



Guttmacher Award **Workplace Violence in Mental and General Health Care Settings**

John Young MD



Dr. Michael R. Privitera, director of consultation-liaison for the University of Rochester Psychiatry Department, presented the Guttmacher Award Lecture for 2012. He summarized his new book, *Workplace Violence in Mental and General Health Care Settings*, the basis for the award. The book's premise was a fitting quotation taken from Former Justice Sandra Day O'Connor: "We don't accomplish anything in this world alone ... and whatever happens is the result of the whole tapestry of one's life and all the weavings of individual threads from one to another that creates something." In keeping with this sentiment he began by thanking mentors, colleagues and family for their support.

Dr. Privitera continued with four progressively more dramatic case histories that prompted the project leading

to the writing of his book. The identification of specific needs gave shape to the development of a Work Place Violence (WPV) Committee under the auspices of the Psychiatry Department. The Committee's first major project was a survey across the Psychiatry Department, published in *Occupational Medicine* 55:480-486, 2005. It found that workplace violence was common, occurring in the form of assaults against a quarter of all respondents, threats to 43%, and endangerment to 57%. Clinicians reported it more frequently than non-clinicians by a factor of 4 in assaults and threats and by 2 ½ times more for endangerment. Assaults decreased with experience, but by no means disappeared.

Next, the WPV Committee identified 14 stakeholders whose interactions generate the complexity inherent in

attempting to address WPV. Along with the victim and the perpetrator they include: administration, including risk management, staff-victim's coworkers, law enforcement, security services, advocate agencies for worker safety, workers' compensation and health insurance carriers, patients on the ward during the event and others after the event, patient advocate agencies, and hospital regulatory agencies.

The Committee went to work with all the relevant representatives together, including multiple personnel of both the local Police Department and the hospital. They undertook the planning of interventions based on a hierarchy of choices to be followed consistently in accord with the characteristics of each incident. These options took into account the applicable law and available resources. The Committee boiled down their findings and promulgated them in the form of a detailed protocol replete with legal references and telephone numbers. It strove to promote maximum communication and to discourage the tendency for administrative "silos" to develop.

The Psychiatry Department Chair, Eric D. Caine, promulgated the protocol developed by the WPV Committee and encouraged Dr. Privitera to apply for a sabbatical leave in order to prepare a book on WPV. Shortly before his leave he took part in the first international conference on WPV in health-care settings. Among those attending were some 30 colleagues of various disciplines from around the world who eventually became contributors to the book. Dr. Privitera showed the 24-chapter table of contents and continued with highlights outlined under seven headings or key concepts.

The first key concept is the "tower of Babel," referring to differences among disciplines that may impair communication. Here, the basic National Safety and Health Administration definition of WPV is important:

(continued on page 17)



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RAPPEPORT FELLOWSHIP

Rappeport Fellowship Awards 2012-2013

Susan Hatters Friedman MD and Britta Ostermeyer MD (Co-Chairs)

AAPL's Rappeport fellowship was named in honor of AAPL's founding president, Jonas Rappeport, MD, and offers the opportunity for outstanding senior residents with interests in psychiatry and the law to develop their knowledge and skills. Fellows receive scholarships to attend the AAPL forensic psychiatry review course and annual meeting. They are also assigned senior forensic psychiatry preceptors, to help guide their training during the year. The Rappeport fellowship committee is pleased to announce the six Rappeport fellows for 2012-2013. Fellows are: Jacob Appel, Carl Fisher, Andrea Nelsen, Raymond Raad, Christopher Racine, and Ryan Wagoner.

Jacob Appel, MD, JD is currently a psychiatry resident at The Mount Sinai Hospital. He also holds MA, MPhil, and MFA degrees. He has published many academic articles at the interface of bioethics, history, psychiatry and law. He is a Ginsburg Fellow at the Group for the Advancement of Psychiatry. He has taught courses at Brown about Medicine, Law and Morality. His pieces have been published in the *New York Times*, and he is a frequent columnist for *Huffington Post*. Too, he is an accomplished playwright, and has won multiple prizes for his short fiction.

Carl Fisher, MD is currently a psychiatry resident at Columbia University/ New York State Psychiatric Institute. He was also named one of the New York State Office of Mental Health Policy Scholars in 2010, and received an APIRE scholarship. He has published multiple articles, including with mentor Paul Appelbaum, MD, including about brain stimulation. He wrote about Manipulation and the Match in *JAMA*. He also performs with the Occasional Opera Company in NYC.

Andrea Nelsen, MD is currently a psychiatry resident at Baylor College of Medicine in Houston, where she is in the Clinician Educator Track. She has participated in the APA's MindGames competition. During residency she has

been active in research on HIV/AIDS treatment adherence. She has been collaborating with an advocacy organization to train physicians about child sex trafficking victims as well. Previously she was a Fulbright Scholar in Philosophy, researching Kierkegaard's political philosophy.

Raymond Raad, MD is a psychiatric chief resident at New York Presbyterian/ Weill Cornell Medical Center. He was selected as a Benjamin Rush Scholar in the History of Psychiatry, and interned in the health policy division at the Cato Institute in Washington. He has published several articles, including with mentor Paul Appelbaum, MD. For example, he has written about capacity of persons with serious mental illness to vote, and also about conflicts of interest in relationships between medicine and industry.

Christopher Racine, MD, MPH is psychiatric chief resident at New York University School of Medicine. His MPH thesis regarded equity in mental health coverage. He authored several publications with mentor Stephen Billeck, MD. For example, he has written about assessment instruments in decision-making capacity, and the right to speedy arraignment vs. the right to psychiatric care.

Ryan Wagoner, MD is currently a psychiatric resident at Western Psychiatric Institute and Clinic in Pittsburgh, where he is in the Academic Administrator Clinician Educator Track. His undergraduate degrees were in Criminology and Entomology. He has been active in committee work at AAPL. He designed an elective between WPIC and the Pittsburgh Police, and is involved in research in police perceptions and reoffending by juvenile offenders.

Over twenty applicants applied for the fellowship, but a limited number of awards are available. The committee noted that there are many excellent residents with an interest in forensic psychiatry, which is fantastic for our field. Thank you for your continuing support.



Guns, Suicide and Mass Homicide

Charles C. Dike MD, MPH, MRCPsych



Another horrendous homicide has just been reported. News is coming in fast and hard. All the news stations are focused on it

and reporters are presenting the picture somberly, or with hysteria, or calmness depending on the news station. Details are emerging by the minute. Dozens of people have been confirmed dead so far and numerous others are injured. Gory pictures flash across the screen. Tearful survivors fight to stave off tears as they try to reconstruct the disaster they have just witnessed and survived.

The nation is in collective depression and shock all at once. Everywhere you go, the atmosphere is subdued and the discussion inevitably drifts to the shooting.

Soon, the same questions are on everyone's lips; does the shooter have a mental illness? Was he seeing a therapist? Did his psychiatrist miss the telltale signs he was going to carry out such a dastardly act?

Yes, the rumors begin to confirm everyone's suspicion; of course he has a mental illness. How else could anyone explain such behavior? Yes, of course, he did. He saw a psychiatrist 5 years ago but did not follow up with outpatient care. He told a friend he was scheduled to see a psychiatrist in one month.

Directors of mental health institutions across the country are getting phone calls or emails from their patients' neighbors, friends, family members and even casual acquaintances, inquiring after some of their patients and asking, "Would I be safe if patient X is released from your hospital? I have not received any threatening information from but I am just curious, you know, one can't be too careful these days; look at what happened the other day."

The drill down (or is it root cause?)

analysis more often than not settles on the mentally ill and how dangerous they are. But... is that the whole story?

Anders Behring Breivik, a Norwegian man recently convicted of committing acts of terror and voluntary homicide after he gunned down 69 people at an Island resort (and killed another 8 by bombing) was reportedly not psychotic at the time of the crime, did not suffer from mental illness and was not mentally challenged, according to a report sent to court by two court appointed psychiatrists.

The question is, is mental illness both necessary and sufficient for mass homicides?

On a smaller scale, the same question could be asked of suicides. According to data from the CDC National Center for Health Statistics mortality report, in 2007, 55.6% of all suicides in the US were committed with a gun. In addition, data from American Association of Suicidology, 1998, showed that on average, 45% of suicides for youth ages 15-24 are committed with guns. Unlike suicide attempts using other methods, most suicide attempts with guns are fatal.

Therefore, while the potential for attempting suicide and homicide may be high in individuals with certain types of mental illness, access to a lethal means greatly increases the likelihood of completing suicides and mass homicides.

For example, the rapid rise in domestic gas suicides (from carbon monoxide poisoning) in 1920s England and Wales, and the subsequent marked decrease in suicide following a decrease in the CO content of the gas, established the connection between easy availability of lethal means of suicide and increase in suicide rates. Also, in Switzerland, a European country with a high rate of gun ownership, the suicide rate through firearms far exceeds any other country in Europe and ranks only second to the United States.

Although the association between

access to firearms and suicide is remarkable, that between firearms and homicide is compelling. In a study (Richardson, Erin G., and David Hemenway, "Homicide, Suicide, and Unintentional Firearm Fatality: Comparing the United States With Other High-Income Countries, 2003," *Journal of Trauma, Injury, Infection, and Critical Care*, June 2010) comparing firearm and homicide rates across 23 high-income countries, firearm homicide rate in the United States was 19.5 times higher. The United States had more firearms per capita than the other countries and has the most permissive gun control laws.

The authors of the article concluded that "whatever our basic level of violence, the empirical evidence from ecological, case-control, and other studies indicate that readily accessible firearms – by making killing easy, efficient and impersonal – increases the lethality of violence." Other studies have confirmed that across developed nations, there is a direct relationship between availability of guns and homicides. The same finding holds true for individual states of the US; the more guns in a state, the more the homicide rate after controlling for poverty and urbanization.

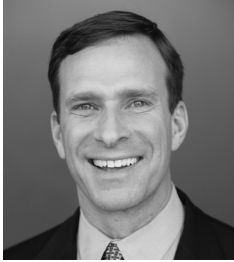
In summary, although the risk of violence to self or others in individuals with certain forms of mental illness is high, easy access to lethal means of completing suicide or engaging in mass homicide, such as availability of firearms, dramatically elevates that risk. Early identification and prompt treatment of severe mental illness would certainly go a long way at decreasing incidents of suicide and mass homicide. But, given the complexity of treating such individuals and providing adequate monitoring in the community, it would be naïve to expect a significant reduction in such acts of violence as described at the start of this article without seriously addressing access to guns, not only to individuals formally identified as having serious mental illness, but to the community at large.

Restricting access to individuals

(continued on page 22)

Advancing in AAPL: What Do I Do Now?

Charles Scott MD



In the last several months, I have frequently been asked the following question: “How does one advance in AAPL?” This

question is an important one for members who wish to obtain a leadership position and positively impact the organization through their efforts. The goal of this newsletter article is to provide an overview of key aspects of the AAPL organization to assist those unfamiliar with the inner workings of AAPL or to serve as a refresher course for those who may be only partially aware of various policies and procedures.

The AAPL Executive Council is the governing body of AAPL. The Council consists of officers and councilors who are nominated by the Nominating Committee at the semiannual AAPL business meeting held during the annual APA meeting in May. If no nominations are received from the floor at the meeting in May, the slate is presented for a voice vote at the Annual Business Meeting in October.

Officers on the Council consist of the following: President, two Vice-Presidents, the most recent living Past-President, Treasurer, Secretary, and nine Councilors. The President, Vice-Presidents, and Secretary serve for one year. The Treasurer’s term is for two years. Three Councilors are added each year to the AAPL Council and each Councilor’s term is for three years. The AAPL Council also includes a nonvoting Medical Director, currently Howard Zonana, MD, and a nonvoting Executive Director, currently Jackie Coleman. A committee appointed by the AAPL President selects the Medical Director from AAPL members who apply for the position. The Medical Director position can be renewed by a vote of the AAPL Council. The Medical Director

serves as an ongoing advisor to the Council and provides leadership continuity to the Council. The Executive Director oversees and manages many important administrative aspects of the organization and plays a vital role in keeping AAPL functioning throughout the year. Other individuals who attend part or all of the AAPL Council meetings include the AAPL Journal Editor and Co-Editor, the Newsletter and Website Editors, and AAPL delegates to the APA and AMA.

The AAPL Council meets on Wednesday prior to the start of the AAPL Annual Meeting and during the APA Annual Meeting. In addition, a President’s Meeting is held at the

“Find ways to collaborate with AAPL members on presentations at the annual AAPL meeting.”

AAPL office in Connecticut each January. Attendees include the President, Immediate Past President, President-elect and Treasurer, plus the Executive Director and Medical Director. Other officers have also attended this meeting on occasion.

The Nominating Committee is responsible for nominating a slate of officers to be presented to the membership for a vote at the AAPL business meeting in May. The Nominating Committee consists of the current President, two immediate Past Presidents, two AAPL members appointed by the current AAPL President, and six of the nine Councilors. The three Councilors who are completing their three-year term are not usually on the Nominating Committee because they could potentially be nominated for a higher office. The President-Elect, Medical Director, and Executive

Director also attend but they are non-voting members of the Nominating Committee.

