: “We are not lawyers!” However, others feel that our educational role in the courtroom demands that we point out and explicitly reference case law that we believe to be relevant. Clearly, if reference is made to Wilson or any other legal case, the physician author should do so with a degree of humility so as not to give the impression of invading the judge’s area of expertise. Most of us don’t appreciate when judges play doctor and we can safely assume that judges feel the same about doctors playing lawyer. That said, making an explicit reference to the Wilson holding in a forensic report can simply be the most straightforward and clear thing to do, assuming that is where the crux of that part of the opinion is coming from. One alternative for those who simply do not feel comfortable referencing case law in their forensic reports is to describe the principles derived from the Wilson case but stop short of actually referencing the case. Although acceptable, this may give the impression that the author is being less than fully transparent in referencing his or her sources.

One way to approach this issue in a forensic report is as follows: “It is my understanding that amnesia alone, even when being of undisputed authenticity, has repeatedly not been held to be a *per se* bar to a finding of competency to stand trial. In light of case law that I believe to be relevant to the issue of amnesia and competency to stand trial (such as *Wilson v. United States* 391 F.2d 460 D.C. Cir. 1968), it is my opinion that the defendant’s amnesia does not itself render him incompetent to stand trial. The Wilson court laid out the following factors for the consideration of the trial court when a defendant claims to be amnesic for his alleged crimes...”

Alternatively, one may offer a split opinion— that but for the issue of amnesia for the time of the offense, the defendant meets the Dusky standard. The practitioner could then go on to briefly explain that according to his or her training and experience, the issue of competency to stand trial in the case

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AAPL – The State of Our Union

Charles L. Scott MD, President



If I was ever asked to give a “State of the Union” address as the current AAPL President, I imagine my opening line might read

something like this: “The State of AAPL’s union is good. But, we can be better. And we should be.”

In my eyes, I see that AAPL’s main mission involves educating our peers, legal colleagues, residents, policy makers, and the general public on key issues relevant to the practice of forensic psychiatry. I envision a day when AAPL members are without question considered the most effective national educators, evaluators, policy makers, and researchers in our field. What might we all do to reach that goal?

First, we should each strive to set the highest standard in our teaching activities. As a forensic psychiatrist, we are always teaching someone as part of our work, even if we don’t actually mean to or aren’t very good at it. Educating a patient about their diagnosis or potential medication side effects is as valuable a teaching experience as is explaining to a jury why you think someone was criminally insane. One obvious way to evaluate our teaching abilities is to enhance the peer review comments from presentation at the annual AAPL meeting. To accomplish this goal, I encourage each AAPL member to provide more detailed feedback to the program and education committees regarding their conference educational experience.

Frequently, there are only a few comments submitted for presentations despite the large number of attendees. Whether you realize it or not, the AAPL leadership, committees, and presenters take your comments very seriously and make adjustments to the next year program as a result of your input. How can we strive for teaching excellence if we don’t have a meaningful understanding of what works or doesn’t work in our own educational

presentations? I’m asking that we all take a few additional moments at the October 2012 meeting in Montreal to provide substantive peer review on the educational presentations attended. If you think someone was unprepared and ineffective, then professionally note that. Similarly, if you encountered a presenter who was well organized and taught you something, then hal-lelujah. Let them know.

Second, I believe our field is rapidly moving toward the routine incorporation of psychological assessments and more structured interviews into the

“At a minimum, a well-rounded forensic psychiatrist should have the ability to administer such tests as the M-FAST, SIMS, SIRS, TOMM, PCL-R, HCR-20, VRAG, ILK, SVR-20, SORAG, and Static-99/Static 2002 among many others.”

forensic assessment process. I do not believe we can or should stand on the sidelines and watch other forensic disciplines take complete ownership of “objective testing.” The generic term “psychological testing” does not mean that psychiatrists appropriately skilled and experienced in administering psychological testing cannot do so. In my opinion, forensic psychiatry residency programs should provide structured training on assessment instruments, which enables fellows to competently and independently perform relevant tests of malingering and risk assessment of future violence and sexual offending. Collaborative efforts with a forensic psychologist are invaluable in providing this training.

Core competencies in this area are easily assessed through supervision of administered testing and mock cross-examinations on each testing instrument. At a minimum, a well-rounded forensic psychiatrist should have the ability to administer such tests as the M-FAST, SIMS, SIRS, TOMM, PCL-R, HCR-20, VRAG, ILK, SVR-20, SORAG, and Static-99/Static 2002 among many others. If you don’t immediately recognize all of these tests and feel competent in administering them, then take that message as a wake up call. If forensic assessments are “your business” then you must become skilled in the basic structured assessments to complement your forensic interview. If you choose not to, proceed professionally at your own peril.

Third, as leaders in the field of forensic psychiatry we must keep abreast of key policy and economic trends that adversely impact the evaluation and treatment of forensic offenders. As one example, there has been a great deal written about the “criminalization” of the mentally ill and for good reason. Jails and prisons have replaced psychiatric hospitals as the largest provider of mental health care. Although the local jail population in 2010 decreased 2.4% in the United States for the first time since the Bureau of Justice Statistics began collecting this data in 1982, substantial numbers of pretrial detainees have a mental disorder. It should come as no surprise, therefore, that evaluations of trial competency remain the most commonly requested forensic evaluation.

In several states, there are emerging concerns that individuals found incompetent to stand trial wait several months in their local jail before they are admitted to an inpatient hospital because there are simply “no beds” available. This problem is not going to go away. Therefore, those of us who work with the various systems involved should proactively propose solutions to help minimize defendants with mental illness having unnecessary delays in care while detained in jail. Emerging interventions to address this problem include the development of community and jail competency restoration pro-

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Program Committee Had Another Hard Task

Jacquelyn T. Coleman CAE, Executive Director



The Program Committee has rated the 181 submissions for the 2012 Annual Meeting in Montreal. The Report on the acceptances and rejections will

be presented to the Program and Education Committees at their meetings May 5 in Philadelphia.

While submissions are down a little from last year's 204, this will still be a highly competitive year. The breakdown of submissions is: Audiovisual Sessions: 6; Course: 4; Panels: 33; Posters: 40; Debate: 1; Research in Progress: 25; Scientific Papers: 12; Workshops: 59; Mock Trial: 1. There were 35 submissions from Committees. The main discrepancy between 2011 and 2012 is the number of posters, with 69 posters submitted in 2011.

Category breakdowns, recognizing that some presentations may overlap two or more categories were Child: 6; Civil: 18; Correctional: 8; Criminal: 47; Legal: 17; Other: Practice of Forensic Psychiatry: 41. Some topics were not specified. This is the last year for this specific list of topics. The Education Committee is working on a master list of topics that will cover all educational activities. This will allow progress to be measured across all of our endeavors.

Three courses were selected: "The Psychiatrist as Expert Witness" was requested by the Education Committee as part of its plan to offer a course on basic content of forensic psychiatry every year. It will be taught by Dr. Philip Resnick.

The Private Practice Committee will offer: "Starting a Forensic Private Practice" with faculty of Drs.: Trent Holmberg, Brian Crowley, Robert Granacher, Camille LaCroix, Henry Levine, James Reynolds, and Celestine DeTrana.

Interpreting Psychological Testing and Neuroimaging for Forensic Psychiatry will be presented by Madelon Baranoski PhD, and Marina Nakic MD, PhD.

The abstract review process starts when the deadline for receipt of abstracts closes. Immediately after that, the AAPL staff assign abstracts to the members of the Program Committee. Members of the Program Committee have approximately three weeks to review the abstracts on line, assign a numerical rating, and add comments. The thought was that extremely good or extremely poor ratings should be elaborated upon. All members of the Program Committee are provided with an indexed copy of the last two year's evaluation summaries so they can refer to a presenter's past performance. Those summaries of previous year's meeting are used, so if you ever thought that no one read what you write in the evaluation form, you would be wrong.

A strong message from the Program Committee is that a scientific paper means what it says. No Scientific Paper submissions will be accepted without the paper. Also, Research-In-Progress is being more strictly interpreted.

Another important point is that a workshop must involve audience participation. Successful submissions are those that show what exactly the audience will learn and how it will participate. I am sure you are aware of much of the published material that suggests that adults learn better in interactive ways. Of course some panels were selected because there is still material that doesn't lend itself to a workshop format. Sometimes people really do want to hear experts presenting their opinions.

Remember that the mandate of our CME activities is to enhance your competence and performance. Your feedback on whether or not we are doing that is very important. In July 2013 we

will be submitting once again for the authorization to continue offering CME credit. We expect to be successful but your opinion is essential to us in completing the circle from planning, to execution, to evaluation. ☪

The State of Our Union

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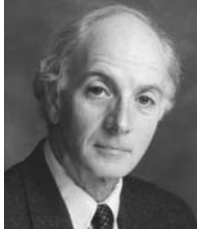
grams, initial triage assessments of those admitted to the hospital in order to identify those likely trial competent with a rapid return to court as appropriate, requirement by the court for evaluators to include malingering evaluations in competency evaluations, more rapid *Sell* order requests for those refusing medications likely to restore trial competency, and efficient evidenced-based pharmacotherapy approaches to treating incompetent defendants. This particular issue represents just one system-wide area where we can make a significant difference. But this shouldn't be the only arena one where we lead the way.

Finally, I believe that AAPL members whose work within an academic setting must enthusiastically embrace forensic research into their academic practice. To maintain competency, credibility, and currency, our knowledge on forensic assessments and treatment should increasingly be driven by data. Avenues to conduct forensic research are readily available. In many circumstances, the very work we do in a forensic setting can be easily studied. However, it requires both effort and emphasis. And so a challenge to my academic colleagues. How can you convert your forensic practice into forensic protocols? If you have implemented a triage assessment process to help decrease the length of stay for those found incompetent to stand trial, what was the outcome? If the inpatient psychiatry nurses are required to report incidents of patient aggression, what does the information indicate? Because we work with and treat individuals in a forensic setting, we are ideally situated to be the leaders in forensic research. It's time we did it.

So, in closing...the state of our AAPL Union is good. But, we can be better. And I believe we will be. ☪

Juvenile Life Without Parole Sentences (JLWOP) - Review of Sentences

Howard Zonana MD, Medical Director



There is a palpable change in views regarding sentencing of juvenile offenders to long prison terms without any review of that sentence. This

is occurring actively in Connecticut and other states as the pendulum sweeps back and forth around this volatile issue. The current proposals are to establish some kind of meaningful mandatory review of sentences of offenders who committed their crimes under the age of 18, and received lengthy prison sentences. In many states there is no current mechanism for review of a juvenile sentence after 10, 20, or even 50 years to determine if it remains appropriate. There is an opportunity for members and APA District Branches to participate with other groups advocating change, if they wish.

In the mid 1980s to mid nineties the rates of juvenile crime showed a substantial rise. In response, between 1993–1997, 47 states and the District of Columbia changed their juvenile crime laws in one or more of these ways: 1) making sentencing more punitive, 2) becoming offense, rather than offender, oriented, 3) expanding allowable transfers to adult court, (23 states have no minimum age; 45 states changed their laws to make adult transfers easier), and 4) doing away with juvenile confidentiality provisions.

The trend has begun to shift back, in response to a decrease in juvenile crime rate, and as a consequence of the Supreme Court deciding a series of cases beginning with *Roper v Simmons* (543 US 551) in 2005. *Roper* held that it is unconstitutional to impose capital punishment for crimes committed by defendants under the age of 18. This 5-4 decision overruled the Court's prior ruling upholding such sentences on offenders at or above the age of 16.

Just before the *Roper* decision, Human Rights Watch published a report on JLWOP with Amnesty Inter-

national, entitled "The Rest of their Lives." It was the first time advocates in the United States formally analyzed JLWOP as a viable human rights issue (<http://www.hrw.org/reports/2005/10/11/rest-their-lives>; viewed 2/15/2012).

After the *Roper* decision in 2005, the Equal Justice Initiative (EJI) of Alabama, an organization founded and directed by Brian Stevenson, began to challenge the life without parole sentences of juveniles. By March of 2008, EJI had JLWOP dockets in 14 states (See <http://www.eji.org/eji/> accessed 2/20/2012).

Next, in *Graham v. Florida* (130 S. Ct. 2011), the Supreme Court barred the imposition of life without parole

“The APA affirms the undesirability of long-term mandatory sentences without possibility of parole for offenders who were younger than 18 at the time of the offense.”

sentences for individuals convicted of nonhomicide offenses committed before the age of 18. In this case, the court extended its categorical analysis to noncapital sentences.

