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Asylum Evaluations in the Terrorism Era

Danielle Kushner MD, Human Rights Committee

The global refugee crisis has reached the highest level since World War II, primarily due to the ongoing Syrian conflict. According to United Nations High Commissioner for Refugees (UNHCR) by the end of 2015, 65.3 million individuals were forcibly displaced worldwide as a result of persecution, conflict, generalized violence, or human rights violations, 5.8 million more than the previous year. Of the total number of displaced persons in 2015, 21.3 million were refugees and 3.2 million were asylum seekers.[1]

Simultaneously, recent domestic terrorism incidents, such as the Orlando and San Bernardino attacks, have led to heightened concerns regarding radical Islamic terrorism developing in the United States. The fight against terrorism has inevitably impinged upon international human rights, demonstrated most recently by Trump's new Executive Order on Immigration.[2] Asylum seekers and refugees have become doubly victimized: persecuted at home and marginalized abroad, as they are increasingly unable to enter safe countries due to a variety of restrictive measures.

More individuals hold radical views than are willing to engage in violent action. The process of radicalization is multi-factorial. For example, research has shown that those vulnerable to its grasp may have personal insecurities, perceived injustices, psychological deficits, or a history of delinquency.[3] A study from Boston Children's Hospital regarding mental health of young Somali refugees in United States and Canada noted that moderate levels of trauma and discrimination are associated with support for both non-violent and violent activism, but personal and social factors determine which type is chosen by an individual. PTSD symptoms were associated with openness to illegal and violent activism, possibly due to cognitive and behavioral changes. They additionally noted a correlation between support for violent activism with social marginalization and time on the Internet. Meanwhile, post-traumatic growth and social bonds to both North American society and their Somali community were protective.[4]

How do heightened American immigration concerns affect the practice and role of the forensic consultant? Forensic psychiatrists can be involved in an asylum application by providing diagnostic information that may support an applicant's claims, along with how culture and mental health symptoms may relate to deficits in credibility or delays in an application.[5] With today's heightened concern about terrorists entering the country, forensic evaluations of asylum seekers will become more scrutinized and key evaluation topics of malingering and cultural issues will become even more crucial.

Research outlines three explanatory models for malingering in an evaluation context: pathogenic, criminologic, and adaptational. Pathogenic malingering describes an individual who has genuine psychopathology, but whose symptoms are not entirely consistent with the malingered diagnosis. The criminological model involves those with antisocial tenden-

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Asylum Evaluations

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cies for secondary gain, while in the adaptational model, the feigner is trying to increase his or her chances to succeed in adversarial circumstances.[6] One of the most prevalent diagnoses in asylum applications, PTSD, is particularly susceptible to malingering due to the high incidence of comorbid symptoms, fewer objective findings, and high incidence of secondary gain. Memory difficulty in trauma is another controversial topic, but research continues to grow regarding validity of memory in trauma. The dual representation model shows that involuntary memories, such as flashbacks or nightmares, occur spontaneously, while verbally accessible voluntary memories are more difficult to retrieve.[7] As with any challenging diagnosis, additional collateral of premorbid functioning, collateral reports, or testing data are important to help support the evaluator's opinion. Yet, for some asylum seekers, collateral information may be non-existent given cultural barriers for testing and little additional documentation or contacts.

Culture is another important topic to be addressed in asylum assessments, especially as some researchers have found DSM 5 diagnoses, such as PTSD, not cross-culturally valid. Consultants may also be asked to discuss cultural issues related to the applicant's behavior and treatment. Linguistic translation needs to be examined closely for euphemisms or mechanisms of collective avoidance. Yet, other researchers have argued that using cultural formulations in forensic psychiatry can emphasize stereotypes and stigmatization of ethnic groups.[5] Evaluators must remember their own objectivity especially in this heated political climate.