AAPL Regular Members can submit their names for consideration by the Nominating Committee and are strongly encouraged to do so. The AAPL office notifies members through the AAPL Newsletter regarding the deadline for submissions. Over the past several years, the most common format for a submission includes a letter that outlines the person’s involvement in AAPL, the position(s) in which they are potentially interested, and their general goals and interests for the organization. Letters of recommendation from others are not forwarded to the Nominating Committee.

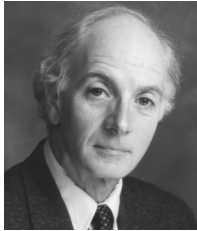
As the organization’s membership has grown, so have the number of interested applicants for leadership positions. If you are sincerely interested, then the following are some general tips.

1. Let the Nominating Committee know the various AAPL activities in which you have been involved. A sample of activities may include any of the following: membership on an AAPL committee, chairing an AAPL committee, presenting at AAPL, serving on an AAPL Practice Guideline Task Force, serving as a reviewer for the AAPL Journal, having publications in the field of forensic psychiatry, achieving teaching excellence in forensic psychiatry, representing AAPL as an AMA or APA delegate, advancing the field of forensic psychiatric research, and other service activities for AAPL. An AAPL member’s involvement in AAPL is one important consideration for being nominated for Councilor or a higher office. Usually a person has been a Councilor prior to being considered for a higher office on the Executive Council.
2. Demonstrate commitment and excellence to those assignments you receive through AAPL committees or other AAPL activities. Consistently attending your committee meeting, volunteering for and fol-

(continued on page 17)

Is the Opportunity to Plead Insanity Required Under the U.S Constitution?

Howard Zonana MD, Medical Director



A recent case from Idaho gives the U.S Supreme Court another potential opportunity to consider whether states are constitutionally

required to offer an insanity plea to a defendant. While the Supreme Court has had other cases that asked for a ruling on this issue, the Court decided those cases on other grounds and left open the ultimate question of a constitutional right to the defense.² This case is currently requesting certiorari from the Court.

Long before psychiatry existed, civilized societies recognized that certain individuals should not be held criminally responsible for their behavior, because they were so substantially different that it was unfair to hold them accountable in the same fashion as others. These included children, the mentally disabled and the insane. These groups were recognized in commentaries to Hebrew Scriptures, and became increasingly codified in Anglo-American law, beginning in the 13th century. At that time moral wrongfulness was incorporated into English Common Law from Christian law, by requiring both a criminal act (*actus reus*) as well as the presence of a guilty mind (*mens rea*). Henry Bracton noted that because children and the insane were incapable of forming both the intent and the will to do harm, they therefore did not have the capacity to form a guilty intent.³ The translation of that concept, in working language and practical standards, has not been easy. While the standards for what an insanity defense requires have evolved in England and the U.S., both countries have long had some version of the defense as part of their criminal code. In the U.S. each state and the federal government has adopted either a variant of the M'Naughten or the American Law Institute test, except for New

Hampshire, which adopted a "product" test. In general, as in England, when individuals have attempted or actually assassinated Presidents or prominent government officials, there are usually calls to alter or clarify the standards - generally in more conservative directions.

Until 1979 all states offered an insanity defense in some form. Since then, four states have abolished the insanity defense: Montana (1979), Idaho (1982), Utah (1983), and Kansas (1995). Nevada (1995) had also abolished the insanity defense, but that was overturned in *Finger v. State*, 117 Nev. 548, 27 P.3d 66 (2001).

Once the insanity defense was abolished, Idaho and the other states shifted to a model that focused on whether a

“Unfortunately — and I think it is unfortunate — his ability to plan intelligently and rationally is not likewise impaired.”

defendant could form the *mens rea* or criminal intent necessary to be guilty of the crime. The prosecution is required to prove beyond a reasonable doubt that a defendant had the mental capacity to form the necessary intent, but it does not allow a mental condition to form a complete defense to a crime. In some states experts are permitted to testify at this stage of the proceedings but in other states such as Arizona they are severely restricted.⁴ In the present case, Delling was initially charged with two counts of murder in the first degree, involving the deaths of two men. These charges were subsequently amended to second-degree murder. Mr. Delling was found incompetent to stand trial and was hospitalized for almost a year before regaining compe-

tence. At that point, the defense filed notice to present expert testimony that he was incapable of forming the necessary *mens rea*. The prosecution responded by wanting an expert of their own to conduct an evaluation. The defense objected, claiming it would violate his right to remain silent and be free from self-incrimination. Rather than proceeding, a plea agreement was reached which preserved the defendant's ability to appeal the insanity defense question and he was sentenced to two concurrent life sentences.

The Idaho Supreme Court in reviewing the case agreed with the trial judge that there was a significant mental illness:

“There is evidence of enormous premeditation around the deaths of these two young men, and the very serious attempt on the life of Jacob. And there's also evidence of the fact that there were four other people on a list who were also marked for death as a result of the defendant's deeply held delusions that other people were trying to steal his powers, and that their actions in his delusional thinking would result in his death. I don't question that that's how he frames it in his own mind, but my function here is to protect society.”

“The district court went on to detail how Delling planned his attacks, and even how he learned from his failed attempt to kill Jacob Thompson. After detailing the complexity of the attacks, the district court did not believe that Delling had the ability to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law.⁵ However, his level of appreciation was to be balanced against other considerations.”

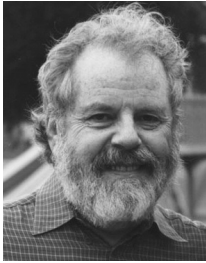
“In terms of 19–2523 factors, there is no question he is mentally ill. He suffers from paranoid schizophrenia. He is profoundly ill.”

“The degree of his functional impairment in terms of his delusional thinking is quite strong. Unfortunately—and I think it is unfortunate—his ability to plan intelligently and rationally is not likewise impaired. So considerable intelligence, considerable ability

(continued on page 23)

On Mandatory Life Sentences for Juveniles

Stephen P. Herman MD



In March 2012, the United States Supreme Court heard arguments in two consolidated cases, *Miller v. Alabama* (No. 10-9646) and *Jackson v. Hobbs* (No. 10-9647), (cite as 567 U.S. _ 2012), which addressed the issue of mandatory life sentences by state law for juveniles who commit murder. The legal history, culminating in the Court's important decision this year, is one of a gradual understanding of juvenile criminals requiring special consideration because of their age. In an important 2005 case, *Roper v. Simmons*, the Supreme Court abolished the death penalty for juveniles based on the neurological differences between them and adults. Five years later, in *Graham v. Florida* the Court ruled that juvenile offenders sentenced to life without parole for crimes other than homicide violates the Eight Amendment's ban on cruel and unusual punishment. That decision had immediate implications for about 130 prisoners convicted of crimes such as rape, armed robbery and kidnapping.

Maintaining its progressive stance on juveniles and their crimes, the Court decided in June that mandatory life sentences without parole for juveniles who commit murder below the age of 18 also violates the Eighth Amendment. The vote was 5-to-4, with Justice Kagan writing for the majority. Justice Anthony Kennedy joined the Court's liberal wing in the decision, along with Justices Sotomayor, Ginsburg and Breyer. Justice Roberts filed a dissenting opinion and was joined by Justices Scalia, Alito and Thomas.

The facts were these: In Alabama, Petitioner Miller, age 14, with a friend, beat up Miller's neighbor and set fire to his trailer after drinking

and using drugs. The neighbor died. His case was heard in adult court, he was found guilty and, because of Alabama statute, sentenced to life without the chance of parole. The Alabama Court of Criminal Appeals affirmed, saying his punishment was not overly harsh and it was acceptable under the Eighth Amendment.

In the other case, in Arkansas, petitioner Jackson, with two other boys, entered a video store to commit a robbery. One of his friends was carrying a shotgun. Jackson waited outside the store for most of the robbery. When he entered, one of the boys shot and killed the store clerk. Jackson was tried as an adult with capital felony murder and aggravated robbery. He was convicted on both charges and sentenced to life without parole. Jackson then filed a state petition for habeas corpus, arguing that the Arkansas statute requiring life without the chance of parole for a 14-year-old murderer is in violation of the Eight Amendment. The court disagreed and dismissed the petition. The Arkansas Supreme Court affirmed the lower court's ruling.

Citing *Graham* and *Roper*, Justice Kagan wrote: "Graham makes relevant this Court's cases demanding individualized sentencing in capital cases." She objected to state laws which do not take into account the uniqueness of youth – even when the crime is murder. She wrote, "By requiring that all children convicted of homicide receive lifetime incarceration without the possibility of parole, regardless of their age and age-related characteristics and the nature of their crimes, the mandatory sentencing schemes before us violate this principle of proportionality, and so the Eight Amendment's ban on cruel and unusual punishment."

The dissents, by Justices Thomas and Roberts, were based on their belief that state legislatures have the right to make these laws and the

Supreme Court has no business overturning them. The dissents challenge the previous rulings cited above and do not see the Eight Amendment being applied to the instant cases.

The importance of this decision cannot be overstated. The Supreme Court has once again recognized that child criminals are not the same as adult offenders. The Court has applied numerous studies of child behavior and neurology to give recognition to this principle – so obvious to child psychiatrists and those who work in the juvenile justice field.

This decision, however, does not declare unconstitutional the actual sentencing of a child to life without parole. It *does* say, though, that the sentence should be left to the trier of fact and cannot be applied automatically by state law. Each case needs to be handled with an individual approach by the judge and/or jury.

The Supreme Court ruling affects about 2000 inmates sentenced to state-mandated life without parole for crimes committed when they were children. The decision declares unconstitutional mandatory sentencing law in 28 states.

But it will be the inmates who must initiate resentencing hearings. If they succeed in having their cases reviewed, they could still be resented to life without parole. So the Supreme Court's decision is actually not as sweeping as it initially appears to be. Someday, perhaps, the Court will declare any life without parole sentence for a child murderer to be a violation of the Eight Amendment. However, that time has not yet arrived.

In the meantime, child psychiatrists and other professionals who work in the juvenile justice arena still have much to do. First of all, those incarcerated will need qualified counsel to represent them as they ask that their life sentences without parole be reexamined. In addition experts on child behavior must continue to provide research and clinical data supporting the importance of seeing child offenders as different from adults. ☐

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 questions 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.

During the evaluation of a civil case involving alleged discrimination/harassment/retaliation at work:

Q1. To what degree can/does/should the examining forensic psychiatrist make judgments as to the actual facts and what occurred?

A. Sadoff: The examining forensic psychiatrist, as I have written many times before, is an investigator. The psychiatric examination is essential, but not



sufficient in these cases. The psychiatrist must have other information to either support or negate the contention of the plaintiff. This other information

includes legal, medical, school, health, personal and other records that may be available. Also, there are statements and deposition transcripts from plaintiff and from the defense, usually denying the allegations. One has to take into account the balance between what the plaintiff says and what is said by the defense. Sometimes, in cases of work harassment, discrimination or retaliation, I visit the workplace to see whether the plaintiff's contention is realistic.

When there is no definitive evidence to support plaintiff's allegations, I utilize the subjunctive case in giving my opinion, rather than a declarative statement affirming the veracity of the allegations made by the plaintiff. For example: "If what the plaintiff says is true and based on fact, then her symp-

toms are related to the stress she alleges occurred from the harassment/discrimination/retaliation." There may be factors in her childhood that make her vulnerable to such harassment if it occurred. For example, she may have been sexually abused as a youngster or raped as an adolescent or young adult. These prior experiences may have made her more vulnerable to the alleged claims.

The forensic psychiatrist is not the finder of fact; that is the prerogative of the judge and/or jury. However, the forensic psychiatrist must have an opinion as to whether or not there is some truth or veracity in the claims made or the symptoms may be referable to other causes, or perhaps even malingered. It does not do the field of forensic psychiatry a service for a "hired gun" expert to routinely declare that the plaintiff was harmed by the alleged discrimination/harassment or retaliation, when the expert has no evidence that it actually occurred. We must be cautious and careful in the way we word our opinions based on the facts we have and the evidence that is available.

A. Kaye: As our faithful readers are aware, Dr. Sadoff and I generally agree on most points, as is the case here. While not officially finders of fact (in the legal sense), forensic psychiatrists are at times investigators. As we don't have police powers, our methodology limits this ability.

Nonetheless, in this complex situation, the forensic psychiatrist must make some judgment as to the fact pattern and to the validity and plausibility of the claims/allegations. This is because a correct diagnosis is predicated on such a conclusion. If the examiner believes the story is fabricated, she might diagnose malingering; if the examiner believes the story is genuine, she might diagnose PTSD; and if the examiner believes the story is unrealistic but not malingered, she might diagnose a psychotic thought process/ disorder. As the reader can see, these very different diagnoses depend on the examiner drawing conclusions as regards at least



some of the alleged "fact" pattern.