In October 2011, the United States Supreme Court denied the Florida Attorney General's request for review in *Ian Manuel's* case (132 S. Ct. 446), upholding the Florida Court of Appeal's decision that juveniles convicted of attempted murder cannot be sentenced to life imprisonment without the possibility of parole.

The US Congress attempted to become involved in 2009 when a bill was introduced (HR 2289) titled the

Juvenile Justice Accountability and Improvement Act (JJAIA). This proposal would have required states to: (1) enact laws and adopt policies to grant child offenders who are serving a life sentence a meaningful opportunity for parole or supervised release at least once during their first 15 years of incarceration and at least once every three years thereafter; and (2) provide notice of such laws and policies to the public and to victims of child offenders. The definition was a "child offender who is serving a life sentence" is an individual who is convicted of a criminal offense before attaining the age of 18 and sentenced to a term of imprisonment for life or a term exceeding 15 years. The bill died in committee, with complaints of it being an additional unfunded mandate being imposed by the federal government.

In November 2011, the Supreme Court granted certiorari in two new cases (*Miller v Alabama*, (63 So. 3d 676) and *Jackson v. (Norris) Hobbs*, (2011 Ark 49) involving juveniles. Both involve fourteen year olds convicted of homicide. The two cases differ only in that one defendant was convicted of felony murder, as he was a minor accomplice, while the other was directly involved in the homicide. There has been no decision at the time of this note.

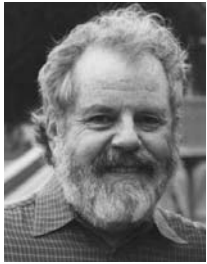
Juvenile justice advocates have been working at the state level for a number of years to effect change and these cases have been an impetus for state legislatures to reassess their harsh statutes enacted in the late eighties and early 1990s. Six states now explicitly forbid life without parole for all juvenile offenders: Alaska, ALASKA STAT. § 12.55.015(g) (2008); Colorado, COLO. REV. STAT. §18-1.3-401(4) (b) (2009); Kansas, KAN. STAT. ANN. § 21-4622 (2007); Kentucky, KY. REV. STAT. ANN. § 640.040(1) (West 2008); Montana, MONT. CODE ANN. § 46-18-222(1) (2009); and Texas, TEX. PENAL CODE ANN. § 12.31(a)(1) (Vernon 2009). Texas, however, only mandates parole review after forty years and is not retroactive.

The APA and AAPL signed amicus briefs on these cases at the Supreme

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Taking Orders

Stephen P. Herman MD



When a judge issues an order to a forensic expert for an evaluation, that order serves as the backbone for the evaluative process and the report. The expert is supposed

to refer to the order and pattern his work from it. But what if an order is poorly written, ambiguous, is based on an incorrect psychiatric assumption or places the psychiatrist in an ethically untenable position? What is to be done?

In my 30 years of practice I have received hundreds of court orders appointing me to cases. The orders have included specific questions from the bench. Most of the orders are lucid and are commensurate with my abilities. But I have also received orders which are difficult to follow and require my contacting the court. The following represent some typical errors found in these orders.

A judge may write an order asking you to conduct “therapy” with a child or adult and then report back to the court after a certain period of time. This kind of order, of course, puts you in the “two-hats” role - not a position of comfort and, possibly, ethically suspect. The patient would need to know, of course, that the “therapy” may very well be monitored by outside sources. Without the protections of confidentiality and privilege, the patient may not be as willing to participate fully in the treatment.

It would make sense for the expert to call the court and speak to the judge’s court order or to the judge herself, respectfully explaining why the basis of the order is problematic. The expert could make the suggestion to the court that the therapy proceed with one professional and any forensic issues ought to be monitored by another. A surprising number of judges are not aware of the importance of this distinction. My experience has been that courts are open to revising such an order.

I once was appointed to evaluate a family and asked to determine who the

“psychological parent” was. This important construct comes from the seminal work of Solnit, Freud and Goldstein in their book, *Beyond the Best Interests of the Child*. This book discusses the many ways children of divorce and custody disputes are hurt by the judicial process. Part of the many criticisms of the book is that it “invents” the idea of one psychological parent - that parent - or another adult - with whom the child has the deepest attachment and who has been the one mostly involved with the care, growth and development of the child.

But what did the judge mean by my assessing who was the psychological parent in this particular custody case, and did he understand the use of the term? I called chambers and spoke to the court attorney. She relayed my concerns to the judge. She called back to

“...read an order very carefully. Do not assume the court knows precisely what it is seeking. If you are confused, contact the court and straighten it out.”

say that the judge was somewhat familiar with the term but wasn’t sure of its origins. Because I do not hold to the belief that there is only one psychological parent, I shared that with the court attorney. She asked me what I could say. I suggested the judge rewrite the order to explicate that I could discuss issues of parent-child attachment, the possibility of psychopathology in family members, the sensitivity of each parent to the special needs of the child and any recommendations I might have in the best interests of the child. The court was fine with these parameters.

Frequently I have been simply asked to do a “forensic evaluation” of a family. What does that mean? The court attorney, who wrote the order, was not sure himself what the judge had in mind. You had better find out. For some

judges, “forensic” in the context of a divorce, indicates a custody evaluation. Other judges are not exactly sure what the word means. Again, it’s important to contact the court for clarification.

Another major issue for the forensic evaluator is whether or not a “custody evaluation” means the expert is to offer an opinion on custody itself. In New York City, judges are getting away from orders asking the forensic expert for a custody opinion. The view of more and more judges is that the evaluator not give an opinion, because that should be the role of the trier of fact. Even if the wording in the order asks for a custody evaluation, it will be important for the forensic expert to make sure he knows what the court is asking.

Sometimes, orders contain a list of collateral interviews for the forensic expert. I recently had one order requiring me to interview both sets of grandparents, neighbors, friends, college roommates, etc. I contacted the court and politely said the list was way beyond what is necessary to do a good forensic mental health assessment of the parents and children. I stated that expanding the evaluation would take extra time and would not add much to my overall conclusions. The court issued an amended order leaving out most of the list of collaterals.

In summary, read an order very carefully. Do not assume the court knows precisely what it is seeking. If you are confused, contact the court and straighten it out. That will allow you to conduct the forensic assessment with all sides having the same expectations. ☪

MUSE & VIEWS

Insanity definitions over time

The great proof of madness is the disproportion of one’s designs to one’s means.

Napolean Bonaparte

Insanity is often the logic of an accurate mind overtaken.

Oliver Wendell Holmes

Years ago, it meant something to be crazy. Now everyone’s crazy.

Charles Manson

Submitted by Charles L. Scott MD

Ask The Experts

Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send question to nskaye@aol.com. This information is advisory only for educational purposes. The authors claim no legal expertise and should not be held responsible for any action taken in response to this educational advice. Readers should always consult their attorneys for legal advice.

Q. I was asked to see two brothers who are alleging sexual abuse by a teacher about 40 years ago. My role in the case is strictly damages, as liability is a different issue being addressed by other experts. How should I proceed if I don't believe the liability is there, yet the damages are clear in that the plaintiffs have psychological problems that could have come from abuse?

A. Sadoff: The question asks: "How should I proceed?" My first response is: "You should proceed by refusing to take the case," since you do not believe there is liability. In civil tort cases damage must be related to an event for which liability may be claimed. There may be psychological damage, but if it is not caused by the defendant, there is no case. You cannot help the attorney for the plaintiff if you cannot give your opinion with a reasonable degree of medical/psychiatric certainty that the damage you have diagnosed is directly related to the alleged abuse. A number of psychiatric conditions diagnosed may arise from various causes, not necessarily from the one the plaintiff claims. That is why we must conduct comprehensive and thorough forensic psychiatric examinations and evaluations before rendering our opinions.

Next, is the statute of limitations, which normally runs two years unless a child is involved, then it is two years after the age of majority (which may be 18, 19 or 21, depending on the jurisdiction.) There is an effort to extend the statute in cases of child abuse and a few States have done so; be sure to know the State law on this issue. Then comes the concept of accrual, which in cases

involving children, means the statute may be waived if the child was not aware of the abuse or its effect upon him or her until within two years of filing the claim. Several cases have been tried on this basis and most failed as the plaintiff who claimed not to know was found upon investigation to have complained to others while still a child, adolescent or young adult.

If you suspect the plaintiff's illness or symptoms was caused by the alleged abuse, you should proceed to conduct a thorough and complete forensic psychiatric evaluation, including collateral interviews and record review, to be able to give your opinion with a reasonable degree of medical certainty. It is not helpful to just describe the symptoms or give a diagnosis without the cause in such cases. There must be a nexus between the damage found and the alleged abuse for the case to prevail.

It is a good question that needs discussion so we continue to act in a truly ethical manner in working with lawyers. We should take only those cases that have merit. Sometimes, we do not know the merit until we conduct an examination. Working with experienced attorneys is often helpful.

A. Kaye: This sophisticated question provokes a host of issues and reactions. While it is up to the trier of fact to decide guilt or innocence, I believe most forensic experts nonetheless tend to reach an opinion about the validity of every case. That impression creates an ethical issue as well as a practical matter. My own personal ethics doesn't allow me to reach an opinion and then advocate for that opinion if it involves a fact pattern that I don't believe. It is nearly impossible to "prove" what occurred that long ago and these cases frequently are "he said, she said" battles. While lawyers will try to get me to address a person's credibility, this is a murky area at best and the law does not recognize any objective test of truth. Absent convincing evidence, the best I can do is to say that the damages are consistent with the allegations, but point out that there are many other potential causes of such symptoms. The presence of the symptoms does not in any way prove that the allegation is

true. In fact, this is a common forensic criticism of clinical work in the area of PTSD, where a clinician will wrongly argue that the abuse had to have occurred because the patient has PTSD.

From a practical perspective, I find it very difficult to testify convincingly and with the requisite passion to be persuasive if I don't really believe in the case. While I suppose I could divorce myself and simply testify about the hard science, my experience is that the opportunity for that type of testimony is rare.

I would contrast this alleged abuse case with a similar scenario where a plaintiff is alleging medical malpractice. I am often able to testify that the damages relate to the behavior/what occurred by a medical colleague, but again, I leave the issue of violation of the standard of care to the appropriate medical experts. This would be the case where a bad outcome causes the clear damages but the legal liability (medical malpractice) may not be provable.

Sadoff/Kaye: Take home point: There is no place for unethical behavior in the medical-legal system and we have a duty to practice to the highest standards possible in order to preserve the dignity and decorum of our profession. Lastly, as experts, we are there to teach and should have no stake in the outcome of the litigation. Let your neutrality be empowering. ☯

MUSE & VIEWS

Funny actual courtroom quotes:

Lawyer: "Now sir, I'm sure you are an intelligent and honest man—"

Witness: "Thank you. If I weren't under oath, I'd return the compliment."

Lawyer: "Officer, what led you to believe the defendant was under the influence?"

Witness: "Because he was argumentary, and he couldn't pronounce his words."

Lawyer: "Any suggestions as to what prevented this from being a murder trial instead of an attempted murder trial?"

Witness: "The victim lived."

Submitted by Charles L. Scott MD

Sex and the Psyche

Stephen Zerby MD



Working with adjudicated adolescent sexual offenders has been quite an adventure for me. A few coverage stints at a secure

facility had piqued my curiosity as the variety and uniqueness of the psychopathology, such as grooming for predatory perpetration, became evident. I had had a few unfortunate run-ins with psychopathic individuals in my daily life so, it was interesting to hear from perpetrators how victims were selected, manipulated, and groomed. I was so intrigued that when a position opened for regular coverage I quickly volunteered. After starting regular shifts at a secure adolescent sexual offender (ASO) program, it became evident to me that some of my constitutional issues would become an obstacle. While I had always known myself to be a shy and retiring type, no one had warned me that entering the world of sexual offender (SO) treatment would so strongly highlight this character trait. When therapists educated me for the first time about a treatment specific to SO work called “satiation” (a technique that involves audible sexual fantasies and masturbation) I found myself blushing, a human reflex that is difficult to control. I realized that I had never actually talked about this stuff with anyone, ever, in such a public forum. The experience was totally new to me.