Traditional risk assessments for violence, such as the HCR-20 and SAVRY, are appropriate for psychiatric patients, but have not been found to be helpful for evaluating radicalization. Psychometric scales and assessment tools currently used

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"The More You Tighten Your Grip... The More Star Systems Will Slip Through Your Fingers"

Susan Hatters Friedman MD

Welcome to the April newsletter. This year has seen a lot of changes in our world. While working overseas, new immigration policies in the United States are the primary topic people have raised with me. I hear frequent tales of colleagues rebooking their international trips so as to avoid the potential to be detained at airports in our country. And I hear worries of American colleagues who are either not of European extraction or who have non-American accents—worries about leaving either to visit family internationally or to attend a conference, and if they will be allowed reentry.

If you happen to be following the titles of these editor columns, and you happen to be a *Star Wars* fan, you'll recognize an iconic, (and a favorite) Princess Leia line. That's because, reflecting on both the immigration ban and the recent sudden death of Carrie Fisher, one of the great celebrity mental health advocates, this line found itself foremost in my mind.

When she died, I was mid-way through listening to Carrie Fisher's reading of *The Princess Diarist* on audio-book— hearing about her teenaged affair with the dashing but married Harrison Ford. Additionally, a fortnight previously having attended the midnight premiere of *Rogue One,* her sudden death was particularly visceral. Playing a formidable woman saving the galaxy from evil by day, behind the scenes she struggled with mental illness and substances. From her unabashed discussions of living with bipolar disorder and addiction in both her writing and public speaking, to her urn shaped like a large Prozac pill (reportedly her favorite possession), nothing about Carrie Fisher was conventional. Despite the fraught relationships with her parents throughout her life, she emerged an outspoken, brave, and witty advocate for mental health. For many, she humanized mental illness and addiction in women, despite facing stigma herself. Her story, not just of Axis I disorders, but also of overcoming difficult developmental upbringing, often, yet unbidden, draws parallels to my female forensic patients struggling with the same trifecta and ending up in very different circumstances. Resilience and humor, food for thought.

I hope that you will find expanding knowledge while reading this issue of the *AAPL Newsletter*. Enjoy the timely articles from various committees about topics ranging from the Women's March on January 21st to transgender legal issues, to terrorism and asylum evaluations. Reading the vast range of committee articles, one cannot help but be reminded of important work that our AAPL committees are doing—on contemporary and critical issues. You will also consider primary prevention of criminal justice system involvement upon reading Dr. Norko's president column. This newsletter issue also features articles about addiction, a new and dangerous drug of abuse (kratom) and marijuana legalization. Discussions of other mental health law herein include updates on *Tarasoff*, the Goldwater rule (in the Fellows Corner), and the impacts of Sex Offender registries. Also, the Faces of AAPL, Ask the Experts, and Child Column present their, as usual, intriguing discussions.

The International Association of Law and Mental Health (IALMH) meeting is upcoming in Prague this summer, providing possibilities for cross-pollination of ideas, not only with others at the intersection of mental health and the law (forensic psychologists and attorneys) but also cross-pollination with our international counterparts. Looking forward to this, we will read about (and see photographic evidence of) the recent Asia-Pacific IALMH Chapter meeting. You will also find ideas for mentorship in research. An in-depth review of Neurolaw from AAPL's 2016 course and an update from AAPL's representative to the APA round out this issue. Hope to see you all at the APA Guttmacher Lecture next month!

AAPL Awards Committee Seeks Nominations for 2017

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

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

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

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

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

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

Please send your nominations to Jeffrey Metzner, MD, Chair of the Awards committee at **jeffrey.metzner@ucdenver.edu**.

Primary Prevention of Criminal Justice Involvment

Michael A. Norko MD, MAR

If we conceptualize criminal justice system involvement (CJSI) as an adverse condition for which individuals with serious mental illness (SMI) in the community are at some risk, then we can think of primary, secondary and tertiary preventive measures for CJSI among clients of public mental health care systems. Tertiary prevention aims to reduce the negative impact of established conditions by restoring function and reducing condition-related complications. Secondary prevention aims to diagnose and treat an existing condition in its early stages before it results in significant morbidity. Primary prevention aims to avoid the development of an adverse condition.