Q2. How is the issue of the plaintiff's perception best handled?

A. Sadoff: I have often put in my reports that the symptoms were based on the plaintiff's perception of the events alleged. I do not know that they occurred, I do not know to what extent they may have occurred, but can record the perception of the plaintiff as she reveals it during the examination. Psychological testing may also be helpful to determine whether there is exaggeration, malingering or actual lying during the investigation of her claim. It is always safer to utilize the word "perception" so the expert is not caught, on cross-examination, agreeing that the perception is actually based on fact. One must keep in mind that there are several levels of "truth." One is the truth the plaintiff wants the world to believe, the second is the actual truth the plaintiff believes to be the truth, and the third is the truth that is actually based on fact rather than perception alone.

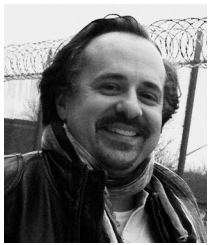
That being said, one then must consider the symptoms revealed by the plaintiff are always based on the perception the plaintiff has of the events, as she believed they occurred. Even though her perception is not based on actual fact or evidence by objective observers, her emotional (and sometimes physical) reaction will be based on her beliefs and her perceptions of what had occurred. These perceptions are often colored by her prior experiences, as noted above. One who has been raped and/or sexually abused as a youngster will be more vulnerable to incidents at work that might not significantly affect women who have a stronger personality and have not been previously sensitized to such events. Thus, questions #1 and #2 are clearly related, and one must keep in mind the plaintiff's perception, based on her prior experiences, when considering the alleged damage to her by what she claims to have occurred in the workplace.

A. Kaye: When there appears to be a significant discrepancy between the plaintiff's perception and the "facts" as I understand them to be, I will also use

(continued on page 17)

Protect This House!

Stephen Zerby MD



The approach of football season reminds me of some old promotional spot featuring a football player screaming “Protect ... this ... house!” into a camera – sending a message that the home team must be victorious in their own stadium. For some reason my recollection of this TV clip has been resurrected after many years by my jail shifts. We spend long years studying hard to train to become forensic psychiatrists working in jails and similar settings. One thing becomes clear very early in such a career: this is not our house – it is *their* house, i.e. correctional officers’. As guests in their home, we must display proper etiquette and pay the respect our hosts deserve. I have noticed that a great deal of supervision time for forensic psychiatry fellows is spent discussing the fine art of navigating such waters during jail or prison treatment rotations. A classic question is when to battle and when to negotiate. Sometimes we just have to tell forensic psychiatry fellows statements such as, “you know, you’re just not going to be able to have your cell phone during those hours – you’re not going to win this battle so let it go.” Thus arises a classic conundrum of correctional work: when do we fight and when do we attempt to work things out peacefully? While I am no expert on such skills, I have consulted with longtime jail psychiatrists who offered some words of wisdom described below in the form of rules.

Rule #1: it’s *their* house: you are only a guest

When we visit someone’s house and are given directives such as taking off shoes, not sitting on a particular seat, or not touching some heirloom, simple courtesy demands that we do not thumb our noses at those rules, or mutter something like “well I’m

touching it anyway” and thereby disrespect our hosts. The hosts know the house and its history and may not be ready or willing to relate the entire rationale for each rule. Therefore, it is common practice for guests to simply obey. Suppose an incident occurred in a jail years back, say an inmate thought of a clever way to transform a common object into a weapon causing the object to be subsequently banned from the setting, years later, with staff turnover, the story behind the banning of such a seemingly innocuous object may be lost, but the ban remains in place. Although current staff members may be at a loss how to explain the ban of such an object, caution should be exercised in questioning it. I’m certain that there are also plenty of rules put into place which actually had nothing to do with some major incident but were more the whim of a manager somewhere along the line; those too end up as rules which are obeyed without question.

Rule #2: don’t lose your cool

A cool red synthetic fiber golf shirt brought me misery. After interviewing an inmate on a pod a CO came running after me, stopping me with a preface along the line of “you do understand that we have rules here that must be followed and that includes a dress code.” Mentally surveying my attire I wondered whether a logo was showing or something worse. I looked at him as he continued, “you’re wearing red.” Looking down I agreed that yes I was wearing a red golf shirt. So I asked what was wrong with that. He continued that because the inmates wear red no staff is permitted to wear red. Wondering how many inmates wore red golf shirts or how someone wearing a red golf shirt could ever be confused with an inmate, I subdued any urge to argue or make a wise-crack, but rather just nodded and said, “Oh, OK” while walking away pitifully. I pictured an absurd scene of staff wearing red golf shirts and khakis

being wrestled to the floor as they attempted to leave the jail for the day, mistaken for an inmate slipping through the door. Nevertheless, the reaction of an experienced colleague to that story was, “oh yes, of course you can’t wear red in the jail; inmates wear red.” I concluded that there must have been a long forgotten back story as to why no one wore red except inmates. Just accept it, I told myself, and let the issue drop.

Rule #3: most psychiatrists will not win shouting matches with corrections personnel

While on the one hand there are certainly some corrections personnel who would feel some form of respect for a psychiatrist who tries to out alpha-male (or alpha-woman) them, something tells me this is a futile exercise. Noting the attempts of some colleagues to out-yell correctional personnel, it seems to be a futile exercise. Al Pacino’s character from *88 Minutes* – “Dr. Jack Gramm, a forensic psychiatrist with the FBI” carries a gun and conducts investigations using his psychological training. Should this be the model for psychiatrists working in correctional settings? A psychiatrist who morphs into a law enforcement professional? I believe I have mentioned this in the column before, but would it not be a better use of mental health professionals’ time and energy to restore tranquility to situations rather than inflame them? We all have training in calming upset people, working with difficult personalities, and navigating turbulent emotional waters. Why not put them to use in these settings? We are supposed to have the training and skills to be peacemakers and settle down tumultuous situations. I believe that would earn us more respect than becoming Jack Gramm.

Rule #4: at least some of correctional personnel’s bravado is an act

I just came across a photo with a former colleague from years ago

(continued on page 21)

Emily Keram MD

US v. Hamdan

Charles C. Dike MD, MPH, MRCPsych

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



In this special issue of Faces of AAPL, Emily Keram, MD will discuss her involvement, experience and thoughts related

to US v. Hamdan in her own words.

Down the rabbit hole

I have often thought that the first interactions between an expert and a legal team can foreshadow their working relationship and the proceedings of the case. That proved to be the case in my work on *US v Hamdan*, the first case prosecuted in the Military Commissions at the U.S. Naval Station Guantanamo Bay, Cuba (GTMO.)

Every aspect of the case, from the referral questions to me, to the charges against Hamdan, to the rules governing the conduct of the Military Commissions, conveyed varying combinations of gravity, randomness, and inconsistency. Everyone involved was in uncharted and changeable waters.

Darryl Matthews first mentioned the case to me at the 2004 AAPL Annual Meeting. The Judge Advocate General (JAG) Corps defense team assigned to represent Salim Ahmed Hamdan, one of Osama Bin Laden's drivers, had referred the case to him. Hamdan was charged with conspiracy in the 9/11 attacks and with providing material support to terrorism. Darryl was unable to accept the case as he had previously conducted a review of detainee mental health care at GTMO for the Department of Defense.

I didn't know how serious Darryl was when he asked me if I were interested in the case. I somewhat casually told him to have the attorneys contact me to see if I had any expertise that would be relevant to their case. I didn't think much about our conversation for the rest of the meeting.

A few days after I returned to California I received ten or twelve emails from a Navy paralegal. These contained portions of Hamdan's medical records from GTMO with a brief explanation that LCDR (Lieutenant Commander) Charles Swift requested the records be sent to me, "ma'am," for my review. No case background, no referral question, and certainly no discussion of my availability, fees, or expertise.

Sentence first - verdict afterwards: the legal history of the Military Commissions at GTMO

I spoke with LCDR Swift several weeks later. He had been detailed to the Office of the Chief Defense Counsel of the Office of Military Commissions in March 2003 and assigned to represent Hamdan the following

"...and me in modest sleeves, full length pants, socks, shoes, and a borrowed headscarf, having been told that Hamdan would find my hair a distraction."

December. He had spent much of the interim immersing himself in relevant international law, the Geneva Conventions, and the evolving workings of the current Military Commissions system. He and the other JAGs assigned to the defense had become increasingly concerned about the fairness of the emerging system. Swift declined to pursue his initial instructions to obtain a pre-trial guilty plea from Hamdan. With Hamdan's consent, Swift filed a federal lawsuit in April 2004 challenging

the legality of the tribunals themselves.

That case, *Hamdan v Rumsfeld*, 548 U.S. 557, 126 S.Ct. 2749 (2006), would ultimately lead the United States Supreme Court to strike down President Bush's Military Commissions. The court declared them illegal under long-established U.S. laws, the Geneva Conventions, and the Uniform Code of Military Justice. The court explained, in part, that the Executive Branch erred in establishing the Commissions without congressional authorization and that their format violated international law.

The Bush Commissions were disbanded and the issue sent to Congress to address. In October 2006, President Bush signed the Military Commissions Act (MCA) of 2006, enacting many of the provisions of the original Commissions. Hamdan's charge of conspiracy was reinstated along with a new charge of material support to terrorism.

His trial was ultimately convened in July 2008.

The Pearl of the Antilles

With the federal lawsuit underway, Swift became increasingly concerned about Hamdan's psychological state. When Swift first met Hamdan in January 2004, Hamdan had already been housed alone for two months. The military denied that Hamdan's housing could be considered solitary confinement as he could, from inside his hut, communicate by screaming across several hundred yards to a detainee similarly housed alone and could also enjoy the sunshine that filtered through the hut's translucent window. Nonetheless, the psychological effects of Hamdan's isolation alarmed Swift.

An evaluation of Hamdan by a Navy psychiatrist, performed at Swift's request, resulted in a V code diagnosis of "Phase of Life Problem." Swift subsequently obtained permission to obtain an independent psychiatric evaluation of Hamdan for diagnostic assessment, as well as evaluation of mental health issues relevant to the charges against him.

(continued on page 10)

Faces of AAPL

continued from page 9

My first trip to GTMO in March 2005 was disorienting. Flying time to GTMO is prolonged by the Cuban government's refusal to allow US aircraft to enter their airspace. We flew down the eastern seaboard from the Naval Air Station in Norfolk, VA and made a long detour around the east coast of Cuba. With Haiti visible to our left, we made a steep banking right turn and entered US airspace.

On landing, our pilot gave us a hearty welcome to "Guantanamo Bay Naval Air Station, the Pearl of the Antilles" and reminded us to deplane according to rank. Shortly after our arrival, I found myself in the Naval Exchange (NEX) staring at a mile high display of Manischewitz Matzoah, gefilte fish, and kosher wine for the Passover preparations of the base's Jewish community, the size of which had considerably increased upon my arrival. The labels of bottled water were decorated with American flags under the brand names "Freedom Springs," and "Patriots Choice." That evening, at dinner in the galley, I watched the Armed Forces Network TV station and enjoyed my Ben & Jerry's "Freedom Pop," while a member of Hamdan's defense team welcomed me to "a propaganda machine rivaling that of the USSR in the 1970's."

Swift, our translator, and I began the next morning with a trip to the NEX for Sara Lee frozen cheesecakes. Our next stop was the drive-thru McDonald's where we bought several orders of every breakfast item they offered. From there we drove out to meet Hamdan. As we approached the area that houses the various detainee camps, we stopped to clear a security checkpoint. A placard reaching over the road between the guard towers announced, "Honor Bound to Defend Freedom."

We cleared the perimeter at Camp Echo; Swift in his summer uniform; our translator in short-sleeves, lightweight trousers, and sandals; and me in modest sleeves, full length pants, socks, shoes, and a borrowed head-

scarf, having been told that Hamdan would find my hair "a distraction." Our food was briefly inspected. A guard escorted us to a hut and unlocked the door. Hamdan, chained to the floor and sitting on a folding chair in front of a card table, greeted the men warmly. He was slight and of average height, dressed in an orange uniform. His face tensed as he turned toward me. Having previously been told that he would not shake my hand, I was prepared for the formality of our introduction. I was not, however, prepared for what happened next.

We handed over our boxes of food to Hamdan. He indicated where we should each sit around the table. He carefully laid out the provisions that, I now saw, we had brought so he could properly receive us. The table strained under the bounty. Piles of sugar packets, single servings of half-and-half, salt, pepper, syrup, utensils, and napkins crowded around platters of Egg McMuffins, biscuits, and pancakes. The numerous cheesecakes were accorded the place of honor at the center. Hamdan stood and bowed to us. He offered us a gracious welcome, apologized for the conditions under which we met, and begged us to enjoy our breakfast. The three men began an animated conversation. I was completely excluded. After an hour, I asked our translator what they were discussing. He explained that Hamdan was teasing them that a hamburger could not possibly be hallal (prepared according to Muslim law) as ham came from pigs.