In an attempt to jump start my new clinical pursuit by sitting in on a sexual offender lecture for the forensic psychiatry fellows, I could again feel the burn of a red face as deviant human sexuality was discussed in a matter-of-fact tone. I experienced the vital neurotic habit of being embarrassed at being embarrassed - perspiration ensued and my level of discomfort grew. Then the worrisome thought arose that I was the only one

sitting there who was uncomfortable. But, why was I so uncomfortable? “Just focus on the lecture material and bury your face in the handout” came the voice of reason from within. Despite following this voice’s command the neurotic fear grew: “now, how do I look: blushing, sweating?” As there were only three other people in the room hiding was difficult and the situation was starting to get a bit uncomfortable. I’m still not sure what I took away from that lecture aside from embarrassment, but it led to my asking the lecturer an obvious 2-part question: how long have you done this line of work and how did you get so comfortable with the subject material, which he discussed in the most matter-of-fact manner? His response was that he had been working in the SO field for about 20 years and he acknowledged that almost everyone had different levels of discomfort when starting out; time and experience were the main ingredients to developing comfort with the topic.

This is actually consistent with what happened over the ensuing months. With regular practice of talking with patients in a non-threatening manner about their sexual fantasies and habits, a level of comfort with the subject material and procedures grew. The approaching end of my first year working with the ASO population brought the realization that this shy and inhibited person was actually going to work and talk openly about patients’ deviant sexual fantasies and intimate sexual practices. When asking a nurse whether KY jelly could be provided to assist with treatment, a sense of “ah, now I’ve made it” arose: a conquest of sorts, indeed.

However, my growing level of comfort with the topic only led to further humiliation. Once, when perusing a used book store I came across Wilhelm Stekel’s *Auto-erotism: A Psychiatric Study of Onanism and Neurosis*. Genuinely excited at

seeing this curious term “onanism” for the first time, I knew I had to have the book. It was only when the guy working at the counter looked at the book’s cover, then turned and whispered to the girl working next to him that fear arose inside me that perhaps something was amiss. I wondered if he was whispering about me. Why would a short middle-aged guy like me be buying a book entitled *Auto-Erotism*? Increasingly self-conscious, I considered volunteering some feeble explanations such as, “this is for um - work” or “uh... uh...” I’m getting this because I work with sex offenders.” But before I could blurt out any defensive explanation for my interest in this erudite work the guy at the register asked, “Would you like a bag?” with what I really thought was an emphasis on the word “bag.” Before I could decide whether or not there was an odd inflection on “bag,” I blurted out my defensive “Yes, I’d like a bag!” with uncharacteristic forcefulness. Of course I would like a bag if I was going to carry around that book on a city street.

Then there was the unfortunate car debate. During this ugly car ride, a former friend expressed an opinion that sexual offenders should be “locked up” as they were untreatable. My offhand and somewhat bland reply that the SO population is not homogeneous, and treatment could be successful in some cases, only led to an all-out verbal assault on my character which was called into question for “monster coddling.” Despite my efforts to maintain a calm and rational approach to the “debate,” it became increasingly clear that there was not going to be a “debate” in the traditional sense. Recalling the maxim of not debating politics or religion because you are unlikely to change either your opponent’s mind or yours, and may only anger both sides, I decided to include sexual offending to politics and religion as taboo subjects. Do not try debating the merits of SO treatment at home.

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Donna M. Norris, MD, DLFAPA

Conflicts of Interest in Psychiatry

Philip J. Candilis MD

(To suggest members for this feature, email philip.candilis@umassmed.edu)



Former APA Assembly Speaker and Secretary-Treasurer Donna Norris has long been part of activities at the heart of AAPL. A

former member of the Journal's Editorial Board, Rapoport, cross-cultural, and child committees, Dr. Norris brings a background in child and forensic psychiatry to some important movements in forensic and general psychiatry. At a time when Medicine was still uncomfortable with new rules for addressing conflicts of interest, Dr. Norris was an important contributor to the development of new standards – namely through the crafting of a conflict framework for the DSM-V revision.

Dr. Norris served as APA Secretary-Treasurer at the inception of the DSM-V revision, a role that encompassed review of the existing conflict of interest (COI) frameworks in the organization. At a time when the medical literature was exposing industry ghost-writers, viewing authors' pharmaceutical company involvement with a skeptical eye, and underscoring the lack of transparency among those who did not report their commercial connections, Dr. Norris found herself in a process that would raise the bar on COI standards in psychiatry.

While other sub-specialties published new COI standards, and major journals and news organizations savaged the medical profession for its lack of scrutiny, the APA took a closer look at whether the mere report of commercial interests was sufficient to allow participation in the DSM revision. A revision that would influence treatment across all diagnoses was an appropriate venue for assuring that COI standards were appropriate and

up to date.

With an eye toward preserving participants' professional reputations, the APA embarked on a path that would not only require reporting outside interests, but the amount of outside work as well. There would be limits on how much contributors could make from their outside consulting, including from courtroom testimony and forensic case-work. This was a step beyond the usual declaration of research sponsorship, consulting agreements, and speakers' fees.

Although some objected to the approach as a presumption of wrongdoing at a time when most if not all prominent experts had relationships with commercial interests, the APA developed a confidential review of potential contributors' sources of income. Within a process that was open to review, those who wished to be part of the revision submitted their information privately and abided by the APA Board's assessment of their potential conflicts. Drawing on standards from prominent research institutions and the federal government, the Board made decisions on each individual's participation and created a prominent panel that will publish its work in May of 2013.

Dr. Norris recalls this as an intense period at the APA, as the organization took the lead in an area that was controversial but necessary for the integrity of the profession. Exploring the appropriate professional balance between funding sources and the amount of industry support that allowed unbiased review was and remains a complex and fraught topic for clinical and forensic professionals. Looking back on it, Dr. Norris observes that most of those she spoke with ultimately felt comfortable with the scrutiny of the new process.

Dr. Norris credits mentor and for-

mer AAPL president Tom Gutheil for bringing her into the Law and Psychiatry group at Harvard – a group that meets regularly to discuss forensic topics and develop collaborations between members. The opportunity to develop papers and research projects is a rich complement to Dr. Norris' child and forensic practice.

Having served on the Massachusetts Board of Registration in Medicine in the 1980s, Dr. Norris brings an important perspective to her work. At a time when psychiatrists were involved in a series of highly publicized sex scandals with patients, the state Board struggled with how to sanction professionals who would resign their professional memberships or settle civil cases in court to avoid more serious sanctions. Some legislators, for example, called for criminal sanctions for this behavior, including prison time. Dr. Norris and other members of the Board met with the leadership of the Massachusetts Psychiatric Society who would develop guidelines for physicians at a time when there were none. This was an important outgrowth of her work and led to a renewed sensitivity to the personal and organizational interactions necessary for managing controversial professional behavior.

Dr. Norris's broad contributions to topics critical to forensic practice, from COI to boundary violations, are an important model for practitioners seeking to balance private practice with service to their professional organizations. They are a cardinal example of an AAPL member at the forefront of forensic practice. ☞

Sex and the Psyche

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The subtitle to one edition of Stekel's 1967 book proved appropriate: "A frank and scientific treatment of a vital subject long clouded by myth, superstition, and common prejudice." This aptly describes sexual offender treatment. ☞

PHOTO GALLERY

Midwest Chapter



Outgoing Past President Joy Stankowski MD presenting the Presidential Plaque to President Philip Pan MD.



The new officers of Midwest AAPL are pictured: Councilor Michael Harlow MD, Incoming President Susan Hatters Friedman MD, Councilor Sherif Soloman MD, Councilor Delaney Smith MD, Secretary Cathleen Cerny MD, Incoming President Elect James Reynolds MD, Outgoing Past President Joy Stankowski MD, and Outgoing President Philip Pan MD. Not pictured: Treasurer Lawrence Jeckel MD.

Tri-State Chapter



Judge Juanita Bing Newton with AAPL Past President Dr. Richard Rosner.



AAPL Past Presidents Dr. Stephen Billick and Dr. Richard Rosner.



American Academy of Psychiatry
and the Law
October 2011

International Relations Site Visit to the Boston FBI Field Office in October 2011.



AAPL's newest committee on International Human Rights, Humanitarian and Refugee Law hard at work.

PHOTO GALLERY



Intense concentration at the ADFPF Meeting.



Jackie Coleman, flanked by two Presidents.



Colorful presentations.



Brain enrichment at the Review Course.



Scrumptious reception dinner.



Council Meeting in progress.

First Impressions: A Forensic Fellow's Transition Between Two Countries

Olubukola Kolawole MB, ChB, MRCPsych



The decision to pursue post-residency subspecialist fellowship training in forensic psychiatry is not often an easy one even for the most aspiring psychiatrist. However, I sought to explore this career path in a different country and continent from the one in which I completed my core specialist training in psychiatry. This decision, understandably, was filled with anticipation, some uncertainty, apprehension and various expectations amidst the challenges of moving home and country. British forensic psychiatry training is well-established and I was opportuned to work in the United Kingdom's forensic psychiatry service as part of my core specialist training. However, I felt an international perspective on further training would be worth the adventure and hence my leap of faith across the Atlantic pond. I moved to Canada in the summer of 2011 to take up a forensic psychiatry fellowship position. I was off to an exciting start in a new medico-legal and academic environment.

On a personal note, the move was remarkable for its timing, the availability of resources and the exceptional support we received in Canada that cushioned the effect of a "big move." The Canadian welcome was exceptional. My wife and I were offered fellowship positions at the same university in radiology and forensic psychiatry respectively.

Prior to leaving the United Kingdom, staff at my fellowship program university gave us crucial contacts that helped us in securing a vehicle and a lovely condominium. Other vital aspects of our re-location were also smoother than we had anticipated.

The culture shock was more around the friendly, diverse and multicultural nature of the environment. People were genuinely willing to help. However, we were surprised at the high cost of living in comparison to the United States

and the United Kingdom. For example, it is now costing us about four times more to insure our car than it did in the United Kingdom. We also got a special welcome from the Canadian weather, enjoying the summer months on arrival and now enjoying one of the mildest winters Hamilton has had in many years. Nevertheless, we have been warned not to speak too soon as the winter months are only just reaching their peak.

Professionally, I had some anticipatory anxiety but in many ways was raring to go. I was prepared for being dropped in the deep end and was ready for the challenges that exposure to a new professional subculture might present. I have had exposure to forensic evaluations and management of cases of varying complexity. I find that one of the striking positive features of the Forensic Service in Hamilton is the "all hands on deck" multi-disciplinary team involvement in the evaluations, treatment and rehabilitation of our patient population. The collegial environment created the physical and psychological milieu for a smooth transition from British to Canadian Psychiatry.

In contrast with my previous experience, I am adjusting to work with a more diverse group of healthcare and legal professionals. I am also learning to use various aspects of Canadian civil and criminal legislation in practice. These differ in a number of ways from British legislation. For example, the legislation governing involuntary admissions and treatment of incapable patients varies from province to province in Canada. Similar legislation in the United Kingdom is applied evenly across each country.

It has also been encouraging to see that a number of challenges identified through departmental surveys are being addressed sensitively and with ample opportunity for multidisciplinary contribution to further service development.

Some of the other remarkable aspects of my experience of the service

as a whole include the excellent liaison and relationship with the criminal justice system, which creates a smooth interface between psychiatry and the law in Hamilton. In this regard, the service is privileged to have a dedicated Forensic Service Coordinator and a full time Clinical Legal Counsel. I have also had exposure to the regular use of a unique inpatient risk assessment tool called "The Hamilton Anatomy of Risk Management" (HARM). This tool was designed by the head of the forensic service and a senior psychologist within the program who currently coordinates the use of this tool in the day-to-day management of inpatients. The program has a Transitional Outreach Team that does a great job at facilitating the community reintegration of forensic inpatients. There is ample opportunity for participation in education, research and development with a regular rotation of students, residents and fellows of the various disciplines represented in the program. These are all nested in an atmosphere that encourages personal and professional development with regular feedback and appropriate supervision. At the core of service provision is the excellent leadership provided by the Head of Forensic Service, Attending Psychiatrists, and Faculty, Service Director, Unit Managers and Team leaders.

From a management point of view, It has also been a pleasure to undertake my fellowship at an exciting time in the history of the Hamilton Forensic Service with ongoing plans for a substantial expansion in pursuit of the Service's vision to be an international leader in forensic psychiatry with strong pillars of dignified and compassionate clinical care, meaningful research, relevant education and progressive management.

On reflection, I have had a very positive experience and feel rather privileged to be working with some of the best and most dedicated group of professionals in the field of forensic psychiatry.