The Sequential Intercept Model[1] was developed as a way to conceptualize efforts to move people with SMI out of the cycle of CJSI by means of stages of interventions described as "filters" or intercepts. The five intercepts are: 1) law enforcement and emergency services; 2) post-arrest detention, initial hearings and pretrial services; 3) post-initial hearings: jail, courts, forensic evaluations and forensic commitments; 4) reentry from jails, state prisons, and forensic hospitalization; and 5) community corrections and community support services. An excellent review by Heilbrun and colleagues describes the literature on community alternatives at these various intercepts.[2] Many jurisdictions in the United States have utilized this model in designing interventions within partnerships between public mental health and judicial systems. A quick internet search on "sequential intercept mapping" will produce examples from all over the country of jurisdictions that have engaged this process.

The last four of the five intercepts all describe tertiary prevention; they include programs such as jail diversion; drug, mental health and community courts; assertive community treatment (ACT), intensive case management, and correctional re-entry; and special mental health probation or parole. The first intercept, which primarily involves the crisis intervention team (CIT) approach, can be considered secondary prevention.

The most important public health technology is, however, primary prevention. Munetz and Griffin referred to this as "the ultimate intercept" and described it as involving "best clinical practices" (Ref 1, p 545). It is also now referred to as Intercept Zero.[3] Munetz and Griffin thought that few people would be intercepted early because few communities are able to make these services available and easily accessible to those who need them.

My experience tells me that even with willing, well-intended, and active collaboration between mental health and criminal justice systems, and even with a well-developed public mental health system, too many people continue to experience most of the intercept stages. Nearly every week, people with SMI are admitted to our forensic hospital for restoration of competence to stand trial (CST) with low level misdemeanor charges on low bonds or a promise to appear. My colleagues in other states report that they have been seeing increases in CST evaluations and restoration admissions as well. Waiting lists and lawsuits are common struggles for forensic system directors. In response, more than a dozen states have already developed programs for CST restoration in jails, because they do not have the capacity in their hospitals to accommodate the influx of such individuals (including the Los Angeles program described in the January Newsletter[4]).

These individuals are often as frustrating to community clinicians as they are to the courts. Services are offered, medications supplied, substance treatment available and people continue to get arrested for manifestations of their mental illness and/or substance use disorders. Clinicians might be relieved that their patient was arrested, and at least relatively safe and abstinent for a while. Courts are relieved to send people to the forensic hospital for 60-90 days for restoration, so that the communities will have some respite from their troublesome behavior.

But this is not how we ought to spell relief.

We need to develop and teach different and better skills to our frontline community clinicians to equip them to be more successful at primary prevention. At the very least this will require 1) proper assessment of risk; 2) risk management to the extent that this is possible in a system of care; 3) effective treatment to reduce risk; and 4) ongoing training, supervision and consultation by forensic psychiatrists and psychologists.

Even these interventions, though, are not enough because they tend to assume that criminal behavior by individuals with SMI is a direct result of psychiatric symptoms and, if symptoms are well managed and basic needs are met, these individuals are unlikely to commit a criminal offense. However, extensive research has found that the same criminogenic factors that predict arrest for the average adult criminal also predict arrest for SMI adults.[5] Criminogenic factors refer to those personal factors that increase risk of criminal behavior, including antisocial behavior, personality, cognitions and associates.

Many offenders, SMI or otherwise, often have deficits in interpersonal skills and in cognitive skills (like problem solving, planning, and future thinking) that need to be addressed to promote prosocial behaviors. Thus, criminogenic needs are targets for intervention to prevent involvement (or further involvement) in criminal activity and can be employed in com-

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Sometimes Embracing Change

Jacquelyn T. Coleman, CAE

As forensic psychiatrists, you know the importance of using correct language.