Thirty minutes later, Swift left and I began my work. It was a ritual we repeated two or three times a day every time I saw Hamdan for the next three and a half years.

Preparation

Although my previous forensic and clinical experience was relevant to some aspects of the case, I needed to understand the context of Hamdan's charges. I relied on experts in various fields to recommend books and articles on Arab and Yemeni culture; Afghan history from the Soviet invasion through the Taliban; the Afghan

and Arab Mujahedeen; the roots of various Islamist movements; the history of Al Qaeda; as well as relevant portions of the Geneva Conventions. I am indebted to the many people who spent countless hours helping me develop competency in the unexplored territory of the forensic psychiatric evaluation of an accused Islamist terrorist.

Among those I consulted were retired CIA case agents with expertise in Afghanistan and Pakistan, other former intelligence professionals, retired and active duty military officers, Arabists, historians, and a Yemeni psychologist practicing in that country's capital.

I developed an understanding of what was and wasn't known about terrorism generally and Islamist terrorism specifically. This allowed me to differentiate areas in which I would be able to form opinions that would meet the *Daubert* standard from areas in which an opinion would be based on anecdote, speculation, or worse, political bias.

Forensic issues

Swift's initial concerns about Hamdan's mental health were somewhat alleviated when Hamdan was transferred to shared housing. The resulting social contact led to some improvement in Hamdan's symptoms. This remitting/relapsing pattern of mental health issues recurred throughout Hamdan's detention, due in part to frequent changes in the conditions of his confinement, but also to the indefinite nature of his detention, his lengthy separation from his young family, and, finally, the stress of his trial.

Early in my work on the case, Swift asked me if I could conduct an assessment of Hamdan's likelihood of recidivism. Based on the preparation I had done, I told Swift that such an assessment could not be conducted. There was simply no evidence, classified, published or otherwise, upon which to base an opinion of the risk of future dangerousness of an accused Islamist terrorist.

(continued on page 13)

Embracing Difficult Issues

George Annas MD



“You’re going into Forensic Psychiatry? That is so cool, so that means you’ll get to interview serial killers!” This was

by far the most common response I received upon informing someone of my plans to enter a Forensic Psychiatry Fellowship. This frequent remark gave me the opportunity to practice and perfect my response. I would briefly explain that the profession involves many aspects of where psychiatry and the legal system interact, including competence assessments, insanity pleas, civil commitment and assessing disability claims. I would then end my response by pointing out how rare it is for someone to get the opportunity to even be peripherally involved in a serial killer case. Then, about 3 weeks into my program, my co-fellow and I were informed that we were to drop everything we were doing and assist our fellowship director with a new project. He had just been retained for a case involving multiple serial murders.

I resisted the strong urge to send out a mass email bragging to my colleagues about this opportunity as my co-fellow and I headed to our director’s office to be briefed on the case and circumstances. He informed us that he was retained by the prosecution for the death penalty phase in anticipation of a guilty verdict which had not yet been passed down. He was asked to form an opinion on whether or not the defendant suffered from a mental illness or defect which caused him to lack substantial capacity to appreciate the criminality of the offenses, which included at least 10 homicides. The defendant’s attorney had already retained two experts who had both formulated the opinion that he lacked capacity and therefore should be spared death.

We got to work, right away, with our first task to critique the reports of the opposing experts. As green as the

two of us were, we still were able to quickly find numerous errors and many conclusions that were wholly unsubstantiated. My first reaction was of surprise. Due to the fact that the stakes were so high, I had assumed everyone involved in such a high profile case would be of the highest quality, or at least put forth significant effort. I asked myself: how could anyone let so many errors and missteps appear in a report, when someone’s life was literally on the line?

But an even more important issue arose. While there was no way of being certain what our conclusions would be prior to reviewing all of the evidence, it soon became clear that we would likely be on the side of arguing

“...how could anyone let so many errors and missteps appear in a report, when someone’s life was literally on the line?”

for the defendant having the capacity to appreciate the criminality of the offenses. Therefore, our efforts would be put towards sending a man to his death. This was an interesting and quite uncomfortable position to be in, considering that none of us supported the death penalty. This was also the first time when I felt slightly less envious of my boss and somewhat grateful for being in the role of the most junior level member of the team.

As we debated these issues we came to the conclusion that much of what was in the opposing reports was at best less than ideal and at worst “junk” psychiatry. While it was difficult to be on the side of prosecutors who would be seeking the death penalty, it was also evident that allowing the opposing reports to enter into evidence without an honest and thorough critique was not an option,

either. Perhaps there was a greater good in elucidating what should be considered in the domain of psychiatric expert testimony and what should not. In the end we also were in agreement that the most important role of our director would be one of an educator for the court as to the most valid way to critique the evidence at hand, from a psychiatric perspective. It would be up to the judge and jury to decide what to do with the opinions and critiques.

It was disappointing but not surprising to find out that the defendant’s attorney would not allow him to be examined by our director. For that reason, we had to rely on as much information as we could gather from the records. I was immediately impressed and excited as to the extent to which one can get immersed in a case. We began by reading through countless documents, including witness statements, police and autopsy reports, as well as the extensive occupational, educational, medical and criminal histories of the defendant. In addition we viewed over 10 hours of interrogation video, which was the closest thing we got to being face to face with the defendant.

I don’t recall if my co-fellow had ever watched an interrogation outside of *Law and Order: Special Victims Unit*, but this was certainly my first. As a psychiatrist it is easy to see oneself as being in the upper echelon of the interviewing elite, but I found it humbling to watch how skilled those officers were. At times, it was also hard not to find humor in their histrionics during many of their approaches to get information from the suspect. Looking back, finding this humor was probably one of our defenses against being consumed by the dark subject matter at hand.

It was about a week into our involvement that I realized that some aspects of this case crept up on me. I had been a new arrival to the city and had not yet purchased a bed, so I was using an uncomfortable inflatable mattress on the floor of my apartment. I was not sleeping well, which I initially

(continued on page 23)

Crossing Frontiers in Forensic Psychiatry: Chile 2012

Carolina A. Klein MD

One year ago, I reflected upon my journey from medical school in Chile to forensic psychiatry training in the U.S. Memory lane then took a group of Spanish-speaking forensic psychiatrists from the U.S. to trek southbound, with the goal of broadening the paths between our systems.

For a full week in March 2012, a symposium devoted to the theory and practice of forensic psychiatry was held in Santiago, Chile. It was hosted by the Chilean Society of Mental Health (Sociedad Chilena de Salud Mental) at the José Horwitz Barak Psychiatric Institute, the main psychiatric facility in the country. The venue was historical, and conferences were held in the Grez Theater, renowned for the murals painted by the famous Chilean artist Pedro Lira.

To illustrate, the venture offered conferences with eight speakers from various locations in the U.S., Puerto Rico and Canada; four from Chile; and two via video/teleconference. Over 100 professionals from at least six professional disciplines were enrolled, including psychiatrists, psychologists, lawyers, social workers, administrators, governmental officials, and professionals in training. Attendees came from Santiago, as well as from remote locations as far as Puerto Natales. A total of 25 lectures and workshops were imparted over a total of 49 teaching hours.

The symposium opened with a day devoted to general topics of interest in forensic psychiatry, including the role and duty of the forensic psychiatrist,



Grez Theater

dilemmas of expert testimony and non-DSM syndromes, history of forensic psychiatry and comparison of systems between the U.S. and Chile, and ethical considerations of the profession. The second day was devoted to cutting edge developments in the field, including neurobiological and neuroimaging advances, psychotherapeutic treatments designed for the forensic population, treatment of specific subpopulations such as the LGBT, and current research in the forensic psychiatry arena. The third day witnessed discussions of ongoing dilemmas faced recurrently in the practice of forensic psychiatry, such as criminal and civil competencies; treatment over objection and civil commitment; assessment and management of sex offenders, psychopathy, and malingering; child and juvenile forensic psychiatry; correctional psychiatry; misuse of substances in specific populations; and the role of stigma. The academic dimensions of the field were a fourth area of focus, and included conferences on design and requirements of training programs, expanding upon the ACGME system of competencies; exploration of the current health network in Chile, and the efforts to design and implement a national system of forensic psychiatry; institutional and governmental consulting; and report writing and training. The final day was spent as an interactive workshop with discussion of a case and analysis of the report, followed by an extended questions and answer session with extensive audience participation.

We believe that this first international symposium was successful not only in meeting the goals we had initially set forth to accomplish, but in exceeding our expectations. The days we shared were fruitful from an academic perspective, and unforgettable in their fraternity. We were able to disseminate clinical and theoretical concepts, and to discuss practical and ethical complexities relevant to the work of the forensic psychiatrist. According to the feedback

surveys collected at the conclusion of the event, over 85% of the attendees considered the symposium to be either excellent or very good in content, organization, and quality of the speakers.

Lines of communication and exchange between U.S. and Chilean institutions were established for future collaboration. To a large extent, the foundations for academic development of the specialty in Chile were laid out. Future collaborations were projected with the psychiatric hospital, the affiliated academic institutions, and the government's Department of Health in its process of designing service network systems. Immediate tangible derivatives of our efforts in March include a planned visit from Chilean government officials to the U.S. in August 2012, and the hospital's plans to establish a library dedicated to forensic psychiatry for provision of relevant references to their practitioners. Our hopes are that the symposium will be part of a growing number of initiatives to promote debate and foster a smooth and positive collaboration between countries and partners, both regionally and at a global level.

We extend our infinite gratitude to everyone who made this project possible. To our speakers who dedicated their time, knowledge, and experience, we are deeply grateful: Drs. J. Arbolada-Florez, C. Casanova, R. Dresdner, R. Elgueta, A. Felthous, R. López, R. Negrón-Muñoz, V. Ortiz, J. Penn, G. Poblete, A. Ruiz, A. Sciolla. To all who collaborated in the planning and execution of a project of this magnitude, to all the government officials who saw its value and agreed to collaborate, and to the institutions who supported and hosted us so graciously, especially the Chilean Society of Mental Health and its director, Dr. R. Riquelme; and the Psychiatric Institute José Horwitz Barak and its medical director Dr. Cancec.

We look forward to crossing the next frontier in forensic psychiatry.

Carolina A. Klein, MD is Associate Program Director – Forensic Psychiatry Fellowship Program, Department of Psychiatry - Georgetown University Hospital, and Forensic Psychiatrist, Saint Elisabeth Hospital – Department of Mental Health Washington, DC

Faces of AAPL

continued from page 10

Swift and I discussed my finding that there was evidence that would allow a *Daubert*-worthy examination of Hamdan's rehabilitative potential. This assessment would be based on studies of terror networks and the effectiveness of programs such as the Saudi government's rehabilitation center, which was established to re-integrate former terrorists into their families, religion, and culture. The evaluation of Hamdan's rehabilitative potential was similar to developing a risk management plan. In consultation with the experts above, I identified both aggravating and mitigating factors associated with positive rehabilitative potential.

As Hamdan and I reviewed his history, additional issues relevant to his case were clarified. These related to the effects of enhanced interrogation techniques on the veracity of a resulting confession and the ongoing effects of confinement on Hamdan's trial competency.

Testimony

Hamdan's Military Commission was set for July 2008. I testified in a suppression motion regarding whether the enhanced interrogation techniques to which Hamdan was subjected while in US custody at Bagram Airfield in Afghanistan and at GTMO were consistent with interrogation techniques associated with false confessions. The military judge, US Navy Captain Keith Allred, subsequently ruled that Hamdan's statements at Bagram were obtained under coercive conditions and were inadmissible.

I did not testify in the guilt phase of Hamdan's trial. On August 6, 2008, Hamdan's panel (jury), all senior officers currently on active duty in the military, acquitted him on the more serious charge of conspiracy and found him guilty on the material support charge. The following day, during his sentencing hearing, I testified about Hamdan's rehabilitative potential. After a brief deliberation, the

panel handed down a sentence of 66 months with the understanding that he would be given credit for 61 of the 80 months he had been in American custody. Unless he were indefinitely detained as an "enemy combatant," Hamdan would be eligible for repatriation to Yemen in January 2009. After the panel delivered its sentence Hamdan asked Captain Allred for permission to speak to them directly. He thanked them for granting him a sentence that gave him the opportunity to be reunited with his family and apologized directly for the results of any of his actions as an employee of bin Laden.

As Captain Allred concluded the proceedings he addressed Hamdan directly. "I hope the day comes that you return to your wife and daughters and your country, and you're able to be a provider, a father, and a husband in the best sense of all of those terms." Hamdan, on the verge of tears, replied, "Insha'Allah" (g-d willing). "Insha-Allah," echoed Captain Allred, looking Hamdan straight in the eye and bringing the Commission to its end.

Epilogue

Hamdan was repatriated to Yemen in November 2008. He served the remainder of his sentence in Yemen and was released to his family in January 2009. He had not seen his wife and ten-year-old daughter since November 2001. He met his eight-year-old daughter for the first time.

Shortly after his release Hamdan

sent an email to our translator requesting that his best wishes be shared with his defense team and me. His conviction is currently on appeal before the D.C. Circuit Court.