Dr. Olubukola Kolawole is a current forensic psychiatric fellow at McMaster University, Hamilton, Ontario, Canada. ☎

Predicting Job Satisfaction: Should I Stay Or Should I Go

Paul J. O'Leary MD, Committee of Early Career Psychiatrists

For many psychiatrists seeking employment, workload and compensation weigh heavily on their ultimate choice of employment. However, according to the work-life model, workload and reward are just two of the six dimensions that influence job satisfaction and burnout.¹ Not weighing all these factors when considering employment risks decreased job satisfaction and burnout, which may account for why more than 40% of physicians are burned out.² Burnout causes increased emotional stress, decreased productivity, and increased risk of medical error.³ Additionally, burned out physicians have a higher likelihood of changing jobs or exiting medicine⁴ altogether⁵, which has its own risks, stresses, and costs.⁶ Therefore, understanding the six dimensions of work-life and how they influence job satisfaction should allow psychiatrist to better predict how satisfying their employment will be and allow them to make choices that will reduce their risk of burnout, and benefit them emotionally, financially, and legally.

Burnout is defined as emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment.⁷ Emotional exhaustion refers to a feeling of being overextended, with depleted physical and emotional resources and leads to feeling drained, used up, and fatigued.⁸ Depersonalization refers to a feeling of cynicism representing an interpersonal dimension of burnout, characterized as feelings of becoming emotionally hardened and callous.⁹ This definition is different from the DSM-IV definition of depersonalization, as in the burnout research it defines how well one relates to others. Realizing that burnout research was first developed in the service industry may help clarify the meaning of the term. Hence, elevated feelings of depersonalization lead to detachment from the job, and distancing oneself from patients or staff. A decreased sense of personal accomplishment is the self-evaluation dimension of burnout and refers to a feeling of incompetence and

low productivity.¹⁰ A decreased sense of personal accomplishment is captured by asking about feeling ineffective in dealing with problems and wondering if the job is worthwhile.¹¹

Although the three core dimensions of burnout overlap, each captures different aspects of the job environment important to a person's satisfaction with their job. The three dimensions of burnout were quantified by the Maslach Burnout Scale (MBI), available from the Mind garden website.¹² Following the development of the MBI, Dr. Maslach developed additional MBI scales to measure burnout in the Human Services industry, called the

"...before taking a job, the psychiatrists should understand the level of control they have over the staff they will be working with."

MBI-Human Services Survey (MBI-HSS), as well as, a broader job survey, called the MBI-General Survey (MBI-GS). The MBI gives a number reflecting the level of a persons overall burnout, as well as, sub-scores for each of the three core dimensions.

Once the level of burnout was quantified, studies began looking at how the work environment affected a person's level of burnout. Continuing her work in burnout, Dr. Maslach developed a conceptual model that identified six core dimensions of work that affects a person's job satisfaction and risk of burnout.¹³ These core dimensions are workload, control, reward, community, fairness, and values.

Workload is defined as the amount of work to be done in a given amount of time.¹⁴ Most psychiatrist are acutely aware of how importance this dimen-

sion is when seeking employment, and therefore ask about the call schedule, call volume, number of patients, administrative duties, and additional responsibilities in order to assess the workload. If the workload is too high, people feel dissatisfied with the job and their own abilities, in turn increasing the burnout risk due to emotional exhaustion and a decreased sense of personal accomplishment. The North American Resident Survey demonstrated this connection when all of the psychiatric residents who worked more than 80 hours per week showed a high level of job dissatisfaction and reported feeling burnt out.¹⁵ Of note, residents who worked less than 40 hours a week also showed decreased job satisfaction. Ideally, the psychiatrist would be able to find a job that allows for a balanced, manageable workload, where they can develop professionally and pursue career objectives.¹⁶

Reward is defined as financial and social recognition for contributions on the job. To illustrate how both financial and social recognition factor into reward, consider the starting salary of university faculty. Inevitably, the more prestigious the university the less the starting salary, since the financial recognition is offset by the social recognition. When structured in a meaningful and clear manner, rewards can be used to indicate the organization's values or to recognize employee contributions to the organization. As such, rewards increase the sense of personal accomplishment, job engagement, and job satisfaction, thereby decreasing the risk of burnout. Conversely, people who do not receive recognition often devalue their work and themselves.

Control is defined as the opportunity to make choices and decisions, to solve problems, and to contribute to the fulfillment of responsibilities.¹⁷ In the work environment, increased control often means increased accountability. However, job dissatisfaction occurs when the level of control and the level of accountability are not similar. A common example of this is the physician who feels powerless when the staff fail to carry out their orders, or when the scheduler books patients in non-

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PHARMA Sunshine Code and Forensic Psychiatry

Neil S. Kaye MD, DFAPA; Gary Chaimowitz MD
Psychopharmacology Committee

In the United States, the Physician Payment Sunshine Act—Section 6002 of the Patient Protection and Affordable Care Act (PPACA), was due to be implemented by the Centers for Medicare and Medicaid Services (CMS) on October 1, 2011. The deadline to promulgate rules to implement the Act has passed without the rules being issued but implementation is still expected.

Nonetheless, many PHARMA companies have already taken action to make public full disclosure of all payments to all physicians by posting this information on the Internet. This information can be found at each manufacturer's website and has also been aggregated into single sites by other entities.

The Sunshine Act requires manufacturers to report all payments to physicians, including consulting fees, honoraria, and travel and entertainment; and for the Department of Health and Human Services (HHS) to publicly disclose the identity of the manufacturer, physician, and the drug or device associated with the payment on the Internet. Additionally, the law requires manufacturers and group purchasing organizations (GPOs) to report all ownership or investment interests held by physicians or members of their family, and to make that information public.

For all physicians, this represents an intrusion into an area long felt to be private and privileged. This new legislation is especially important to forensic psychiatrists involved in cases in which medication is an issue, as it opens a new avenue of cross examination on *voir dire*. Each side can be expected to use this information to their advantage. The side calling you as a witness might claim your association enhances your expertise and knowledge and makes you more credible, while the opposing side will try to use it to show bias on behalf of the

pharmaceutical industry or to impugn your credibility.

An expert should be prepared to know if she/he has ever written a prescription for a product made/distributed by the company; had dinner with employees or management of that company; spoken on behalf of the company; conducted research for the company; attended a program sponsored by the company; been in litigation involving the company; known family members/friends who have used product made by the company; and ever said anything positive/negative about the company. It is especially important to know if you or a family member has held any ownership interest (including stock) in or been an investor in any drug, device or market-related to the product.

The AMA reports that 98% of physicians have received PHARMA "gifts", including accepting medication samples for patient use. Most of us can expect to find our names and amounts of money paid to us or spent on us listed on websites. We need to be prepared to handle questions about this in a straight-forward, non-defensive and non-apologetic manner, much as we do questions about the fees we charge for our work on other medical-legal matters. The current listings include monies spent on meals and other "gifts" besides payment for services rendered, such as delivering talks or conducting research.

Given that you may have to answer questions about the payments received and the implication of a *quid pro quo*, this may be a time to carefully consider your interactions with pharmaceutical companies or device manufacturers. If you do not wish to answer questions in court about payments or gifts received, you may wish to refrain from accepting the payment or gift in the future. However, payments for 2011 will be reported regardless, so all of us will be impacted. ☯

JLWOP

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Court level, emphasizing that human brains are still undergoing restructuring and development during adolescence, as well as other factors making adolescents different from adults.

The APA has published a Position statement representing APA policy on juveniles and long-term sentences in 2011 as follows: (<http://www.psych.org/MainMenu/EducationCareerDevelopment/Library/Position-Statements.aspx> -accessed 2/20/2012). Prepared by the APA Council on Psychiatry and the Law.

Position Statement on Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment.

Approved by the Board of Trustees, December 2011

The APA affirms the undesirability of long-term mandatory sentences without possibility of parole for offenders who were younger than 18 at the time of the offense. Such sentences fail to take account of the significant prospects of maturation and rehabilitation for most youthful offenders, even those convicted of serious offenses. States should require reviews for all juvenile offenders who are sentenced to lengthy mandatory terms of imprisonment.

The reviews should:

- take place within a reasonable period of time after sentencing and periodically thereafter;
- include evaluations by qualified mental health professionals when an offender's current developmental maturity or mental health status are relevant to the reviews;
- be conducted by mental health professionals trained to evaluate children and adolescents for offenders still under age 18; and
- include a thorough review of the offender's developmental, educational, legal, social, medical, mental health and substance abuse histories; and interviews with knowledgeable informants, including family members; and additional testing when needed."

Since state law is generally control-

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Standard of Care for Suicide Risk Assessment: How Much is Enough?

Mace Beckson MD, Joseph Penn MD (Chair) - Suicidology Committee

In 2003, the American Psychiatric Association published its practice guidelines for the management of suicidal patients based upon the extant literature and clinical consensus. The guidelines include recommendations for assessment of suicide risk, including a process of identifying both risk factors and protective factors, followed by formulation of the magnitude of risk to guide appropriate intervention and treatment. This process has become influential in the training of psychiatric residents in academic settings. Residents are taught that saying or writing, “-SI, contracts for safety” is inadequate both for assessment and documentation of risk. In some training programs, residents may complete long checklists of risk and protective factors and document detailed reasoning in their formulations of the magnitude of suicide risk. Electronic medical records may contain such templates. These are efforts to apply the practice guidelines in the assessment of individual patients. However, the clinical guidelines are “best practice” and not the “standard of care,” which reflects what would be expected of any prudent practitioner under similar circumstances involving the suicide risk assessment of a patient.

There is no standard psychiatric rating scale to determine the magnitude of acute suicide risk. There is no algorithm to “crunch” the data and determine the correct answer. There are no standard relative weightings of risk factors and protective factors, or relative weightings of static vs. dynamic risk factors. Clinical judgment is necessary to develop an opinion about the magnitude of suicide risk in an individual patient. Clinical experience, intuition, and “gut feeling” in response to the patient are important elements in this process. Two patients may appear to be similar when looking at a tabulation of risk factors and protective factors, but the circumstances leading up to the suicide risk assessment may be different in their meaning and significance to the patients. In addition, the patients may

“feel” different during their mental status examinations. One patient may create a great deal of apprehension in the clinician, while the other does not. These factors, which do not appear in a list of risk and protective factors, may be highly influential in the formulation of magnitude of risk.

A psychiatrist’s opinion regarding an individual patient’s magnitude of suicide risk is a clinical judgment. The practitioner is not required to predict accurately the outcome in an individual case, i.e., a patient clinically judged to be a “low risk” might commit suicide shortly thereafter, and while the practi-

“...expect witnesses, often retained because of their impressive academic and teaching credentials, must be mindful not to confuse the standard of care with the optimal care that clinical practice guidelines recommend.”

tioner would appear to have been “wrong” about the level of risk, the practitioner would not necessarily have fallen below the standard of care. In the courtroom, the inability of the psychiatrist to predict suicide is hammered home by every defense attorney. Jurors may not comprehend what appears to them to be more of a semantic difference between “risk assessment” and “prediction.” How is it that the psychiatrist can assess the magnitude of risk, but cannot predict suicide?

The standard of care for a suicidal patient is to do a suicide risk assessment. The practitioner must make reasonable efforts to obtain information,

which can then be utilized as the basis for a clinical judgment of risk magnitude. But how much is enough when it comes to meeting the standard of care for suicide risk assessment? How many risk factors need be identified? Is an emergency assessment without a collateral source of history not enough? Is it a dereliction of duty not to inquire about possession of firearms? Can poor documentation in and of itself constitute negligence? There are no specific rules that define what must be done in any particular case; relevance and reasonableness should be considered in analyzing a psychiatrist’s suicide risk assessment process.

Some elements have “face” validity. A good faith psychiatric interview and examination of the patient is required to meet the standard of care. Questioning the patient about suicidal ideation, intent, and plan is required. However, beyond these basics, each case is different such that variations in approach are to be expected. Jurors may be satisfied that the psychiatrist who has done the basics has met the standard of care for assessing suicide risk. Jurors may not be as perturbed by seeing written “-SI” and “contracts for safety,” as might be the plaintiff’s expert witness. Philip Resnick has said, “Poor documentation never killed anyone.” Consequently, what may have satisfied a jury that the standard of care for suicide risk assessment was met, nevertheless may differ greatly from what is recommended by APA practice guidelines.