I was brought up by a strict constructionist. My father allowed no slang in our house. Among the words he abhorred were "stupid," "meaningful," and "relevant." Yes, it was a long time ago.We had to express ourselves clearly and say what we meant. He put a Roget's Thesaurus in my hands when I was barely able to carry it.

So it's no accident that I view with alarm new words and expressions that creep into our language. However, I have gradually come around to the point of view that language is living and people can be very creative. I haven't given up on my belief that sloppy is sloppy and if you are going to invent a new expression, it should be "meaningful" and "relevant." Ooh, I am going to be punished for that!

What are the sources for new words and expressions? Washington is first on the list. Government relishes inventing new words, for obfuscation of course, but also for a way to be in the clique where only they know the code. The media, especially street reporters on local channels, do come up with the weirdest things, and they spread like wildfire. A third source is the so-called silicon valley, no longer a geographic entity. Having been forced to interact with many software and hardware designers over the years, I cannot say that they actually speak English, whereas I can usually understand what the Washington types and the media are trying to say. But I need to acknowledge that some of my favorite word columnists often point out that words we think are new were really used by Shakespeare and other famous writers a long time ago.

I am going to indulge in a few comments about my likes and dislike. This list is by no means complete.

Went missing. What happened to disappeared? On my bad list.

Slew: This is now an acceptable word in all major media. Why?

Massive: Everything is massive now, even if it has no mass.

Decimate: Don't even get me started.

Here is a sentence that recently gave me pause, and I do not mean in a good way: "We are going to use this presentation to homage…" OK, that one made me gag.

As such: This meaningless expression was given to us by Washingtonians. Yes, the term has been used for a long time, in the proper way, but it's not a short cut for telling us what you mean. If you have ever submitted to the Journal, you may have noted that you lost all your "as suches." The Managing Editor is allowed some privileges….

A fact (or is it a factoid): impact used to be a noun. I believe I was in on the creation of "impact" as a verb. Early in my career as a journalist, I interviewed the Governor of Vermont. He was the first person I ever heard say "we don't know how that is going to impact…"

I am not hopeless however. I can tolerate spoken expressions that are funny or in my judgement creative. I think the expression "own it" has a nuance that makes it an acceptable replacement for "it's your responsibility," but NOT if it's used in every sentence for everything, as if I can have any influence over that.

"I can't even" is kind of fun, especially when accompanied by a wide eye roll. Another one I like is "Is that even a thing?"

Speaking of constantly changing language, I am still struggling with "no matter" versus "no matter what." The "what" is losing its grip. When I analyze expressions such as "No matter the weather" I have a hard time justifying why the "what" was there in the first place, since the expression seems perfectly clear without it. This is a hard one for me and I haven't made up my mind.

I have been saving for last a relatively new expression that I just love – gaslighting. I know it has been around a while and is a recognized phenomenon, but in the current political climate it is really gaining ground.

According to Wikipedia, and yes, I know it's not Roget's Thesaurus, but I can lift it:

"Gaslighting is a form of manipulation that seeks to sow seeds of doubt in a targeted individual or members of a group, hoping to make targets question their own memory, perception, and sanity. Using persistent denial, misdirection, contradiction, and lying, it attempts to destabilize the target and delegitimize the target's belief…

"Instances may range from the denial by an abuser that previous abusive incidents ever occurred up to the staging of bizarre events by the abuser with the intention of disorienting the victim…

"The term originates in the systematic psychological manipulation of a victim by the main character in the 1938 stage play Gas Light, known as Angel Street in the United States, and the film adaptations released in 1940 and 1944. In the story, a husband attempts to convince his wife and others that she is insane by manipulating small elements of their environment and insisting that she is mistaken, remembering things incorrectly, or delusional when she points out these changes. The original title stems from the dimming of the gas lights in the house that happened when the husband was using the gas lights in the attic while searching for hidden treasure. The wife accurately notices the dimming lights and discusses the phenomenon, but the husband insists she just imagined a change in the level of illumination."