Hamdan continues to live with his family in Yemen. He drives a cab, the same job he had before his employment as one of Osama bin Laden's drivers.

The website of the Office of Military Commissions (<http://www.mc.mil/HOME.aspx>) is an excellent source of information about the history of Military Commissions from the time of the Revolutionary War, legislative and case law governing Military Commissions, the current Rules of Military Commissions (2010), and the Military Commissions at the US Naval Station Guantanamo Bay, Cuba.

Dr. Emily Keram is Assistant Clinical Professor, Psychiatry and the Law Program, University of California, San Francisco, and Staff Physician, Santa Rosa VA Mental Health Clinic, Santa Rosa, California. She is an active AAPL member who has served in various capacities for AAPL, including Councilor (1996-1999), Secretary (2000-2002), founder and chair of Early Career Development Committee, past chair of Membership and Law Enforcement Liaison Committees, and membership in a host of other AAPL committees. A regular presenter at AAPL, Dr. Keram frequently consults to law enforcement departments on various issues relevant to psychiatry when she is not volunteering her time on issues of local and national importance. ☎

MUSE & VIEWS

Here are some of the reported most ridiculous lawsuits of 2011!

- Convict sues couple he kidnapped for not helping him evade police
- Man illegally brings gun into bar, gets injured in a fight, then sues bar for not searching him for a weapon
- Young adults sue mother for sending cards without gifts and playing favorite
- Man suing for age discrimination says judge in his case is too old

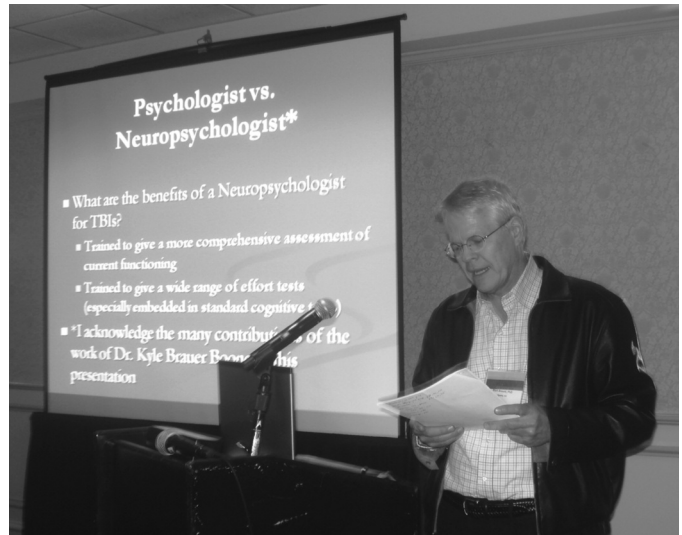
Source: <http://news.yahoo.com/10-most-ridiculous-lawsuits-2011-175104066.html>

Submitted by Charles L. Scott MD

PHOTO GALLERY



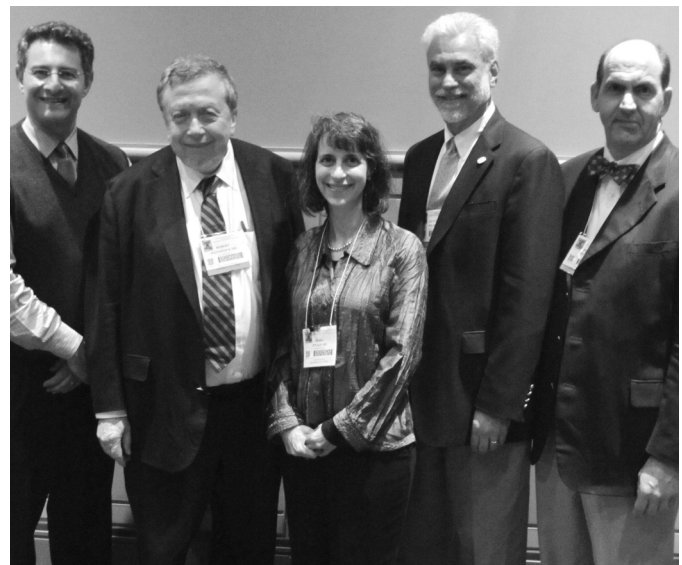
Dr. Privitera showing off his well-deserved Guttmacher Award.



AAPL meeting...education at every level.



Keynote speaker Edward Kennedy at the APA.



New officers ready to take over stewardship of AAPL.



Enjoying the reception at the last AAPL Annual Meeting in Boston.



Discussions center on institutions as the Institutional & Correctional Committee members huddle.

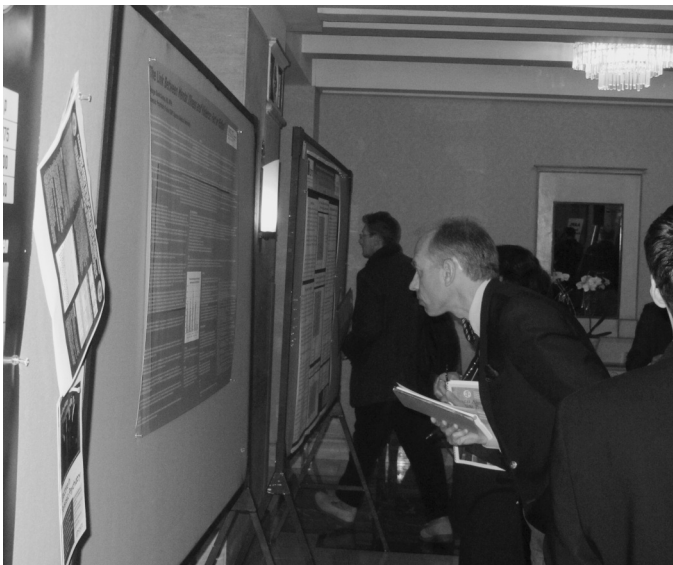
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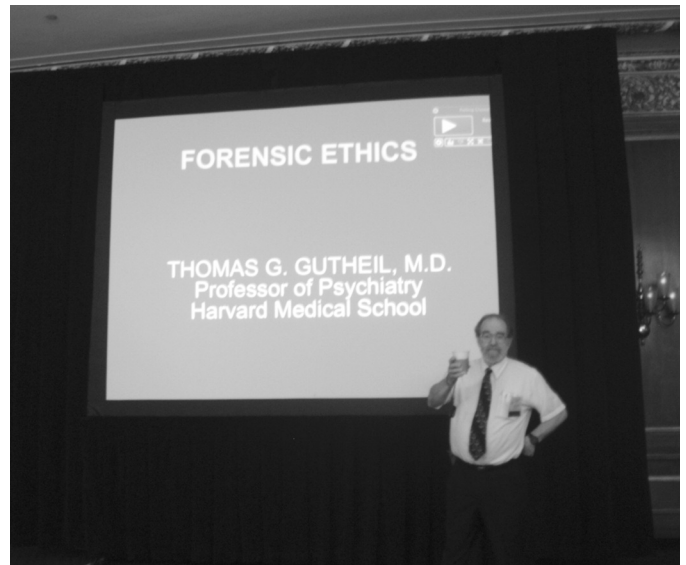
At the council meeting during the APA meeting in Philadelphia.



Immediate Past President and the next President of AAPL pose for a picture.



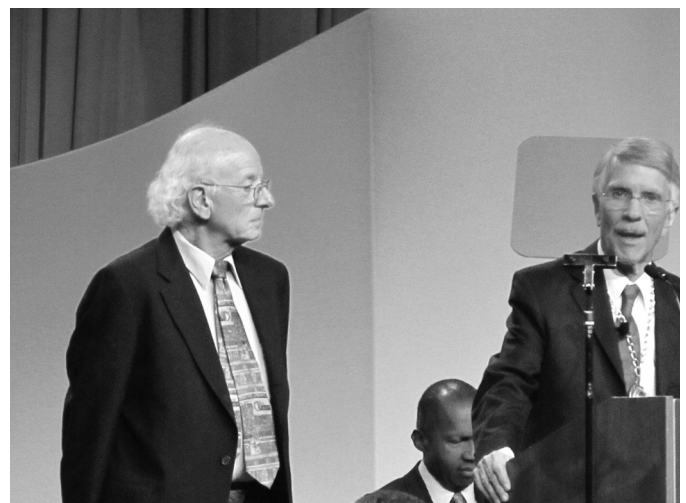
Attention-grabbing posters at the AAPL Annual Meeting.



Dr. Gutheil raises his glass to toast forensic ethics.



Cross section of the crowd at the APA meeting in Philadelphia.



Dr. Zonana receiving the Issac Ray Award from APA President.

Prognosticating Emotional Distress: What September 11, 2001 and Other Traumas Reveal

Stuart B. Kleinman MD, Chair, Committee on Trauma and Stress

Significant numbers of individuals do not develop severe, prolonged, or even any, clinically significant psychiatric difficulties following high magnitude stressors. For example, approximately 35% of those directly exposed to danger during the September 11, 2001 attack on the World Trade Center developed PTSD. A similar number did so following the Oklahoma City bombing¹. Traumatologists are increasingly focused on attempting to understand what enables this marked adaptation. Understanding such is central to: effective screening and efficient allocation of resources after mass traumas; developing means of preventing and more effectively treating pathological post-traumatic stress states; formulating in legal settings reliable prognoses regarding individuals' emotional distress claims; and assessing how long individuals may qualify for disability benefits.

Responses to traumatic events follow different trajectories². Resilience reflects an individual's adaptability, and involves no more than transient dysfunction. Recovery, in contrast, involves a significant period of dysfunction with subsequent (relative) return to an individual's pre-event mental state. Post-traumatic growth involves development of psychologically-beneficial capacities independent of (or even because of) post-traumatic distress.

Risk and resilience are not synonymous. More is known about factors which promote risk for developing PTSD than those that facilitate adaptation to high-magnitude environmental stressors. Important risk factors for PTSD development include: 1) Extent of physical danger accompanying an event; 2) The contemporaneously perceived magnitude of threat posed by an event. Such may determine an individual's response independent of the objective magnitude of threat confronted. (Retrospectively determining how an individual perceived an event can be

complex. Variables such as context of recall may distort memory, creating the need to review multiple collateral data sources); 3) Peritraumatic dissociation; 4) Peritraumatic panic attacks; 5) Level of perceived social support; 6) Psychiatric dysfunction during year preceding the index trauma; 7) Number of negative life events before and following the index trauma; 8) Age; 9) Gender; 10) Acute, perhaps gender-specific, post-event generally elevated heart rate, and/or stimulus specific elevated heart rate.

The role of neurological disturbances, especially traumatic brain injury, in generating risk for development of independent psychiatric conditions, such as PTSD, requires special attention.

Important to the provision of adequate mental health treatment services to returning war veterans, post-trauma stressors which are unrelated or only tangentially related to PTSD-inducing traumatic events have been found to intensify PTSD symptomatology. Appreciating such is also important to ascertaining the cause, and legal responsibility for, the magnitude of PTSD suffered following exposure to civilian stressors, for example, employment discrimination and negligent security related events.

The following post-September 11 and other recently compiled data illustrate the range of trajectories of responses to violent victimization and suggest factors to consider when prognosticating outcomes of such events:

1. Two years after the September 11 World Trade Center attack, a longitudinal survey³ found PTSD prevalence declined from 5% at approximately 12 months, to 3.8% at approximately 24 months. Indicating the importance of the timing of conducting forensic psychiatric assessments, 3.9% of the sample first evidenced PTSD at 24 months.
2. Amongst 2,960 September 11, 2001

World Trade Center non-rescue disaster workers⁴ screened with the Posttraumatic Checklist-Civilian (PCL-C), 9.5% had probable, and 9.3% had partial PTSD approximately one year after the attack. By three years afterwards, the rates had decreased to 4.8% and 3.6% respectively, and by six years, to 2.9% and 1.8% respectively. In comparison, an a priori chosen high risk group assessed throughout the study period with the Clinician-Administered Posttraumatic Stress Disorder Scale (CAPS) displayed rates of 5.8% and 2.2% respectively after six years. Translating between PCL-C and CAPS scores complicates data interpretation.

3. Amongst 178 police officers who were exposed to life-threatening events, 158 of whom were exposed to such during the first six months of starting active duty, and assessed 6, 12, 18, 24, and 30 months following beginning active duty: 88.1% displayed little or no adverse psychological reactions during the 24 month study period; 10% early on developed moderately severe PTSD symptoms which subsequently improved, but remained subsyndromal through the next two years; 1.7% suffered progressively worsening symptoms.

The third group was exposed to the most traumas. The second (i.e., subsyndromal) group may have experienced sequential traumas. Peritraumatic dissociation strongly distinguished between the resilient, and improving but subsyndromal group.