The vast majority of psychiatrists currently in practice completed their residency training before the APA published its practice guidelines in 2003, although practitioners are responsible for keeping abreast of developments in the field, and licensing boards and credentialing committees require continuing medical education hours. Nevertheless, what may be practiced in residency training programs and academic medical centers does not define the standard of care for the average prudent psychiatrist in practice in the community. Checklists and templates may be an effective way to train residents, but a good seasoned clinician might have other assessment methods better suited to an individual case. Also, a psychia-

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Boston FBI Field Office

Ronald Schouten MD, JD and Kenneth Busch MD
Chair of the International Relations Committee

The International Relations Committee sponsored its 12th yearly site visit at the Boston FBI Field Office during the 42nd Annual Meeting. The site visit was coordinated through the local host, Dr. Ronald Schouten, who has been a Consultant to the Bureau for several years. The FBI Boston office, which is located in the heart of downtown Boston across from City Hall Plaza, consists of over 500 special agents, intelligence, language and financial analysts, surveillance teams, and a variety of professional staff members. It is responsible for the investigation of federal offenses, including organized crime and terrorism, in Massachusetts, Rhode Island, New Hampshire and Maine. This geographical area poses special challenges in law enforcement due to the extended border with Canada and coastline.

The site visit was organized by Edward Valla, Ph.D., a senior Intelligence Analyst at the Boston office of the FBI, and included several sessions on cutting edge topics of interest to participants. Dr. Valla offered an excellent presentation on counterterrorism. He noted that prior to 9/11 the FBI's work focused on criminal investigations and law enforcement. After 9/11, counterterrorism has become the main priority of the FBI. He pointed out that international terrorists continue to plot ways to attack the U.S. and cause immense distress and psychological impact. In addition, home-grown terrorists, including some whose plots arose in New England, have increased in number. Terrorism threats are designed to create maximum disruption to the economy and undermine public self-confidence and sense of security. The FBI maintains extensive data bases on domestic and international terrorist organizations, their members and leaders. Methods and terrorist operations change over time and the FBI assesses new threats on an ongoing basis.

Dr. Valla indicated that small cells of one or more terrorists can pose great danger. Some of the most serious plots have included the 2009 plot to place

bombs in the New York Subway during rush hour and the 2010 plot to plant a bomb in Times Square. New terrorist recruits are often trained overseas to replace losses and plot attacks against critical infrastructure. They frequently communicate with each other through internet chat rooms in Arabic. Rather than focusing on past attacks, the FBI takes the approach that the biggest worry facing the U.S. Intelligence Community and the country in general, is the next attack as terrorists learn to modify their behavior and techniques. Future terrorists might take new approaches to change the nature of their threat and the type of operation and damage they could inflict. In many

“The number of intelligence analysts throughout the Bureau has increased from 1000 to 3000.”

cases, the same terrorists would be attempting to do harm, but they would be striking in different ways. For example they might join forces with others to pursue their goals and objectives. The greatest challenge facing the FBI is to remain several steps in front of the adversary since the future threat may be something entirely different from previous plots.

The next presentation was given by a senior FBI Special Agent assigned to the Special Weapons and Tactics Team. SWAT team members are specifically trained to intervene in high-risk events. SWAT teams are part of each of the 56 field offices. If local law enforcement does not have the resources to handle a high risk situation, SWAT teams from the local field office can be dispatched to aid the local authorities. SWAT teams are versatile and operate in high risk incidents when there is potential for violence and risk to the public and

law enforcement. These situations can include high risk arrests, hostage rescue, specialized sniper operations, high risk events in buses, trains and airplanes, WMD threats, and fugitive tracking.

FBI agents apply on a competitive basis to become members of the SWAT team. Training is rigorous and is conducted over a span of two years. The trainee must pass enhanced physical fitness tests in order to move on to the next aspect of training. This training includes all types of scenarios such as hostage rescue simulations and other high risk events in real world situations. The trainee must learn to operate in all types of terrains and climates such as cold weather and water, and in urban and rural settings. They also learn to carry a variety of weapons and to operate specialized vehicles found in most other law enforcement tactical teams. In the Boston Field Office there are 30 agents on the SWAT team. They continue to train several days each month to maintain their physical and tactical edge. They are dispatched to about 25 SWAT missions in the region each year. They go through extensive planning prior to engaging in the event and they have extensive debriefing sessions after the event.

The next presentation described the FBI Hostage Negotiation Team. This team consists of FBI agents who are part of operational support for the critical incident response unit. There are 12 agents assigned to the hostage negotiation team at the Boston Field Office. They have responsibility for managing on the scene negotiations for any significant crisis event in the region. Like the SWAT team they are on call 24 hours per day for operational response. They participate in training, research and program development with state and local law enforcement departments in addition to field operations with these agencies. They can be deployed on a domestic or international basis such as Afghanistan and other countries where U.S. citizens have been kidnapped. Their goal is the safe release of the hostage and to prevent death and serious injury. Special negotiation techniques are focused on building rapport and changing behavior with the perpe-

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Tri-State AAPL Meets in New York City *Mastering the Art of Forensic Psychiatry; Selected Topics*

Manuel Lopez-Leon MD

On Saturday January 21, about 50 devoted AAPL members and committed guest speakers made their way through the first snowstorm of the year to the New York Academy of Medicine where the Tri-State Chapter's 37th annual conference was held. The program offered five hours of Category 1 CME credits and it was held in cooperation with the New York State Office of Mental Health and the Forensic Psychiatry Clinic for the Criminal and Supreme Courts of the State of New York.

The first presenter was the Honorable Judge Juanita Bing Newton, Dean of the New York State Judicial Institute and acting Justice of the NY State Supreme Court. She spoke on "Gatekeepers or Swing Sitters: The Role of New York Judges in Courtroom Forensic Sciences Issues (Demonstrable Need for Science Education)." Judges and other Court officers have little or no understanding of mental disorders, and furthermore, the terms used in the diagnostic labels are "completely foreign" to them. Some Judges opt to accept the DSM as the Bible, and "that may be a problem." Judge Bing Newton stressed that having little knowledge may in fact be worse than having no knowledge at all; "Judges may be quick to dismiss an expert witness' testimony without further exploration if a term used is not in the DSM."

There is a significant need to educate Judges with respect to mental disorders and as to what psychiatry has to offer to the legal system. Psychiatric expert witnesses frequently are "sandbagged while testifying mostly due to ignorance." Judges need to be attuned as to what psychiatrists think is important for them to know, and furthermore, they should undergo training that would allow them to become aware of the psychiatric issues at hand and potential implications. Judges need to have some fundamental understanding of mental disorders so that they can become more thoughtful and

sophisticated when hearing psychiatric cases. During the question and discussion segment of the presentation Judge Bing Newton stated: "let me give you all a piece of free advice on writing your reports; put upfront on the first page what you want the Judge to know."

Carol A. Bernstein, M.D. Associate Professor of Psychiatry & Vice Chair for Education in Psychiatry, NYU School of Medicine, and Immediate Past President of the American Psychiatric Association, spoke on "Maintenance of Certification: The Good, the Bad, and the Ugly." Dr. Bernstein

"...if a patient or family member calls for an explanation don't avoid the call, bite the bullet, and talk them through it."

explained the process for maintenance of certification in General Psychiatry by the American Board of Psychiatry and Neurology, Inc. (ABPN), and touched on issues pertinent Forensic Psychiatry.

Since ABPN announced that there would be new requirements in maintaining certification, including ABPN rating forms filled out by the diplomates' patients and peers, there has been uproar due to strong opinions caused by resistance, fear, and anxiety of further scrutiny; "the rubber meets the road really with the parts of the process related to being evaluated by patients and peers, this seems to create a great deal of anxiety."

The ABPN will be auditing 5% of the diplomates, which will be randomly selected. They will undergo a review of the documentation requested, which is explained in their website; www.abpn.org. There are at least two

important reasons for the new ABPN's requirements for maintenance of certification; "1) there many pressures in our society today to have standards and regulations, and 2) in principle, standards are good". Dr. Bernstein explained that much of the requirements are based on the honor system, and stated that, "at running the risk of sounding 'all tongue-in-cheek', the idea is to allow diplomates to be able to gather the information requested by ABPN without corrupting the access." The rating forms will not reflect the patient's name or any protected health information; therefore ABPN will trust that the rating forms were generated legitimately. In the process of having evaluations filled out by patients and peers, diplomates may learn a thing or two about how they are perceived as clinicians; "this is based on the honor system, but it's a good way of keeping your practice in check."

According to the new ABPN requirements diplomates will be expected to meet certain requirements every three years starting from the first time they are recertified. The requirements for each subspecialty may not be the same; "you may need a different amount of CME credits for your general psychiatry certification than for your forensic psychiatry certification, for instance." Dr. Bernstein stated that, "I don't think there are penalties [other than not being certified until the requirements are met], they just want people to do it right; the idea behind this is to move medicine into the direction of having physicians continuously reevaluate their skills and knowledge, and not to be punitive."

During the discussion segment of the presentation, some AAPL members suggested that if we as physicians don't take the lead on this, the government might; "it is important that we do it because if we as a medical-professional organization don't take an active roll in establishing the standards, it will be done by someone else such as a government agency." An example of the government backing away from monitoring physicians if an educational organization is doing it, would be

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Tri-State AAPL

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the recent government retraction from taking responsibility for monitoring the duty hours of residents after ACGME undertook that role. Dr. Bernstein urged AAPL members to consider presenting ABPN with a self-assessment program to be taken into account as a tool to comply with the requirements of maintenance of certification.

The third presenter was Kevin Hayes, MD, MBA, FAPA, medical consultant at Unum Life Insurance Company of America. Dr. Hayes' presentation was on "The Psychiatric Independent Medical Examination." He provided an overview of the inner workings of the insurance companies' review process of disability claims. The speaker explained some concepts behind the Employee Retirement Income Security Act of 1974 (ERISA) and provided a historical background for its creation. ERISA governs almost all group policies, with exception of government agencies, religious, and non-profit entities. Furthermore, he explained that ERISA requires the company to always first exhaust their internal appeals process before proceeding to litigation. There have been variations in the way Courts have addressed contested claims.

Claims based on psychiatric disabilities cost insurance companies several billions of dollars a year, despite "the inherent *subjectivity* of the science and lack of biological markers" in making psychiatric diagnoses. Insurance companies pay close attention to the inability to perform activities of daily living and cognitive impairments caused by psychiatric conditions. In their review process, claims are closely examined to determine recent or acute changes in the psychiatric conditions, the chronicity of the individual's psychiatric history, evidence of character pathology, and possibility of malingering.

Insurance companies usually consult with Independent Medical Examiners when there is conflicting information, or flares are detected when

reviewing the claims. In conclusion, the Independent Medical Examiner should not have a conflict of interest, should understand the questions, answer the questions, integrate clinical information, provide clear documentation supporting the rationale for their opinion, and provide citation of pertinent case law if appropriate. In addition, the IME should keep in mind that the details of each case may vary by jurisdiction and policy language.

The final speaker was Bruce Brady, Esquire, Senior Partner, Callan, Koster, Brady & Brennan, LLP, who specializes in defending psychiatric malpractice cases. Mr. Brady began his presentation by pointing out that the most common malpractice claims are due to medication management, suicide, sexual misconduct, negligent treatment/ misdiagnosis, and involuntary commitment. As a mnemonic strategy Mr. Brady suggested using "drugs, death, sex and bondage."

The speaker stated that in order to successfully defend a psychiatrist who has been sued, it is important that good documentation be available. In case of being the target of a malpractice lawsuit, the relationship with the attorney is very important; "we are your best friends and need you to be flexible and available to better defend you." It is important to be fully cooperative, available, take an affirmative role, and realize that you will have to be flexible changing your schedule in order to prepare your defense and comply with depositions.

By and large, forensic psychiatrists have very low rates of lawsuits. The most commonly seen lawsuits are due to disputes related to custody, matrimonial, mental competency, confidentiality protection (Domestic Relations Law §235), and retention in Personal Injury Action. Mr. Brady explained that as a "witness in any legal proceeding you have immunity; the judges, the parties involved, and the witnesses have immunity." The legal system wants people to participate in the judicial system without fear of retribution, and this applies to the witness. If a forensic psychiatrist is involved in a judicial or quasi-judicial proceeding

(i.e. arbitration) there is immunity.