I'd love to hear your favorite and not-so-favorite words and expressions. You do not need to write to me

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The Tarasoff Pendulum Swings Back: Expansion of Washington State Psychiatrists' Duties to Protect Third Parties

Jeffrey S. Janofsky MD

In *Volk v. DeMeerleer*[1], in a 6-3 decision the Supreme Court of the State of Washington significantly expanded the duty of outpatient psychiatrists towards third parties whom their outpatients might harm, even if the outpatient made no threat to a specified potential victim. The APA's Committee on Judicial Action had helped draft an unsuccessful amicus brief written by the Washington State District Branch and other medical societies in support of limiting such a duty. This case essentially creates a strict liability standard for Washington State psychiatrists whose patients harm third parties

DeMeerleer had begun treatment with psychiatrist Dr. Howard Ashby in September 2001. At Dr. Ashby's initial evaluation he diagnosed DeMeerleer with bipolar disorder and prescribed Depakote. DeMeerleer provided a written list of bothersome experiences including "delusional and psychotic beliefs," as well as other beliefs indicating a lack of remorse for others. DeMeerleer's wife provided written documentation of DeMeerleer's dangerous rages as well as his dreams of going on killing sprees.

In 2003 DeMeerleer found out his wife was having an affair. She divorced him soon after. DeMeerleer reported suicidal ideations as well as homicidal thoughts towards his wife, but assured Dr. Ashby that he would not act on them, and he did not. DeMeerleer told Dr. Ashby about "revenge thoughts and fantasies," but did not report an identifiable victim. Dr. Ashby continued medication and psychotherapy.

In 2005 DeMeerleer began a new relationship with Rebecca Schiering, the mother of three sons. During that year DeMeerleer exhibited volatile behavior, and took firearms to the location of where his truck had been vandalized. DeMeerleer's family intervened, removed the guns from DeMeerleer's house and then informed Dr. Ashby the DeMeerleer's thoughts had "progressed from suicidal to homicidal."

DeMeerleer's relationship with Schiering progressed. In 2009 Schiering became pregnant with DeMeerleer's child. However during the pregnancy DeMeerleer lost his job and assaulted Schiering's nine year old autistic son. Schiering moved out and terminated the pregnancy. DeMeerleer contacted Dr. Ashby's clinic in "serious distress" and was referred to a community mental health clinic (the opinion does not make it clear whether DeMeerleer was in treatment with Dr. Ashby from 2005 until 2009, nor on what date DeMeerleer restarted treatment with Dr. Ashby.

In April 2010 DeMeerleer had his last visit with Dr. Ashby. According Dr. Ashby's note from that meeting:

> Jan indicates that his life is stable, he is reconstituting gradually with his fiance[e]. They are taking marriage classes, he can still cycle many weeks at a time. Right now he is in an expansive, hypomanic mood, but sleep is preserved. He has a bit more energy and on mental status, this shows through as he is a bit loquacious but logical, goal oriented and insight and judgment are intact. He states when depressed he can get intrusive suicidal ideation, not that he would act on it but it bothers him. At this point it's not a real clinical problem but we will keep an eye on it. Plan: We will continue Risperdal, Depakote and [bupropion].

Later DeMeerleer and Schiering mended their relationship when DeMeerleer's mental condition had improved. They ceased their relationship for good on July 16, 2010. There was no subsequent contact with Dr. Ashby.

On July 17, 2010 DeMeerleer entered the Schiering's home and killed Schiering and one of her sons. Another son escaped. DeMeerleer committed suicide.