Relative inoculation to stress may derive from naturally occurring events, including early childhood trauma, individual attachment style, and hardiness (i.e., approach to control, commitment, and challenge). Psychological interventions, e.g., adaptation training, and, potentially, biological interventions, for example, acute use of anti-memory consolidators, notably beta-blockers, or Neuropeptide Y injection, may be able to create or enhance such inoculation. As understanding and means of fostering resilience progresses, rates of development of post-traumatic stress pathology may eventually be dimin-

(continued on page 23)

Gutmacher Award

continued from page 1

“any physical assault, threatening behavior, or verbal abuse occurring in the workplace.” Violence includes harassment and threats and has to be grasped as occupational rather than merely personal. Communication about this can be facilitated by means of visual “translational models,” the second key concept. It comes to light in The World Health Organization’s more detailed definition for WPV. An example: eight subtypes of aggression can be distinguished by combining the categories “physical,” “active” and “direct” and each of their opposites.

The third key concept is that violence is under-reported and high-impact. There are at least seven well-understood common reasons for the under-reporting, including self-blame and peer pressure.

The fourth key concept is violence as coming from and harming various parties. A recent global report covering over 18,000 patients with psychoses including schizophrenia finds the patients both more likely to be victims than perpetrators yet also more violent than non-psychotic controls. Also small numbers of patients account for large numbers of violent acts. Some aggressive patients are chronically so. It is also possible for an organization to be run in ways that foster violence.

The fifth key concept is the reality of multiple areas of disruption from WPV. Victims of trauma are permanently changed by it. In some cases there is a dose-response relationship, with responses including fear, intent to leave, and physical and mental health problems. Some express this using the term “orphaned” since no clear agent exists for the staff member who becomes a victim.

The sixth key concept is WPV’s global effects on staff shortages and other costs. These include productivity losses, disruption of organizational function, less efficiency and decrements in institutional memory. These losses may be compounded by workers when they try to return to the job prematurely. The quality of care is likely to suffer.

The final key concept has to do with “periventions;” this very broad term extends the concept of prevention indefinitely towards both the past and the future. It includes promptly resolving any distressing concerns of patients, having the unseen but nearby presence of security personnel especially at vulnerable times in the daily routine, attentively communicating, supportively supervising, debriefing and the like. In conclusion Dr. Privitera asserted the value of his approach to WPV as a means of ameliorating acute stress disorder and lowering the risk of chronic posttraumatic stress disorder. ☞

President’s Report

continued from page 4

- lowing through on committee projects, making assigned deadlines, and presenting on behalf of your committee at the AAPL meeting are just some examples of membership interest that illustrate leadership potential.
3. Get to know other AAPL members throughout the organization, to include those in leadership positions as well. I have experienced AAPL members as incredibly gracious and willing to help when approached. Say hello!
 4. Find ways to collaborate with AAPL members on presentations at the annual AAPL meeting. Work hard to make your presentation “stand out” in a positive way. Good educators are highly valued and good presentations are remembered.
 5. Don’t give up! There are certainly times when incredibly worthy and dedicated AAPL members may not be nominated for an office despite being qualified. Many Executive Council members (if not most) were considered multiple times before they were actually nominated. Persistence combined with excellent contributions and a committed interest will pay off.
- Committees consist of AAPL members appointed by the current AAPL President. The AAPL President assumes the Presidency at the end of the AAPL business meeting during the

annual meeting. The AAPL President is responsible for appointing committee members and committee chairs. Committee appointments last for three years and can be renewed by the President for another three-year term. The President appoints committee chairs each year. If you are not on a committee and would like an appointment, it is appropriate for you to contact the current AAPL President to request an appointment to the committee. As the President’s term nears its end each October, she or he may defer the request to the incoming President. Many committee chairs serve for several years due to the nature of their committee and ongoing work. However, if you are interested in serving as a committee chair, you should let the incoming AAPL President know of this interest and your contributions to the committee.

AAPL is a wonderful organization committed to sharing knowledge regarding the field of forensic psychiatry. I encourage those who wish to take a leadership role in AAPL to let those interests be known. You are needed. ☞

Ask the Experts

continued from page 7

the subjunctive language and “perception” approach to help explain the reaction being claimed. For many people, “perception is reality” and indeed there can be more than one correct perception of the same incident or series of events. The law struggles with the idea that there can be two truths and that these may even be contradictory, but science is able to accept such a reality.

Sadoff/Kaye: Take home point: Cases involving alleged discrimination/harassment/retaliation at work are some of the most emotionally laden and hardest fought cases a forensic psychiatrist will ever be called to assess. Often the fact patterns are little more than “he said-she said” claims and counter-claims. Remaining professional can be challenging under the heat of cross-examination and the emotions of the claim. Remaining calm and striving to preserve the dignity and decorum of our profession is advised. ☞

Transgenderism

Renee Sorrentino MD, Daniel Reilly MD, Anna Glezer MD
Gender Issues Committee

Gender variance, most commonly called “transgenderism,” is an umbrella term that describes an individual whose gender expression is anything other than “male” or “female” and is not consistent with that individual’s anatomical sex. For example, someone who is born with male genitalia, but whose gender expression—that is, the individual’s gender identification and outward expression of gender—is female would be considered a transgendered female. The term “transsexual” is subsumed in the gender variant description and refers to an individual who has had sex reassignment surgery and/or has begun hormone therapy. Within psychiatry, gender variant individuals are most commonly associated with the DSM-IV TR diagnosis, Gender Identity Disorder.

The prevalence of transgenderism is not known within the United States, and international studies are generally limited by the variance in terminology. Epidemiological studies tend to underestimate the number of gender variant individuals because studies are typically limited to transsexual individuals (thereby excluding individuals who are pre-operative but have variant gender expression). Bakker et al., in a 1993 study from the Netherlands, estimated that transsexualism occurred in one out of every 11,900 males and one out of every 30,400 females. Data from the Human Rights Campaign estimate that 0.25%- 1 % of the US population has undergone at least one sex reassignment surgery (<http://www.hrc.org/files/assets/resources/hrcTGguide.pdf>).

The population of gender variant individuals in the prison system is even more poorly understood. Data from the Transgender Law Center suggest that transgender individuals are two to three times more likely to be incarcerated than the general population.

Hormonal treatment: Transsexual individuals often seek hormonal treatment with the goal of developing the

physical characteristics of the desired gender. Effective hormonal regimens suppress the individual’s endogenous hormone secretion and maintain physiologic sex hormone levels within the normal range for the individual’s desired gender. The Harry Benjamin International Gender Dysphoria Association (HBIGDA), now known as the World Professional Association of Transsexual Health (WPATH), published the first guidelines on the “Standards of Care” in 1979. These “Standards of Care,” now in their seventh version, provide mental health and medical professionals with general guidelines for the evaluation and treatment of transsexual individuals. Other

“Data from the Transgender Law Center suggest that transgender individuals are two to three times more likely to be incarcerated than the general population.”

organizations, such as The Endocrine Society (2009), have appointed task forces to formulate evidence-based recommendations for the diagnosis and treatment of transsexual individuals. Of note, no randomized controlled studies have been undertaken to determine the optimal combination and dosages of hormonal treatment.

Hormonal treatment is considered after a comprehensive diagnostic evaluation. Individuals must meet the diagnostic criteria for Gender Identity Disorder as defined in DSM-IV. In addition to meeting the diagnostic criteria, the individual must demonstrate a commitment to live as the preferred gender, as evidenced by a continuous period of time living full time as the

preferred sex, prior to consideration for hormonal treatment. HBIGDA has established eligibility and readiness criteria for hormone treatment.

Endocrinologists are the most commonly consulted medical specialty in the pharmacologic treatment of transsexual individuals. The goal of hormonal treatment in male to female transsexuals is to suppress androgens. Medications that suppress androgen production or action include estrogens, GnRH analogues, and antiandrogens. The desired physical changes include decreased facial and body hair, breast tissue growth, and redistribution of fat mass. The goal of hormonal treatment in female to male transsexuals is virilization by testosterone administration. Testosterone is administered parentally or transdermally to achieve values in the normal male range. Testosterone treatment results in an increase in muscle mass, decreased fat mass, and increased facial hair.

The long-term treatment of transsexual individuals is determined by a risk benefit analysis of the treatment. Continued administration of hormones is necessary to prevent hormone deficiencies. However long term hormonal treatment carries known and unknown risks. Although little evidence exists to indicate an increased risk of hormone dependent cancers over time, theoretically this is a serious risk incurred with long-term treatment. Informed consent for hormonal treatment must include a review of the efficacy of treatment as well as the known and unknown effects and risks.

Recommendations for clinical assessment and follow up of transsexuals on hormonal treatment include a baseline physical examination, bone mineral density exam and routine laboratory studies. Maintenance monitoring includes annual physical examination, annual bone mineral density exams and regular interval laboratory studies of cardiovascular risk factors including serum lipid levels, glucose and liver enzymes.

Sex reassignment surgery (SRS): The main surgery in sex reassignment is genital surgery and removal of the

(continued on page 19)

Transgenderism

continued from page 18

gonads. The surgery consists of cosmetic genital surgery, which maintains integrity of the neurological (sensation) system. In order to undergo surgical sex reassignment an individual must meet a criterion of eligibility and readiness. A multidisciplinary team typically consisting of a mental health professional and endocrinologist determine whether a candidate meets the specified eligibility and readiness.

Many studies have demonstrated an increase in the quality of life of transsexuals who are treated with hormonal medications. However, studies of the type of hormones, dosage, and duration are lacking. Decisions regarding hormonal treatment are based on expert consensus guidelines, which have become the standard of care, not empirical evidence.

DSM Considerations: Despite inclusion of Gender Identity Disorder in the DSM, general acceptance of transgenderism as a psychiatric or mental disorder does not exist. An international survey on various issues related to the *DSM-IV* gender identity disorder diagnosis was conducted among 201 organizations concerned with the welfare of transgender people. 55.8% believed the diagnosis should be excluded from the DSM (Vance et al, 2010). The major reason for wanting to keep the diagnosis in the *DSM* was health care reimbursement (Vance et al, 2010). The *DSM-V* proposed that the name Gender Identity Disorder (GID) be replaced by "Gender Incongruence" (GI) because the latter is a descriptive term that better reflects the core of the problem: an incongruence between, on the one hand, what identity one experiences and/or expresses and, on the other hand, how one is expected to live based on one's assigned gender (Meyer-Bahlburg, 2009a; Winters, 2005).

Gender variance and the courts: The only US Supreme Court case to address the issue of transgender individual rights in prison is the 1994 case of *Farmer v. Brennan*. The petitioner, Dee Farmer, was a transgendered

woman (male to female) who had undergone hormone therapy and had undergone sex re-assignment surgeries (breast implants). Ms. Farmer was placed in the male general population during a transfer from a state to federal prison. Shortly after her transfer, she was raped and beaten by her cellmate. The court held that a federal official could be liable under the Eighth Amendment by acting with "deliberate indifference" to a prisoner's health or safety, but only if the official knew that the prisoner faced "substantial risk of serious harm."

This holding by the Supreme Court affirmed transgendered individuals' right to humane confinement conditions under the Eighth Amendment's prohibition against "cruel and unusual punishment." Simultaneously, it raised the bar for transgender individuals seeking relief or care with the narrow construction of deliberate indifference, which requires a liable party to have subjective knowledge of a risk.

Since *Farmer v. Brennan*, there have been numerous cases brought to the lower courts regarding transgender rights in prisons. Suits in lower courts are typically about classification (where individuals are housed), hormone treatment within prison system, sex re-assignment surgery within prison system, and sexual violence against transgender individuals. The lower courts have not consistently ruled in favor of the individual bringing the suit, and at least, as far as classification is concerned, most U.S. jurisdictions house transgender individuals based on their genitalia, not on their gender identity.

Ethical Issues in Incarcerated Populations: One central issue for transgendered individuals is, as noted above, DSM classification. The question of whether transgenderism is a psychiatric condition remains unanswered. Incarcerated transgendered individuals may be subject to further stigma by being labeled as "psychiatric" and by receiving mental health services. In the incarcerated setting the confidentiality of psychiatric treatment is compromised. Currently, psychiatric and endocrinological care for these individuals is done for the treatment of

GID. It is unclear how the available treatments may change or decrease should this diagnosis be removed from the DSM the way that homosexuality was in the last major revision.

Adequate versus best medical care: The term "medical necessity" at face value appears to be one for clinicians. However, it is, in fact, a legal term defined by the courts and legal system. The courts have stated that the responsibility of the correctional system is not to provide the best possible medical care, but "adequate" care. This leads to potential conflict for the clinician in terms of allegiance to the patient and one's own desire to provide the best possible clinical care versus the realities of working in a correctional institution.

Appropriate Housing and Victimization: The transgendered population has been shown to be both disproportionately larger in the prison setting compared to the prevalence rates in the general population (Brown and McDuffie, 2009) as well as disproportionately more frequently victimized while incarcerated (Sexton, Jenness, and Sumner, 2009). This leads to the question of what is the most appropriate place for transgendered individuals in the prison setting. Most correctional institutions use genitalia as the means of housing assignment. Therefore, male-to-female transgendered individuals who have not had sex reassignment surgery (SRS) are housed in male facilities. Within some institutions, this means being placed in administrative segregation or other protective custody. Other institutions have a specific unit for this population.