The speaker's most important piece of advice to psychiatrists was; "practice good medicine. That really helps when you are sued for malpractice!" Mr. Brady believes that in 2/3 of the cases he has been involved in, the psychiatrist really didn't do anything wrong. A recent survey from Harvard came to the conclusion that the majority of malpractice cases brought up should not have been. In Mr. Brady's experience attempting to figure out why each case ends up in a lawsuit, he has concluded that often times the patient or his/her family feel that there was a lack of availability of the psychiatrist, and that their questions related to a poor outcome were not satisfied; "if a patient or family member calls for an explanation don't avoid the call, bite the bullet, and talk them through it." He pointed out that although a patient or its family initiates the lawsuit, an attorney makes the decision as to whether the case will proceed into a lawsuit. The decision is made based on the severity of the injuries, the type of the existing insurance coverage, and lastly the degree of negligence involved; "attorneys rely on the records, not on the patient's accounts, so if you have good documentation, the attorney is less likely to want to pursue the case."

Mr. Brady emphasized that documentation is extremely important; the Office of Professional Misconduct expects psychiatrists to keep records just as any other medical specialty. Stressing the punitive nature of the Office of Professional Misconduct he stated that, "If they can't find anything else, you will at least be cited for not keeping proper records; they want to see a thorough intake, focus on past psychiatric history, suicide risk assessment, a well thought-out rationale of your diagnosis, and reasoning for usage and adjustment of medications". Informed consent is important to be documented, at least in the progress note, reflecting that there was a discussion with the patient of the risks, benefits, and alternatives of the treatments recommended.

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Treatment of Mental Illness in Pregnancy and Malpractice Concerns

Susan Hatters Friedman MD and Ryan C. W. Hall MD for the Psychopharmacology Committee and the Gender Issues Committee

Many physicians find themselves in the uncomfortable position of treating a woman with mental illness, who is either planning pregnancy or who already is pregnant. Resources such as the FDA categories and scientific articles are often consulted in attempts to determine an appropriate course of action, but this may not be enough to make an individualized treatment decision or to protect a physician from complaints of malpractice. FDA categorizations are only a small piece of how the treatment of mental illness in pregnancy should proceed, because each patient has their own acceptable risk-benefit concerns. In addition, evidence-based medicine and the known risks may change with time. For example, the medication paroxetine which once had a category C classification was reclassified as a D, after an FDA warning was issued in December of 2005. Since then over a billion dollars has been paid by the manufacturer to settle over 800 lawsuits. These occurrences may have led to concerns in the public's mind about the safety of other class C antidepressant medications such as sertraline. To further complicate the issue on December 16, 2011 the FDA issued a statement partially rescinding a previous 2006 warning based on the results of a single study that found all SSRI's "potentially" cause Persistent Pulmonary Hypertension in a Newborn (PPHN). The FDA current position on the issue is "There have been conflicting findings from new studies evaluating this potential risk, making it unclear whether use of SSRIs during pregnancy can cause PPHN." Physicians who were already fearful and confused about how best to treat pregnant women with mental disorders may stop all together in light of the rapidly changing recommendations of "evidence-based medicine" and government bodies, and the current national advertising campaigns by law firms regarding "bad" drugs which seem to have emerged since the paroxetine settle-

ments. The net result may be fewer practitioners willing to see women with mental illness and needed care becoming harder and harder for one of the most vulnerable classes of patients to find.

Treating psychiatrists have several potential problems they must consider when engaging in pharmacotherapy for mental illness in pregnancy. These include whether medication may increase risk of spontaneous abortion (miscarriage), whether it increases risks of teratogenesis (malformations such as seen with mood stabilizers like Valproic acid), whether there is perinatal toxicity or withdrawal, and whether there may

"...behavioral teratogenesis is a developing concept looking at whether neurobehavioral sequelae occurring years later are due to medication exposure in utero."

be a risk of behavioral teratogenesis. In addition psychiatrists should consider a treatment plan that can be maintained in the postnatal period. The classic example of this is trying to choose a medication which is most compatible with breastfeeding.

In general, the baseline risk of a malformation without medication treatment or a mental illness is approximately 2-4%. That is, even if she 'does everything right', a woman is not guaranteed a healthy baby free of anomalies. When a birth defect does occur, most of the time a clear causative factor cannot be identified. These are facts that many individuals and juries do not appreciate. This lack of understanding also leads to the erroneous belief that—

just because there was a psychotropic medication prescribed, it had to have been what caused a poor outcome.

In addition the mother may not be the only "patient." Another concern in the infants of psychiatrically ill mothers is perinatal toxicity or withdrawal. Toxicity or withdrawal typically present in the first days after delivery, are time limited, and are either caused by high levels of a maternal medication in the infant or alternatively, the sudden withdrawal of a medication or substance (e.g. high dose benzodiazepines or opiates) which the baby had been exposed to *in utero*. In a similar vein, behavioral teratogenesis is a developing concept looking at whether neurobehavioral sequelae occurring years later are due to medication exposure *in utero*. Behavioral teratogenesis is being postulated by some professionals and laymen to explain trends in childhood mental health—such as developmental delay and autism. Considering that in many jurisdictions the statute of limitations for filing a civil lawsuit for medical malpractice related to birth is the age of majority there is a particularly long period of time before lawsuits based on this type of proposed injury could be filed.

The other side of the coin is the risk of not medicating, which needs to be considered. Often forgotten in these cases are the well-known risks of untreated mental illness including harm to self, poor self care, poor prenatal care, neglect of other children, substance abuse, and poor mother-infant bonding. Also, negative pregnancy outcomes have been associated with untreated depression. The risks of untreated mental illness must be weighed against the risks of the treatment, both of which have some uncertainty. Due to fear of malformation, some may be overly hesitant to prescribe medications, increasing the risk for relapse or exacerbation of psychiatric illness, which can be as harmful if not more harmful than the potential risks of medication. We do not intend to imply that pharmacotherapy is needed for all pregnant patients with mental illness. Some cases, such as a mild depression or anxiety, may be appropri-

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Pregnancy

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ately treated utilizing only psychotherapy with no medication, but severe mood disorders or psychotic illness almost always requires pharmacologic treatment. In some cases, hospitalization and/or electroconvulsive therapy are appropriate.

So what should a physician do? We intentionally chose the word 'physician' because this is a problem that many physicians outside of psychiatry face as well, such as obstetricians and family practice physicians. The first step is communication between the physician, the patient/family, and other treatment providers. It is important to identify and understand the patient's concerns and level of comfort with risk (e.g. fear of disease relapse compared with concern for potential defect), closely examine the history of the individual patient (e.g. the risk for a patient with a past history of postpartum psychosis is different than for a woman with her first pregnancy), history of medication response and severity of illness, level of social support, and expectations and desires regarding the experience of delivery and motherhood (e.g. home delivery versus hospital, and plans regarding breast-feeding). It is also key to have good follow-up, consultation with other treaters, and to reassess the situation relatively frequently due to the potential of changes during the course of the pregnancy. The theoretical concerns which a woman has when she is planning to become pregnant often change over the course of pregnancy and delivery.

In terms of prescribing, guiding principles include the importance of a careful past medication history, utilizing appropriate doses and the least number of medications due to potential for unexpected interactions. Because pregnant women are usually excluded from research studies, when data is available it is usually for older medications, because more women have been unexpectedly exposed to them in pregnancy. Physicians should not stop medications in a "knee jerk fashion" if a pregnancy occurs. For example the FDA reports the risk of relapse of depression during pregnancy in women

who stop taking their antidepressant medications is 5 times greater than for women who continue on their medication. An informed consent discussion with the mother (and if possible her partner) of benefits of the medications, risk of the medication, and risks of no medication is critical and should be documented. Having a well informed patient may help them psychologically later if there is a problem (eliminating the hindsight distress of "if I only knew") and help protect the prescribing physician in showing that due diligence was done. Also physicians and patients need to have clear contingencies plans in place. For example, some inpatient psychiatric units are hesitant to accept pregnant women as patients.

Ideally these discussions and preparations will occur before pregnancy, but in reality more than half of all pregnancies are unplanned with unplanned rates thought to be even higher among individuals with mental illness. Thus, a woman may be unwittingly exposing her fetus to a psychiatric medication for much of the period of organogenesis (the first trimester) when the nervous system and the cardiovascular system are forming. When treating women of reproductive age, psychiatrists should consider the possibility of future pregnancies in their medication decisions, and should discuss risks of unplanned pregnancies.

Forensic psychiatrists may be called upon to consider the appropriateness of psychiatric treatment received during pregnancy. Experts in these cases not only need to understand the medication risks and medical literature but also need to understand legal medical liability concepts such as the Learned Intermediary Doctrine. (e.g. if manufacturer knew of risk and conveyed information to physicians then physicians are responsible, but if the risk was unknown then liability may be with the manufacturer for not "adequately studying" the medication—as happened in the *Kilker v. SmithKline Beecham* case). An understanding of existing case law is also important for providing legal insight when it comes to the individual physician as seen from the case *Knipe v. SmithKline Beecham* (2008) which identifies that drug companies have a responsibility to notify

physicians of potential harmful medications effects discovered in stage 4 surveillance even if medication is being used in an off label manner. In addition it is also often helpful for forensic experts to have an appreciation of historical cases such as the lawsuit history surrounding thalidomide (e.g. 13 cases brought against Merrell Dow Pharmaceuticals in U.S. with other larger cases and settlements in Europe and Canada), Diethylstilbestrol [DES] (e.g. *Sindell v. Abbott Laboratories* (1980) shared liability among companies making the drug since no one manufacturer was identifiable), and Bendectin (Made by company that made thalidomide and pulled from market after several lawsuits such as *Mekdeci v. Merrell National Labs* (1983) even though an FDA panel concluded that no association had been demonstrated between Bendectin and birth defects).

Also as noted by the recent FDA medwatch statement regarding SSRI's, forensic experts in these cases need a strong understanding of research techniques and scientific theory to help explain what conflicting data means and how and why studies can conflict (e.g. sampling bias, reporting bias, lack of sufficient power). Forensic experts need to be able to communicate all of these concepts to a jury—to prevent rampant speculation and unchecked emotion from clouding the issue. It is important for everyone involved in the treatment of the pregnant mentally ill to understand even when everything is done right there can still be a bad outcome. ☹

MUSE & VIEWS

911 Calls Gone Wild!

Dispatcher: 9-1-1 What's the nature of your emergency?

Caller: My wife is pregnant and her contractions are only two minutes apart.

Dispatcher: Is this her first child?

Caller: No, you idiot! This is her husband!

Source: http://www.laughitout.com/2007/06/funnyreal-911_calls.html#ixzz1oN4afCsn

Submitted by Charles L. Scott MD

Modern Malady

Anne Hanson MD
Institutional and Correctional
Committee

Recently in an online prison newspaper I found an article entitled “The Malady of Melancholia,” written by an anonymous British prisoner in his sixties who had spent more than half of his life incarcerated. In his piece he gives a moving and vivid description of life as a severely depressed inmate. His prose is painfully detailed: “I was inert, apathetic, lachrymose and utterly defeated.” He was seen by three institutional mental health workers who all confirmed his diagnosis, but being labeled as a psychiatric patient lead to unforeseen humiliations. Depression was seen as a weakness and he was ridiculed and bullied both by peers and correctional staff. He was required to shave under supervision, to have a continuous escort and at one point he was placed on regular observation. In spite of this, he did not rely on his mental health issues to minimize his previous crimes or to avoid responsibility for them.

He was prescribed medication which he took, without question and apparently without clinical review, for a year. He felt no better as a result of this treatment and his thoughts vacillated between resignation to a life of constant misery and suicide. In spite of his lack of progress he trusted his doctor’s diagnosis and treatment plan, but doubted if he would ever be free of the “black dog.” The questions that he had about his treatment are common to many psychiatric patients: How can depression be a chemical imbalance when there is no test for it? How do you know what medication will help this, and will I ever get better? As an aside, he questioned if depression could ever be completely resolved in a prison environment.

The anonymous prisoner’s writing brought to mind my experiences treating inmates on death row or serving life sentences without parole. Most of these offenders were not suffering from clinical depression. They found meaning in life through education or institu-

tional jobs. They enjoyed visits from friends and family, looked forward to letters from home and opportunities to make phone calls. Even inmates not destined for release would throw themselves into productive activity: filing complaints or administrative remedies, requesting permission for televisions and programs and special considerations. Clearly these were not the inert or apathetic individuals described by the Malady author.