Schiering's mother and surviving son sued Dr. Ashby, alleging failure to follow the standard of care. Ashby denied any failure of the standard of care and moved for summary judgment because DeMeerleer's behavior was not foreseeable, and because Dr. Ashby did not owe DeMeerleer's victims a duty of care. Ashby argued that there could be no foreseeability without actual threats by DeMeerleer towards the victims, and that no such threats had been made at any time during treatment. Ashby further argued that the only available actions that he might have taken were to seek civil commitment or warn any potential victims or the authorities of DeMeerleer's potential danger to others. Ashby claimed immunity for failure to hospitalize or to warn under a Washington State statute. Ashby filed supporting affidavits from DeMeerleer's family members and friends attesting that DeMeerleer had had no unusual behaviors and had made no threats around the time of the homicides/suicide. However Ashby did not provide an expert psychiatric report about the standard of care.

In response, the Plaintiffs argued that under *Petersen v. State*[2], once a special relationship existed between a mental health professional and his patient, the mental health professional owed a duty of reasonable care to any foreseeable victim of the patient. Plaintiffs argued that Dr. Ashby breached the duty owed by failing to perform a risk assessment on DeMeerleer and failing to provide

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The Tarasoff Pendulum

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intensive psychiatric treatment for DeMeerleer with more frequent clinic visits. Their theory was supported by an affidavit from a forensic psychiatrist, who also opined that Dr. Ashby's failures were a, "causal and substantial factor" in causing the harm to occur.

The trial court granted Dr. Ashby summary judgment, finding that there was no data indicating that DeMeerleer had made threats towards Schiering or her sons, and that therefore Ashby had no duty to warn Schiering.

Volk appealed to Washington's Appellate Court. Volk argued that Petersen did not require actual threats towards a specific victim before a duty could be imposed on a psychiatrist. Asbury argued in part that the Washington State legislature settled the public policy in 1987 when it adopted RCW 71.05.120(2) that limited the duty owed by mental health professionals to third parties only to those reasonably identifiable persons actually threatened by a patient. The Court of Appeals held that the legislative limits placed on the Petersen decision applied only when an involuntarily committed inpatient was released. The Appellate Court reversed the summary judgment opinion in part. Both sides appealed to the Washington State Supreme Court.

The Washington Psychiatric Association argued in their amicus brief to the Washington Supreme Court that the 1987 legislation should apply to both in both inpatient and outpatient settings, and that the broader duty imposed by the Court of Appeals, which created a strict liability standard, was both inconsistent with the legislative mandate of 1987 and contrary to common sense.

The Washington State Supreme Court ultimately held that under Petersen this is a medical negligence case and not a medical malpractice case under Washington law. The Court noted under medical malpractice the psychiatrist owes a duty to his patient and that Washington does not recognize a cause of action for medical malpractice without a physician patient relationship. The Supreme Court affirmed the trial court's summary judgment decision with regards to any claim of medical malpractice.

However the Supreme Court went on to explain that Washington law imposes an alternative duty, that of medical negligence, which occurs when there is a special relationship between the mental health professional and patient. Citing *Petersen, Tarasoff II*[3] and *Lipari v. Sears*[4], the Court explained that once a mental health professional and a patient establish a treatment relationship, either outpatient or inpatient, the professional "incurs[s] a duty to take reasonable precautions to protect *anyone* who might foreseeably be endangered by the patient's condition" [emphasis in original].[5] The Court noted that the psychiatrist is not necessarily required to control the patient's future actions, but was under a duty to "take reasonable precautions" to lessen the dangerous propensities of the patient. These precautions are to be informed by "professional mental health standards." The Court also noted that it explicitly rejected California's post *Tarasoff* approach that had limited that victims must be readily identifiable before liability can be imposed on treating psychiatrists.