Financial Considerations: Gender reassignment surgery is expensive. At this time, no state or federal corrections department contains provisions to pay for this surgery for any inmates. In contrast to other countries, such as Canada, the US also does not allow inmates to pay out of pocket for any medical procedures. Hormone therapy, as it is available in generic prescription, is significantly less expensive. These costs must also be balanced by the costs of the medical treatment of

(continued on page 21)

Royal College of Psychiatrists: Forensic Faculty Annual Conference - 2012

*Professor Jennifer Shaw, Dr. Graham Glancy, Dr. John Baird,
for International Relations Committee*

The 2012 residential meeting of the Forensic Faculty of the Royal College of Psychiatrists was held in Gateshead, Newcastle February 1-3, 2012. About 350 delegates attended, the majority of whom were from the United Kingdom and Ireland, but there were also overseas delegates from a number of European countries and United States, Canada, Australia and New Zealand. As in previous years, there was a welcome reception for delegates from overseas which gave them a chance to meet with members of the Faculty Executive, and also with the six medical students from different medical schools throughout the United Kingdom who had been sponsored to attend following competitive application. Trainees are also invited to this welcome reception in order to ensure that they feel fully involved in the proceedings.

The program extended over three days and was opened by Dr. Richard Bradshaw of the UK Department of Health with a lively presentation of policy relating to court liaison and diversion. There were three keynote sessions. In the first, Professor Kevin Douglas of Simon Fraser University, Canada, spoke of developments in violence risk assessment and gave us some preliminary information about the HCR 20 version 3 instrument, which in due course will replace the HCR-20 version 2. He described that the developments were evolutionary rather than revolutionary, that there will be changes in the process of considering each risk factor and that it is hoped that the predictive power of the instrument will increase.

The second keynote lecture dealt with the phenomenon of civil disturbance and rioting and was presented by Emeritus Professor Clive Bloom of Middlesex University, London. He described that these social phenomena

have been occurring over centuries and will undoubtedly continue. The background to them is complex but requires to be understood and they present particular challenges for law enforcement.

The third keynote session dealt with malingering in forensic psychiatry and was based around a case presentation by Dr. Ian Cummings of Belmarsh Prison, London, of an unusual case of suspected malingering and described the novel and imaginative interventions that were employed. The second half of this final session considered the complexity of apparent malingering and the need for caution and circumspection when evaluating a suspected case and concluded with an engaging debunking of the polygraph or 'lie

“Amongst those guilty of serious abuse to a non-abusive partner, women outnumber men.”

detector' from Professor Aldert Vrij, University of Portsmouth.

Plenary sessions dealt with a range of topics and among the more provocative was a lively presentation by Dr. Amery Clark, London, who persuasively made the case for patients to complete their own risk assessments. A paper of special interest to North Americans related to the use of GPS tagging on patients when they were on leave from hospital was presented by Professor Tom Fahy of Kings College, London. A number of important issues arose including those in relation to information sharing between agencies in health and criminal justice when they jointly have responsibility for the management of forensic patients during their rehabilitation. Professor Fahy

noted that this technology is inexpensive and serves to relieve public as well as staff anxiety. It is monitored from a distant source and staff is only involved if there are any infringements or if the technology is interfered with.

Dr. Huw Stone presented an interesting talk related to the bigger picture of the treatment of mentally abnormal offenders. He described that there are now 3500 medium secure beds in England and that this represents the largest single investment in mental healthcare in the country. Each patient costs £176,000 per annum. The proliferation of these units followed the Butler report in the mid-70s. Prior to that it was believed that most mentally abnormal offenders were either in generic psychiatric hospitals or were within the prison services where there was little mental health input. Dr. Stone conjectured that we might be reaching the stage where we should consider transferring to prison in-reach services as a more feasible way of delivering care. This is not inconsistent with the Isaac Ray lecture given by Professor John Bradford at AAPL last year regarding the St. Lawrence Valley Unit that he instituted. This concept deserves attention but will require much discussion that will probably continue in the years to come.

Professor Tonya Nichols of the Canadian Institute of Health Research presented a paper on intimate partner violence (IPV) with her opinions supported by extensive research, that challenged to the core many of the conventional views of this area of practice and offending and she questioned what she termed feminist dominated myths. She presented that in intimate partner violence, in fifty percent of cases both partners are violent to each other; with the remaining fifty percent of cases when only one partner was violent being equally divided between men and women. When both partners are violent, women more often than men strike the first blow, and patriarchy is only one of a range of factors which predispose to violence by men. Amongst those guilty of serious abuse to a non-abusive partner, women out-

(continued on page 21)

Transgenderism

continued from page 19

inmates who attempt to self-castrate or attempt autopenectomy. The second issue that relates to cost is that of gender parity. If the department of corrections pays for male to female gender reassignment surgery, which costs approximately \$10,000 in physician fees alone (Alexander and Mesheleimah, 2010), it would also be obligated to fund the more expensive female to male procedure, which is approximately \$70,000 in physician fees.

Public Policy Considerations:

Because of the costs of SRS, some public officials have made the argument that having the government pay for this procedure may encourage indigent transgendered individuals to engage in criminal activity for the purpose of incarceration and therefore hormonal and surgical treatment.

There is also the public relations aspect to contend with – that is, the issue of public perception of providing expensive services for the inmate population, which affects the clinician indirectly in that this is a consideration for public officials such as wardens or judges. ☞

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Protect This House!

continued from page 8

whose edginess made her the ideal fit to be the unofficial police liaison, counseling police officers who had just been through traumatic experiences. To fulfill hospital requirements, all persons counseled in the emergency room had to be seen by a physician. This form of counseling was intriguing to me. It was really quite a surprise how emotional these tough guys sometimes were behind closed doors. This reminded me of those Hulk-like juvenile detainees who stride into the counseling office full of a bravado but then, immediately dissolve into cries of "I want my mom" as soon as the door closes behind them. I have seen some correctional officers truly shaken by the actions of inmates. If you think about it, the last thing these people need at such a time is some psychiatrist full of bravado, trying to behave like what he/she believes would be a popular persona in such a setting. In the words of a juvenile patient from long ago, "Just be a doctor, man."

Guests in a house do not have to alter their personas to match their hosts' but are welcome to bring only

their own distinctive skills and personalities. Shouldn't the same apply to us in our work in correctional settings? I'm sure there are plenty of great stories out there along the theme of this column – the experience of being ersatz visitors to places far removed from medical schools and hospitals. Please feel free to email any to zerbysa@upmc.edu - I'd love to read and include them in future columns. ☞

Royal College

continued from page 20

number men. She also described that in her view, the causes of intimate partner violence varied from case to case but were similar across the sexes, with coercion, anger and punishing the other partner being the most common. She described that self-defense by women was over-stated and in her view the general theories of violence were a good explanation of IPV and the similarities were greater than the differences. To those working within a criminal justice system where domestic violence programs are held in high regard, it was disappointing to learn that in research, Professor Nichols has found that batterer intervention programs were ineffective. They largely tended to be punitive and were based on a patriarchal model. Furthermore, male IPV did not always escalate and recidivism was not as common as it was believed to be. Challenging views indeed!

A popular feature of the conference again this year was the fun-run. Led by a local, Dr. McKinnon, this provided a pleasant break as well as an impressive sightseeing experience of the city. Dr. McKinnon and Professor Tony Maden were front runners throughout and hardly seemed to break a sweat.

It was a tribute to the program and the conference as a whole that few delegates left before the end – as good a measure as any of delegate satisfaction. Next year's event will be held in early February 2013. The venue is still to be decided, but Amsterdam is a definite possibility. Wherever it is held, AAPL members who attend are guaranteed a warm welcome. ☞

American Medical Association 2011 Annual Meeting Highlights

Robert T.M. Phillips MD, Ph.D., Delegate; Barry Wall MD, Alternate Delegate; Katya Frisher MD, Young Physicians Delegate; Ryan Hall MD, Young Physician Delegate; Howard Zonana MD, Medical Director

The AMA inaugurated psychiatrist Jeremy Lazarus MD, former speaker of both the APA Assembly and the AMA House of Delegates, at its annual meeting in Chicago in June. Dr. Lazarus's private practice is in Denver, and he is a dedicated runner and athlete who has completed many marathons and triathlons. In his inaugural speech, he emphasized endurance and persistence in meeting the challenge of strengthening the health care system for the long run. AMA's Annual Meeting occurred before the US Supreme Court upheld the Affordable Care Act, yet Dr. Lazarus's call for endurance and persistence was still timely, as the House of Delegates still debated the implementation of the act, and called for examining new ways to finance Medicare, including a defined contribution program that would allow beneficiaries to purchase traditional Medicare or a private health insurance plan.

Other meeting highlights include the following:

Physician Stewardship of Health Care Resources: The House of Delegates adopted the Council on Ethical and Judicial Affairs' recommendations pertaining to stewardship of health care resources. The document aims to help physicians make fair, cost-conscious individual patient care decisions while balancing availability of health care for others.

Physician Responsibilities for Safe Patient Discharge from Health Care Facilities: The House of Delegates adopted the Council on Ethical and Judicial Affairs' recommendations pertaining to physician responsibilities for safely discharging patients. The recommendations stem from challenges physicians face in coordinating discharges of patients to homelessness, prisons, rural areas, other countries in

the context of deportation, and the like.

Maintaining Mental Health Services by State: AMA acknowledged the significant challenges mental health professionals face as most states cut their public mental health services due to budget shortfalls. AMA is advocating that states maintain essential mental health services at the state level, increase funding for Mobile Treatment Team services to locate and treat homeless persons with mental illness, and enforcement of the Mental Health Parity Act at the federal and state level.

Support for Drug Courts: AMA also passed a resolution supporting establishing drug courts as an alternative to incarcerating non-violent offenders. It hopes such courts would be a more effective means of overcoming substance abuse and dependence. Similar to the House of Delegates action pertaining to the need to maintain mental health services at the state level, this resolution highlights the AMA's attention to and support of mental health issues.

"Clear and Convincing Evidence" standard for medical liability actions: The House of Delegates deferred action on a well-intentioned resolution to support the application of a clear and convincing evidence standard to all medical liability cases. The resolution stems from ongoing frustration over lack of federal tort reform, but problems with implementation and whether it would impact reform of the medical liability system resulted in referral for further consideration.

Sales of Tobacco in Pharmacies: While AMA already has policy opposing the sale of tobacco by pharmacies, at this meeting it adopted policy that would create a recognition program for pharmacies that voluntarily eliminate the sale of tobacco. The AMA

also passed policy to block legislation that would exempt flavored cigars from Food and Drug Administration oversight, as tobacco companies market cigars to youth in a range of attractive flavors like candy, alcohol, fruit and chocolate.

Evaluate ICD-11 as a New Diagnostic Coding System: AMA will evaluate ICD-11 as a possible alternative to replace ICD-9. AMA will conduct more research on this issue and will report back to the House of Delegates in 2013. ICD-10 coding is seen to create unnecessary and significant financial and administrative burdens for physicians.

National Drug Shortages: AMA continues to address national drug shortages. There is evidence that advance notification of potential problems can help prevent or resolve such shortages. AMA voted to require manufacturers of FDA approved drugs to give the agency at least 6 months notice, or as soon as practicable, of anticipated voluntary or involuntary, permanent or temporary, discontinuance of the manufacture or marketing of such a product.

AAPL will be searching for a Resident Physician Representative position to the AMA. If you know of or are a psychiatry resident with an interest in forensic psychiatry and AMA advocacy, please contact the AAPL office for information on the position. ☎

Guns, Suicide

continued from page 3

already identified as suffering from mental illness misses the point. Apart from the fact that there are many individuals in the community suffering from mental illness but as yet undiagnosed, there are even many more individuals without mental illness but whose characterological deficits or extreme ideological bend place them at increased risk of violence. Providing easy access to lethal means of carrying out their misguided fantasies is a flaw in public health and safety policy. It is not, and should not be a political issue. It is a safety issue. ☎

Plead Insanity

continued from page 5

to plan and premeditate is unimpaired by the illness that he suffers from.”⁵⁵

By this interpretation, his delusional thinking and the effects of that delusion on his ability to make rational choices and correctly interpret real threats from illness-generated ideas, plays no role in the consideration of *mens rea*. The fact that he evidenced planning overrode his underlying thinking. This essentially guts the appreciation or knowing right from wrong elements. He was sentenced to two concurrent life sentences, primarily because the judge believed him to be a continued danger because of the possibility of a recurrence of the delusions and mental illness. This seems punishment primarily to accomplish deterrence, rather than retribution. The fact that he could be confined in a hospital indefinitely in most states was not a part of the consideration. In many ways the importance of the insanity defense is to decide who is deserving of punishment, which should be important to the integrity of the criminal justice system.

The law has traditionally focused on the importance of the will in determining culpability. As Sir Matthew Hale put it:

“And because the liberty or choice of the will presupposeth an act of the understanding to know the thing or action chosen . . . it follows that, where there is a total defect of the understanding, there is no free act of the will in the choice of things or actions.”⁵⁶

Our understanding of defects of reason has come to include delusional beliefs, which distort the ability to reality test.