The question of whether depression can be completely resolved in prison is a valid one, and it reflects psychiatry’s struggle between meaning and disease. The cost of an error in either direction could be costly: to focus on disease to the exclusion of meaning would overlook the patient’s essential world view and individuality. To focus on meaning rather than disease might lead one to

“Depression was seen as a weakness and he was ridiculed and bullied both by peers and correctional staff.”

neglect potentially helpful treatments out of the false belief that depression is the inevitable result of incarceration. In his book “Man’s Search for Meaning,” Viktor Frankl discussed the importance of finding meaning in suffering through positive action, an active spiritual and mental life, and the conscious decision to pursue love and relationships rather than boredom and emptiness. These ideas are still relevant.

In the correctional context it may seem cavalier to suggest a pill as a substitute for a meaningful life or hopeful future, but the promise of wellness itself is a form of hope. It is possible to be incarcerated without feeling constant misery. The correctional psychiatrist’s job is to help the inmate patient understand this as well. The prison environment can be unforgiving, but severe depression is equally harsh.

In the words of the Malady author:

“Prison is decidedly not a place in which to be depressed, but where is?”

http://www.insidetime.org/article-view.asp?a=1075&c=the_malady_of_melancholia&cat=Mental%20Health ☎

JLWOP

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ling for the criminal code, legislative groups in states that are reviewing sentencing guidelines are looking for support from professional groups and individual psychiatrists to support such reforms.

Some of the discussion points in these review committees involve such issues as

1. Where the review should take place—Should it be at the original trial court or the Board of Parole? One of the differences is that a Court review might end with a recommendation for a change in sentence rather than just a consideration of release under parole.
2. When should mandatory reviews begin and with what frequency should they continue?
3. How to decide when psychiatric evaluations are needed.

The briefs and policy statements cited above can be useful in guiding the structure of any statements that an individual or APA or AAPL District Branch may want to write. (An interesting saga of an individual case was published by Knopf in 2010—“In the Place of Justice: A Story of Punishment“ by Wilbert Rideau). ☎

Book Reviewers Wanted!

The Journal of the American Academy of Psychiatry and the Law is looking for reviewers of texts of interest to forensic psychiatrists. Book reviews of 750-900 words are printed in the Journal four times a year. If you are interested in becoming a book reviewer please contact AAPL at office@aapl.org or Cheryl Wills, MD, JAAPL Book Review Editor, at cwforensic@earthlink.net.

Computers in Technology and Forensic Psychiatry

Mark J. Hauser MD, Computers Committee

At our 2011 Annual Meeting, the AAPL Computer Committee hosted a workshop entitled “Computers in Technology and Forensic Psychiatry.”

This year, one highlight of the workshop was a presentation by Dr. Alan Newman which demonstrated the digital workflow of a forensic case. By using the programs Scrivener and a “mind-mapping” app, Dr. Newman showed how to store, organize and arrange relevant information, as well as how to generate final reports of the material into various formats. Scrivener, which is available on both Windows and Mac computers, is a powerful aggregation and organizational tool. It can be used to efficiently store and display all case-relevant information, including pertinent medical literature and PDFs of scanned and electronic documents. Scrivener can generate a final report using a wide variety of methods, including LaTeX, as well as any other major format.

Separate software tools, including mind mapping tools such as Mind-Manager, can be used to illustrate connections between different elements of a case and to represent a formulation, in a flow chart. These programs are excellent tools to help mentally organize the relationships between complex issues, with categories, subcategories and other connections being visually represented. Mind-mapping tools have the added benefit of being able to export files into formats which can be imported into Scrivener.

Dr. Andrew Nanton demonstrated the use of text expanders and showed the audience how easy they are to create and utilize for improved efficiency in our work. There are many text expander products available including one called TextExpander! You can create a small snippet of typed text and arrange to expand it into any phrase or more as you desire. Dropbox is a file and folder synchronization tool that allows you to easily sync files across different computers with a cloud based backup and the ability to share individ-

ual subfolders with others securely. Using Dropbox is an excellent way to access all of your text expanders at each computer you choose.

Dr. Tyler Jones and Dr. Paul O’Leary gave a presentation on integrating telemedicine into their practice and how to make it work successfully, despite the obstacles and limitations.

Dr. Mark Hauser reiterated the importance of backup strategies, and demonstrated the use of an audience response system with a live survey about current technology usage that received instant feedback from 35 of the participants. Interesting statistics gleaned from the survey include:

“Dropbox is a file and folder synchronization tool that allows you to easily sync files across different computers with a cloud based backup and the ability to share individual subfolders with others securely.”

- Over half of participants own an iPhone
- Over half own a tablet computer (compared with one in four doctors and one in ten American adults)
- 2/3 of the participants sync contacts and email between their various devices
- 1/3 at least occasionally use regular email to communicate with patients
- Over half use Skype as a means of communication with family members, while almost none use Skype to communicate with patients, lawyers or colleagues.
- 1/3 still use or prefer to use Internet

Explorer over other internet browser options

Dr. Hauser gave an overview of current internet browser usage, with Firefox, Chrome and Internet Explorer as the main contenders. He described current trends in the browser market, with Chrome steadily drawing users away from other browsers. He outlined the importance of choosing a secure browser that releases security updates frequently, and the necessity of installing these updates whenever available. ☎

Boston FBI

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trator during the crisis event.

The site visit concluded with an enlightening discussion on how the FBI has changed its culture since 9/11. The FBI is constantly vigilant to new terrorist threats. The number of intelligence analysts throughout the Bureau has increased from 1000 to 3000. They are responsible for analysis of intelligence information to assess the level of any given threat and for criminal investigations. Many of the threats are evaluated directly by the analyst on-line in chat rooms and then further evaluated in terms of how the threats play out. The Bureau continues to seek new talent in counterterrorism operations especially candidates with language skills or with special expertise in political science and international studies.

The site visit was well-received by the participants. We had a unique opportunity to interact informally with FBI agents and intelligence analysts and learn about their career tracks in the Bureau. We were particularly impressed with their loyalty and devotion to homeland security and protecting the country, as well as their attention to privacy and protection of Constitutional rights. Interesting insights about the challenges of their work were provided by the speakers. A certificate of appreciation was presented to the FBI Boston Field Office in recognition of the valuable contributions to AAPL. We thank the FBI agents and FBI staff in Boston for being wonderful hosts and for arranging such an exceptional program. ☎

“Teaching Movies” for the American Academy of Psychiatry and Law

Proposed by Thomas G. Gutheil MD

The author thanks AAPL members, Tatiana Gutheil BA and Kenneth Pope PhD, who suggested films and lessons.

Several years ago residents at the Massachusetts Mental Health Center spontaneously developed, and now run, an after-hours program entitled Psychiatric Cinema. In this program the residents ask individual faculty to choose movies that relate to psychiatric practice and to lead the discussion. The training office provides pizza or comparable fodder; the movie on DVD is shown and the residents discuss it, led by the faculty member.

As one of the regular leaders of Psychiatric Cinema I offer an annotated filmography of movies that I consider valuable for teaching particular aspects of forensic psychiatry. Of course, such lists are influenced by subjective considerations and cannot be considered exhaustive. My hope is that such an introduction will encourage forensic fellowship programs to utilize the Psychiatric Cinema model to add variety and interest to their training. I have divided the list into fairly arbitrary categories as a sop to organization; I respectively submit that all are worth seeing on cinematic grounds alone. I also tend to favor older movies, not only because they are, in fact, often better than the swill Hollywood is turning out nowadays, but they are less likely to have been seen already by the young.

This list is best regarded as a work in progress. AAPL members are welcome to submit their favorites together with their suggested discussion points. Ludicrous examples (Lovesick, Analyze This/That) not welcome.

The Psychopath

1. **Kiss of Death:** the original with Richard Widmark and Victor Mature, not the effete remake. Widmark’s giggling psychopath is unforgettable: to put you in the mood early in the film, he pushes an old lady in a wheelchair down a flight of stairs – and he’s just getting started.

2. **The Onion Field:** based on Wambaugh’s novel alluding to an actual crime, this remarkable movie features two psychopaths (one played by James Woods) and four (count ‘em) separate climaxes. It is also a funny/ghastly portrayal of the inertia of the legal system.
3. **Le Samourai:** in French with subtitles starring Alain Delon as a schizoid hit man. It focuses on details of his daily actions to illuminate how measured and distant his methodical approach is; it is obsessive focus without anxiety. The viewer is held at a comparable distance.
4. **Mr. Brooks:** Kevin Costner plays the hidden serial killer as model citizen. Yes, we have seen this on “Dexter” but it still works here. Costner is more convincing than usual.
5. **Cape Fear:** actually either the original with Robert Mitchum or the remake with Robert DeNiro can illustrate the entity. Good points about the difficulty dealing with psychopaths who are smart enough to stay within the lines and, in the remake, about the seductiveness of these individuals.
6. **American Psycho:** the narcissism of psychopaths is on display in Christian Bale’s amazing performance, over the top deliberately.
7. **The Talented Mr. Ripley** and **Catch Me If You Can:** two excellent versions of the impostor psychopath, extending the original classic of this field, Thomas Mann’s “Confessions of Felix Krull, confidence man.”
8. **Goodfellas:** More about the dyssocial, as it used to be called (meaning groups with a code but not the consensus code), than the antisocial, except for Joe Pesci’s unforgettable Tommy DeVito: “How do you mean, funny?”
9. **Manhunter, Red Dragon** and **Silence of the Lambs** may be included as examples of profiling but there are no forensic psychiatrists around.

Courtroom procedure

1. **Twelve Angry Men:** THE classic jury room drama featuring Henry Fonda and probably every major contemporary character actor around.
2. **Mr. Deeds Goes to Town:** parodic but pointed depiction of expert witnesses taken down a peg not by the cross examining attorney but by the examinee, played by Gary Cooper.
3. **My Cousin Vinny:** Yes, it’s a farcical comedy, but there’s a lot of discussion mileage on expert witnesses, lawyers, judges, all played by top actors.
4. **The Verdict:** The plot is a bit overdone but good for behind-the-scenes of sneaky lawyers in action.
5. **Anatomy of a Murder:** Featuring James Stewart, George C. Scott and Ben Gazzara, this complex murder trial touches most of the key bases, including a brief sequence with Orson Bean as a forensic psychiatric witness.
6. **A Few Good Men:** classic by now, with some teachable points about courtroom shenanigans.

Expert witness

Examples of good work are hard to find; the other kind are legion. The extreme bad version is

1. **Basic Instinct II:** Well worth seeing if only because the forensic psychiatrist —played by David Morrissey, excellent in “State of Play”, British version – makes every possible error and boundary violation it is possible to make, under the perverse influence of Sharon Stone. Let him say once, “I don’t usually do this...” and you know that not much later – you get the idea.
2. **Primal Fear:** Great stuff by Richard Gere and Edward Norton in a priest-torture-murder case, but Frances McDormand as an expert forensic psychiatrist does a great job of avoiding embarrassment and coping with a very difficult situation for an expert. Multiple personality is touched on.
3. **Final Analysis:** Gere again as a forensic psychiatrist involved in a

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Teaching Movies

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steamy affair with the sister of his patient. It contains the wonderful bit where Gere says he called the APA and claims they told him it was OK to have sex with a patient's sister (!).

4. **The Young Philadelphians:** In a great cross examination of fact witness Richard Deacon by attorney Paul Newman, the fact witness is pulled out of position into spouting expert opinions: an object lesson for experts who can meet disaster by being led into assuming they know where the attorney is going.

Witnesses

1. **Rashomon:** the classic treatise on diverse views of witnesses to the same event. A rape-murder in the woods is told sequentially from the viewpoint of the rape victim, the murder victim (by his ghost), the criminal and a hidden observer. Possibly Kurosawa's best.
2. **Atonement:** witness error based on subjective interpretation. Saoirse Ronan is the child witness to "something sexual" which she does not understand.
3. **Oleanna:** a personal favorite of mine, this duo drama pits a male professor against a female student who says, near the outset, "I don't know what people mean" and parlays that into a career ruination. Known to start screaming fights in the theater lobby, this might be the "anti-date" movie.
4. **Witness for the Prosecution:** the killer cast of Charles Laughton, Tyrone Power and Marlene Dietrich give a most complex object lesson about the agendas that witnesses can bring to the courtroom's "search for truth."
5. **The Accused:** a lesson in how victims may be treated by the legal system and become "the accused" themselves.
6. **Lilith:** with Warren Beatty. Great portrayal of what can happen when a member of the clinical team gets involved with severe borderline. A cautionary tale well told.