Based on the facts of this case, as well as Dr. Ashby's concession that a special relationship existed between himself and DeMeerleer, the Court held that the special relationship requirements were met. Once the theoretical duty was found to exist, the question remained whether the injury was reasonably foreseeable and this is a question of fact to be decided by the jury. The Court held that the plaintiff's forensic psychiatrist's affidavit "created a genuine issue of material fact as to whether, based on the standards of the mental health profession, the harms experienced by Schiering and her family were foreseeable." The majority relied in part on a misreading of Douglas Mossman's paper, *The Imperfection of Protection through Detection and Intervention*.[6] The majority wrote that the paper stood for the ability of psychiatrists to accurately predict future violence. However Dr. Mossman actually wrote that while violence risk assessment had advanced since the *Tarasoff* decision, predictions about whether a specific patient would be violent or not in the future could not be made accurately, because of the low base rate of violence. The case was returned the trial court to resolve the medical negligence claim.

The dissent pointed out that *Petersen* was a case where psychiatrists had the ability to control their patient because the patient in *Petersen* had been involuntarily hospitalized, and that the psychiatrists in *Petersen* had an ability to exercise continued control of their inpatient. This was not the case here as DeMeerleer was never an inpatient under Asher's control. The dissent noted that the majority imposed duty on psychiatrists without regard for this "control principle" which was novel and incorrect under Washington State Law. The dissent further noted that the majority was essentially adopting new language from Sec. 41 of the Third Restatement of Torts that, rather than requiring a controlling relationship before imposing a duty to exercise control, explicitly state that control is not necessary in mental health contexts.[7] The dissent pointed out that this language has not been adopted by any State that has considered it.

There is no Federal issue here so current Washington Law now imposes what I believe is an unworkable strict liability duty on psychiatrists to somehow protect society in general from potential harm, even when no specific threat was made towards anyone. To correct this problem the Washington State Psychiatric Society could ask for a re-hearing, and failing that could lobby the legislature to pass another limiting statue, explicitly rejecting the holding in this case.

In Maryland, in response to such potential expansion of psychiatrists' duty to third parties, the Maryland Psychiatric Society successfully lobbied for legislation that created a duty

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Primary Prevention

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munity forensic mental health.[6] A recent encouraging development has been the creation of a forensic hospital version of START NOW (available in the public domain[7]) from Robert Trestman and colleagues at the University of Connecticut Health Center, in collaboration with members of the Forensic Division of the National Association of State Mental Health Program Directors (NASMHPD). START NOW uses a cognitive-behavioral and motivation interviewing-focused treatment approach to offenders with behavioral disorders and has demonstrated positive outcomes in several correctional studies.[8] The hope is that forensic clinicians in hospital settings will be interested in employing the program and conducting evaluation or research on its effectiveness with that population. START NOW has already been used with good effectiveness in Connecticut in a community program at the fifth intercept, involving specialty probation/parole, case management and clinical supports.[9]

What we need next is to develop the capacity to utilize the programs cited by Rotter & Carr and by Trestman with clients in the community who are not yet (or at least not currently) involved in the criminal justice system. I am encouraged by the current enthusiasm for collaboration among the AAPL committees devoted to community, hospital and correctional forensic practice. I am also encouraged at the potential for development of a forensic recovery committee within AAPL, under the leadership of Sandy Simpson.[10] I am particularly intrigued at the notion Simpson cites of the "moral agenda" of recovery for forensic patients – learning to live better so as not to re-offend.[11]

Perhaps members of these committees can continue to help develop programs and training for public mental health systems to encourage primary prevention of CJSI. This is an area ripe for AAPL members' leadership in education and implementation, with the potential for tremendous public health advances in the mental health and justice systems.

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Sometimes

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to point out that many of the words I used in this article, not the highlighted ones, were once new and different.

Finally, many thanks to the printer of the Newsletter, whom I know is going crazy with all my quotes and ellipses.

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to third parties under very limited circumstances, gave explicit instructions on how to discharge that duty, and created immunity for mental health professionals who act in good faith.[8] California[9] and Nebraska[10] have adopted similar limiting statutes and Washington State could do the same.