This case is asking the U.S. Supreme Court to grant certiorari in order to decide whether the Constitution mandates some form of insanity defense or merely leaves it to the states as an option, if they so elect.

The APA and AAPL wrote a brief in July 2012 in support of the request to grant cert. and decide the issue outlining the organizations support of a meaningful insanity defense option. ^(P)

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2. *Powell v. Texas*, 392 U.S. 514, 88 S.Ct. 2145, 20 L.Ed.2d 1254 (1968), *Leland v. Oregon*, 343 U.S. 790, 72 S.Ct. 1002, 96 L.Ed. 1302 (1952), and then-Justice Rehnquist’s dissent in *Ake v. Oklahoma*, 470 U.S. 68, 105 S.Ct. 1087, 84 L.Ed.2d 53 (1985) (Rehnquist, J., dissenting). *Clark v. Arizona*, 548 U.S. 735, 126 S.Ct. 2709, 165 L.Ed.2d 842 (2006). “We have never held that the Constitution mandates an insanity defense, nor have we held that the Constitution does not so require. This case does not call upon us to decide the matter.” *Id.* at 752 n. 20, 126 S.Ct. at 2722, 165 L.Ed.2d at 861 n. 20.
3. Maeder T: Crime and Madness: The Origins and the Evolution of the Insanity Defense. New York: Harper and Row, 1985
4. See *Clark v. Arizona* 548 US
5. State of Idaho v. Delling, 267 P.3d 709 at 720.
6. Quoted in Quen, 2 Bull. Am. Acad. Psychiatry & L. at 116 (ellipses in original); see also ABA Standards 7-289.

Prognosticating

continued from page 16

ished, reducing suffering, and even diminishing the frequency with which compensatory emotional distress damages are sought in trauma-related civil litigation. ^(P)

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1. North, CS, et al. Trauma Exposure and Posttraumatic Stress Disorder Among Employees of New York City Companies Affected by the September 11, 2001 Attacks on the World Trade Center. *Disaster Med Public Health Preparedness*. 2011; 5: S205–S213.
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4. Cukor J, et al. The longitudinal course of PTSD among disaster workers deployed to the World Trade Center following the attacks of September 11th. *Journal of Traumatic Stress*. 2011; 24(5): 506–514.
5. Galatzer-Levy I, Madan A, Neylan T, Henn-Haase C, Marmar C. Peritraumatic and trait dissociation differentiate police officers with resilient versus symptomatic trajectories of posttraumatic stress symptoms. *Journal of Traumatic Stress*. 2011; 24(5): 557–565.

Fellows Corner

continued from page 11

attributed to my less than ideal quarters. However I realized that this also occurred around the time we had been reviewing the crime scene photos, the images of which were not easy to remove from memory. Perhaps this was my important reminder of the tragedy I was witnessing and the price to pay for such a fascination with the mind of a killer. Or perhaps I was just getting soft. I know at least that something would have felt wrong if I had gone through all of that material unscathed.

Either way, my insomnia was short-lived. My co-fellow and I continued to participate, hoping to help out as much as we could, while trying to be mindful to not get in the way. In the end, while we did not get the time off in order to travel and watch the testimony in person, we did get to see some video excerpts, afterwards. Even the short excerpts were rewarding to watch, especially to see how effective and clear our director’s testimony was and how much his hard work had paid off.

As I look back, soon after graduation, I realize how valuable that experience was. It forced my co-fellow and me to learn early the practical aspects of diplomatically critiquing a report as well as the limitations to a forensic opinion when one is denied access to examine the subject in person. It also brought up many unresolved issues in our profession, such as the ethics of getting involved in a death penalty case. I still sometimes get the “serial killer” comment when people find out I am a forensic psychiatrist. My answer to them is . . . the same. However, I can appreciate now more than ever, how valuable the opportunity was, even if I do not get the chance to participate in a case such as that ever again.

Dr. Annas is Clinical Instructor, SUNY Upstate Medical University, and attending Psychiatrist at Hutchings Psychiatric Center. He is a recent graduate of the SUNY Upstate forensic fellowship program. ^(P)

Letter to the Editor

Dear Editor,

Re: Forensic Psychiatrists and Psychological Assessments

In his recent “State of Our Union Address,” AAPL President Charles L. Scott MD stated that the field of forensic psychiatry “is rapidly moving toward the routine incorporation of psychological assessments and more structured interviews into the forensic assessment process,” and that he did not believe forensic psychiatrists “can or should stand on the sidelines and watch other forensic disciplines take complete ownership of ‘objective testing.’” Dr. Scott correctly identified a need for those administering such tests to be “appropriately skilled and experienced,” and we further agree with his observations that “forensic psychiatry residency training programs should provide structured training on assessment instruments” and that “collaborative efforts with a forensic psychologist are invaluable in providing this training.”

We are concerned, however, by Dr. Scott’s assertion that “core competencies in this area are easily assessed through supervision of administered testing and mock cross examinations on each testing instrument.” In particular, we hope our colleagues will realize that “supervision of administered testing” must include rigorous and thorough training in the selection, administration, scoring, and interpretation of these measures—a multifaceted skill set that can hardly be assessed “easily.”

Those utilizing psychological tests must possess a thorough and evolving grasp of test construction and the empirically established reliability and validity of each measure. Will the forensic psychiatrist be able to describe the latest approved procedures for assessing the litigant’s ability to take a particular test? What of a test’s normative procedures, construction, “standard error of measurement” and other psychometric properties? Mastering the gamut of psychological assessment

considerations will require extensive training and supervision that cannot be obtained during a single weekend seminar, or imparted successfully within the crowded schedule of a single year of forensic fellowship. This is not to suggest that such instruction won’t be useful; rather, we maintain that it will not be sufficient, in and of itself, to enable the forensic psychiatrist to employ psychological testing and testify effectively regarding the results. Ongoing “supervision of administered testing”—of sufficient duration and intensity—will be necessary to achieve this goal.

Forensic psychiatrists—and for that matter, psychologists—who are unfamiliar with core psychometric principles expose their reports and testimony to intensive negative scrutiny, imperil the work of retaining counsel, negatively affect the fate of litigants, and run the risk of engaging in unethical behavior. Depending on the jurisdiction in question, such use of psychological test measures—even with training—may be illegal, based on state psychological licensing laws. In fact, the use of psychological tests has steadily become more rather than less restricted, particularly as a result of statutes and regulations that limit the use of the terms “psychologists and psychological” to those duly licensed as psychologists (Dattilio, Tresco, & Siegel, 2007).

If forensic psychiatrists elect to employ psychological testing, we urge that this be focused upon such essentially straightforward appraisal measures as the ones identified by Dr. Scott (i.e., the M-FAST, SIMS, SIRS, TOMM, PCL-R, HCR-20, *et cetera*). We also strongly agree that the use of such measures should be supervised by bona fide forensic psychologists, and that collaborative efforts with forensic psychologists should remain a consistent component of forensic psychiatry training programs and postgraduate mentorship.

Frank M. Dattilio, PhD
Eric Y. Drogin JD, PhD
Robert L. Sadoff MD
Thomas G. Gutheil MD 

References

Dattilio, F. M., Tresco, K. E. & Siegel, A.

(2007). An empirical survey of psychological testing and the use of the term “psychological”: Turf battles or clinical necessity? *Professional Psychology: Research and Practice*, 38, 682-689.

Dattilio, F. M., Sadoff, R. L., Drogin, E. Y., Gutheil, T. G. (in press). Should forensic psychiatrists conduct psychological testing? *Journal of Psychiatry and Law*.

Response to Letter to the Editor

I wish to thank Drs. Dattilio, Drogin, Sadoff and Gutheil for their letter to the editor regarding my newsletter article that mentioned the use of a limited number of psychological assessments in forensic psychiatry training programs. I appreciate their response and agree with nearly all of their points.

In my article I listed a small number of assessment instruments that I believe forensic psychiatrists can learn to competently administer. I appreciate that my colleagues acknowledged that the specific assessments I mentioned were limited only to those that used “essentially straightforward appraisal measures.” It is my opinion that the specific assessments I noted can be learned by a forensic psychiatrist resident over a 12-month period with appropriate training and rigorous supervision. I would agree that other psychological assessment instruments not described in my article may not be appropriate for forensic psychiatry residents to independently administer.

The word “easily” was used in a separate sentence and meant to be in a separate context. In a separate sentence, I wrote the following: “Core competencies in this area are easily assessed through supervision of administered testing and mock cross-examinations on each testing instrument.” The intent of this sentence was referencing the general *ACGME core competencies*, which are six specific categories that all training must be conceptualized in the field of medicine as defined by the Accreditation Council for Graduate Medical Education (ACGME). Core competencies in this context include the following: patient care; medical knowledge; practice-based learning and improvement; inter-

(continued on page 25)

Letter to the Editor

continued from page 24

personal and communication skills; professionalism; and systems-based practice. Within each of these six core competencies are various knowledge and professional areas important to forensic psychiatry and these include relevant psychological assessments. Specific knowledge areas are delineated by ACGME in their program requirement guidelines. ACGME also describes specific assessment tools for addressing the general core competencies. These include such terms as “portfolios,” “exam-oral,” and “global rating of live or recorded performance.” When having an accreditation review, the site reviewer requests to see how such general core competencies (with specific content to each) are assessed. Because many of the assessment methods are defined and recommended by the ACGME and requested by the site reviewer, I was trying to communicate that the ACGME assessment methods defined for the general core competencies could be “easily” adapted to assess knowledge areas of psychological testing. Without this explanation in my article, I can “easi-

ly” understand the confusion by those who responded and likely others. Perhaps a better word to communicate my message would have been the word “readily.” I did not mean to suggest that learning or mastering psychological testing was “easily” done. My goal was to remind training directors that the ACGME has already developed assessment methods that can be “readily” implemented to assess competence in this arena.

I agree with nearly all of the points raised by my colleagues. I sincerely look forward to reading their upcoming article and continued collaborative discussions on this issue.

Charles L. Scott 

AAPL Committees

AAPL members who are interested in serving on committees for a three-year term beginning on October 31, 2012 are invited to send a letter to the Executive Office by October 31, 2012. Committee members must be full voting members of AAPL.

The President-Elect, Debra Pinals MD will be making appointments after the Annual Meeting. Letters should indicate particular interests or qualifications for the committee appointment desired.

MUSE & VIEWS

Ex-Wife a Witty Witness

The following is a courtroom transcript when a wife is asked about her ex-husband.

Lawyer: “Are you married?”

Witness: “No, I’m divorced.”

Lawyer: “And what did your husband do before you divorced him?”

Witness: “A lot of things I didn’t know about.”

The Alias

The best criminals all have colorful aliases. Names like Jimmy Nostrils and Joe Bananas really liven up a criminal’s résumé. Look what happens if you don’t have one prepared.

When Sheboygan, Wisconsin, police pulled over a car for not having proper registration, a passenger did what many criminals do — he supplied the cops with an alias. Bad move. Turns out, that particular alias was wanted for vehicular homicide.

Source: <http://www.rd.com/home/stupid-criminals/>

Beware of Witnesses

Good criminals arrange it so no one is aware that a crime has taken place. Last year a German psychologist was accused of taking advantage of three of his patients. He had sex with one, named Kathrin; convinced another, Finja, to buy him some shoes and shirts; and conned the third, Leonie, into cleaning his house and paying for his vacations. This all came to light when a fourth patient, Monika, became suspicious and called the police. Why would she do that when the three victims hadn’t? Because the four are one person: Kathrin, Finja, and Leonie are Monika’s multiple personalities. When Monika confronted the psychologist, he refused to discuss the matter, saying it would violate therapist-client confidentiality, something he owed all his clients, including alter egos.

Source: <http://www.rd.com/home/stupid-criminals/>

Submitted by Charles L. Scott MD

Slate Announced

The slate of officers and councilors who will take office at the end of the Annual Meeting in October was announced at the Semiannual Business Meeting held May 6, 2012. No additional nominations were made and the nominations were closed as specified in the AAPL Bylaws. There will be a vote at the Annual Business Meeting Saturday, October 27, to elect the slate as presented.

Nominees are: President-elect: Robert Weinstock MD, Vice Presidents: Stuart Anfang MD and Kenneth Weiss MD; Secretary: Richard Frierson MD; Councilors: Elissa Benedek MD, James Knoll MD and Ryan Hall MD.

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Springfield Hospital Center in Sykesville, MD is accepting applications for a **Forensic Psychiatrist**. Eligible candidates must have board certification including added qualifications in forensic psychiatry (or equivalent). Duties include pretrial evaluations of competency to stand trial and criminal responsibility, competency restoration, and training of residents and students. Please forward a CV and inquiry to Erik Roskes, MD, Director, Forensic Services, Springfield Hospital Center, by fax (410.970.7105) or email (erik.roskes@maryland.gov).

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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.

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