Psychosis and other ills

1. **Frailty:** Bill Paxton unusually good in what might be an imaginative portrayal of *folie a deux* but turns into something else. Excellent illustration of how families deal with symptoms in one of their number.
2. **Peeping Tom:** A classic paraphilic serial killer movie with some unusual details involving voyeurism.
3. **M:** The great Peter Lorre in a great portrayal of a compulsive child murderer hunted by both the law and the underworld; contains a famous soliloquy of conflict and compulsion.
4. **Out of the Past:** Classic noir with opportunities to discuss character formation, fatalism and the like. ☪

Job Satisfaction

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clinic time slots. Such situations create job dissatisfaction, and when they continue, burnout. As such, before taking a job, the psychiatrist should understand the level of control they have over the staff they will be working with. Developing a clear policy with the organization that couples control and accountability is very important to improve job satisfaction and reduce the likelihood of burnout.

Community is defined as the quality of an organization's social environment.¹⁸ The social environment includes how conflicts are dealt with, the level of support staff receive, how close people feel to their colleagues, and how well the group works together. Feeling supported by those within the organization increases the feeling of engagement in the work. Additionally, a strong community can reduce the feelings of inequality. Without a sense of community, trust in each other decreases and depersonalization increases. Before taking a job, a psychiatrist should meet as many physicians in the practice as possible; at minimum, the ones with whom they will be sharing responsibilities. The psychiatrist should also meet as many of the employees they will be working with as possible. Further, asking current employees if they trust their colleagues to complete their assigned tasks will help reveal the level of community in the organization.

Fairness is defined as the extent to which the organization has consistent and equitable rules for everyone. If punishment and rewards are arbitrarily allocated, there is a higher risk of burnout, and less ability to tolerate changes.¹⁹ When evaluating a job, considering how disputes are handled, resources allocated, and responsibilities divided, will reveal how fairly the organization treats its employees. For psychiatrists, asking about how call duty (especially call duty on holidays) is shared can be a good measure of the organization's attention to fairness.

Value is defined as what is important to the organization and to its members. If the organization places a high value on the number of patients evaluated per day, but a physician in the organization places a high value on spending time with each patient, there arises a conflict over values. Another example is a department that places a high value on publications versus a physician in the department who places a high value on clinical time and teaching. Having different values from the organization affects employees on every dimension of burnout and has a significant effect on job satisfaction²⁰. The degree of disparity between a psychiatrist's values and those of his/her department is predictive of the psychiatrist's level of job satisfaction and burnout.

A work-life tool²¹ that quantifies job satisfaction is available through Maslach²². It can help identify areas of the job that could be improved or modified to enhance job satisfaction. Additionally, the work-life tool can predict staff burnout and identify areas of the job creating job dissatisfaction. Ultimately, knowledge of these could assist psychiatrists anticipate burnout and subsequently take steps to decrease the likelihood of its occurrence, thereby saving them from emotional, financial, and legal distress. ☪

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Letter to the Editor

Dear Editor,

Just a note to let you know that I very much enjoyed your article in the AAPL newsletter on MOC and patient feedback. Your comments brought back similar memories (and affects) of mine about trying to take care of both “easy” and “difficult” patients. It is for just the reasons you discuss in your article that the ABPN believes strongly that any patient and peer feedback should only be used BY THE PSYCHIARISTS THEMSELVES to determine whether or not they might need to consider doing something to improve their practices. Feedback that is obviously inappropriate or hostile to the psychiatrist can just be ignored. You never know though when a patient or peer might uncover a “blind spot” that will be very helpful to a clinician. Asking for that type of feedback seems the least we can do in this era of public accountability.

Regards,


Larry R. Faulkner, MD
President and CEO, ABPN

Tri-State AAPL

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In concluding his presentation, Mr. Brady stated that it is “easy to defend a psychiatrist if there is good documentation; the law is on the side of doctors in malpractice cases and the fundamental principle is whether you acted carelessly.” He stated that physicians are not required to be “right,” but just to be careful at arriving at their diagnoses and treatment recommendations. Physicians are expected to act prudently and if the documentation reflects the thinking process in making a decision it helps the psychiatrist be on “solid ground.” Psychiatric cases involve more judgment than any other medical discipline since laboratory markers or imaging findings are not used as part of any diagnostic criteria. Therefore it is important to document “how you came up with the decision that you made.”

THE DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES AT TULANE UNIVERSITY SCHOOL OF MEDICINE is recruiting forensic psychiatrists for full-time faculty positions. Candidates selected for these positions will be part of forensic team responsible for supervision of residents, forensic fellows, and medical students during their rotations at Feliciana Forensic Facility and in various state mental health facilities where they will provide clinical services. You must be professionally competent and board certified/eligible in general psychiatry and forensic psychiatry. You must be eligible for medical licensure in State of Louisiana and have a current state and federal narcotics number. Candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Salary is competitive and commensurate with level of the candidates' academic appointments. We will continue to accept applications for these positions until suitable qualified candidates are identified. Qualified applicants should send email of interest, updated CV and list of references to John W. Thompson, Jr, MD, Professor and Vice Chair for Adult Psychiatry, Director of the Division of Forensic Neuropsychiatry at jthomps3@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.

 Oregon Health & Science University (OHSU) has an outstanding opportunity for a BC/BE forensic psychiatrist for both clinical and forensic work in a new State forensic hospital. The position involves four days of clinical work and one day of protected time to pursue community service and academic interests. Opportunities include competency and insanity evaluations, risk assessments, court testimony, resident and fellow supervision and patient care.

Academic rank begins at the level of assistant professor and may be higher depending on credentials and experience. We provide very competitive pay and benefits, and will pay for moving expenses.

OHSU is Oregon's only academic medical center and is highly ranked nationally. Here at OHSU, we highly value a diverse and culturally competent workforce. When you join us, you join a dedicated team of caregivers, educators, researchers and administrative professionals who diligently pursue the advancement and application of knowledge to directly benefit the individuals and communities we serve.

We sincerely invite your interest in this very unique and rewarding opportunity. If you would like more information, please contact Christopher Lockey, M.D. We look forward to hearing from you.

Contact Information:

Christopher J. Lockey, M.D, Assistant Professor of Psychiatry, OHSU
OHSU Chief Psychiatrist, Oregon State Hospital
lockeyc@ohsu.edu

Job Satisfaction

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Department of Mental Health and Addiction Services
A Healthcare Service Agency

Director, Whiting Forensic Division (WFD)
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Yale University School of Medicine, Dept. of Psychiatry

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AAPL Awards Committee Seeks Nominations for 2012

The AAPL Awards Committee would like your help. We would be interested in receiving nominations by June 1 for the following awards:

Red AAPL - For AAPL members who have provided outstanding service to AAPL, e.g., through committee membership.

Golden AAPL – For AAPL members over the age of 60 who have made significant contributions to the field of forensic psychiatry.

Seymour Pollack Award – For APA members (who may not be AAPL members), who have made distinguished contributions to the teaching and educational functions of forensic psychiatry.

Amicus Award – For non-AAPL members who have contributed to AAPL.

Best Teacher in Forensic Fellowship Award – For outstanding faculty member in fellowship program.

Please send your nominations to Renée Binder, MD, Chair of the Awards committee at reneeb@lppi.ucsf.edu.

Suicide Risk

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trist's documentation may not clearly capture the process and reasoning of the suicide risk assessment. In conclusion, expert witnesses, often retained because of their impressive academic and teaching credentials, must be mindful not to confuse the standard of care with the optimal care that clinical practice guidelines recommend. ☯

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RFPs for AAPL Institute

The AAPL Institute for Education and Research (AIER) accepts submissions for educational and research grants on March 1 and August 1.

AIER was developed as a 501 (c) (3) corporation to stimulate educational and research activities, provide educational resources and activities, and aid education and research by encouraging tax-exempt donations to forensic education and research programs.

AAPL members are encouraged to apply for educational grants to develop an innovative educational product or for research grants to conduct research in forensic psychiatry. AAPL members can collaborate with non-AAPL members but the lead developer of the educational projects or the principal investigator of research submissions must be an AAPL member.

The Education Committee will consider proposals for educational projects that will benefit forensic psychiatry, forensic psychiatry trainees, and other professionals.

The Research Committee will consider proposals for research that advances the field of forensic psychiatry.

Awards can be used for production of materials, data analysis and collection, and salary support to free up time to work on this project.

Funds may be used to purchase technology needed for the project that is not otherwise available. The reviewers reserve the opportunity to request further information about proposed purchases or uses of specific technology.

Indirect costs are not covered, and funds cannot be used for travel and lodging to the AAPL meeting where members generally pay for themselves.

Proposals should be submitted for no more than \$15,000. Proposals for smaller amounts are encouraged.

Requirements for submissions are available from the AAPL office. ☎



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Traumatic Brain Injury

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of amnesia for the time of the offense is best left for the trial judge to evaluate and is not the province of the mental health expert.

Responding to Cross Examination: Cross examining defense attorneys may appear not to accept the Wilson case as dispositive and may ask the forensic expert to explain how someone with total amnesia for their alleged crime can possibly assist in their defense. This is a challenging line of questioning. For example, “What if my client was actually across town playing poker when this crime occurred? If he can’t remember that simple fact, how can he possibly help me prepare a defense?”

First, as always, don’t dispute the obvious. The forensic expert will quickly lose credibility in the eyes of the fact-finder if seen as reluctant to admit that defending a client with amnesia presents very real potential challenges. Responding with something like, “Certainly, amnesia can greatly interfere with a person assisting their attorney. But it is my understanding that, in a situation like this involving amnesia for the period around the alleged crime, the impact on the fairness of the proceedings is best left to the judge to monitor and evaluate as the trial progresses.”

This raises the issue of the extent to which a forensic practitioner should attempt to evaluate the strengths and weaknesses of the evidence against the defendant in making a Wilson-type determination. For instance, is an exculpatory alibi feasible? Does the evidence suggest that the defendant could reasonably have been playing poker across town at the time of the crime? Or is there clear video evidence of the defendant entering the victim’s house on the day and time in question? Unsurprisingly, forensic psychiatrists do not all agree on their appropriate role in this regard. However, the average practitioner who is asked to evaluate competency to stand trial will likely not have the kind of expertise, time and access necessary to truly evaluate the quality of the evidence for and against

a defendant. Further, depending upon defense counsel or the prosecuting attorney to assess the quality of the evidence would simply introduce a source of bias into the examiner’s opinion. Consider the question of whether or not an exculpatory alibi is reasonably feasible. The defense attorney may answer this with a strong affirmative while the prosecutor may take the exact opposite position. Even if the average forensic psychiatrist was qualified to sort this out, it would be dangerous to assume that he would be given access to the entire body of evidence in the case. The prosecutor and defense would have to mount their entire cases for the forensic psychiatrist, which obviously is not going to happen. For this reason, we think it is better for the forensic expert to follow the guidance of *Wilson* and leave the determination of competency around the amnesia for the crime issue to the trial judge. ☎

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Peer Review of Psychiatric Testimony Seeks Submissions

Dear AAPL Members:

The Committee on Peer Review of Psychiatric Testimony seeks the submission of video testimony for the AAPL Annual Meeting in Montreal this October. This can be recent or older material, and may be from television or video deposition. In recent years, Dr. Rosmarin has self-submitted, as have Drs. Binder, Resnick, Gutheil, Schwartz-Watts, and Mills. Early career and senior submitters are both encouraged.

This is a collegial experience.

In addition, the Committee reviews non-video testimony in the forms of transcripts or reports in a confidential closed-door setting. Complex, compelling, or personally challenging reports are particularly welcome.

Please send any suggestions or submissions to David Rosmarin, MD, Chair at rosmarin.david@gmail.com. Dr. Rosmarin can be reached by telephone at 617-699-8113. ☎

MUSE & VIEWS

911 Calls Gone Wild!

Dispatcher: 9-1-1

Caller: Yeah, I’m having trouble breathing. I’m all out of breath. Darn....I think I’m going to pass out.

Dispatcher: Sir, where are you calling from?

Caller: I’m at a pay phone. North and Foster.

Dispatcher: Sir, an ambulance is on the way. Are you an asthmatic?

Caller: No

Dispatcher: What were you doing before you started having trouble breathing?

Caller: Running from the Police.

Source:

<http://www.laughitout.com/2007/06/funnyreal-911-calls.html#ixzz1oN4LaULn>

[html#ixzz1oN4LaULn](http://www.laughitout.com/2007/06/funnyreal-911-calls.html#ixzz1oN4LaULn)

Submitted by Charles L. Scott MD



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