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Ask the Experts 2017

Neil S. Kaye, MD, DFAPA
Graham Glancy, MBChB, FRCPsych, FRCP(C)

Neil S. Kaye, MD, DFAPA and Graham Glancy, MB, ChB, FRC Psych, FRCP (C), 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.

Q. Recently I started doing Compensation & Pension Exams evaluations for Veterans. I'm finding the material grueling. How do I manage this?

A. Kaye: There is no doubt that forensic work can frequently entail emotionally disturbing and draining material. In many ways, this is not unlike clinical work. One difference is that in the clinical setting, dealing with transference and countertransference is often part of the therapeutic process and so it is often acknowledged and addressed. This is perhaps less commonly confronted in the forensic world.

I think it is important for every forensic psychiatrist to be aware of her/his own sensitive areas, blind spots, biases, and Achilles' heels. As an example, if you are against the death penalty, don't do capital cases. If you are emotionally vulnerable to child issues, you shouldn't do sexual abuse cases. I highly recommend screening cases before you sign on to make sure you can stomach the material that may be presented. It is always better to turn down a case with which you are not comfortable than to try to get through it while being avoidant.

That being said, I also hope that each and every one of us is affected by the stories we hear from evaluees regarding their trauma. To fail in this endeavor would be inhuman and impede our goal of truly hearing what is being expressed during the evaluation. Empathic listening does have a role in forensic psychiatry, so long as it is not used inappropriately to disarm an evaluee in the effort of obtaining information that would not otherwise be shared.

The role of consultation with a colleague to help manage the emotions stirred up by a specific case can be invaluable. Supervision has been part of our educational foundation and is integral to our learning and growth as psychiatrists and as forensic scientists. Discussion with a colleague about your feelings can help you emotionally; it can also help you to see the case in a more objective and impartial light.

A. Glancy: If a forensic psychiatrist as eminent and experienced as former President of AAPL, Dr John Bradford, acknowledges experiencing secondary trauma, rest assured you are not alone. Dr Bradford has gone public and lectured on this topic to forensic psychiatrists and other professionals. What you mention is the *forme fruste* of secondary trauma, the first sign of this syndrome. Professor Cheryl Regehr has researched this topic in emergency services personnel and has found that 20-50% of these workers suffer from secondary trauma. It arises when repeatedly working with clients who discuss traumatic events, when the worker is responsible for serious outcomes, and often when the worker is under stress and working alone. Repeated exposure to traumatic material, the dosage model, or expressing forensic empathy, contributes to symptoms. Often old scars are opened by new material. This is especially the case when other things in one's life contribute to stress and anxiety. One aspect that may be particularly important for forensic psychiatrists is the viewing of pornography in photographic or particularly in video form. In the case of John Bradford, he was involved in a particularly gruesome serial murder case, where the victims were video recorded, and 15 years later he was involved in two cases that involved video evidence in quick succession.

The consequences can range from the full range of posttraumatic symptoms to burnout. Forensic psychiatrists tend to work in isolation and assess case after case. They may well be particularly at risk of developing these syndromes. As well as the well-known symptoms above, this can lead to a change in one's worldview, and also to cynicism and lack of caring, which are likely protective mechanisms.

One particularly interesting aspect arises in child pornography cases. We discussed this issue amongst our colleagues in Toronto, in our Journal Club. One psychiatrist, Dr Jeffrey McMaster, was asked to view a video of the kidnapping and sexual assault of a young girl. He raised his reluctance to view the video with his colleagues, and we all agreed that viewing the video would not further his understanding of the client or his risk assessment. He, therefore, wrote a letter to the retaining counsel who presented this to the judge. The judge was indignant, making the point that he had to view the video, why shouldn't the forensic psychiatrist. Dr McMaster replied that it was repeated exposure to this material, which is common for forensic psychiatrists who do these types of cases all the time, that could make one vulnerable to secondary trauma.

Regarding self-care, it is important to try and be aware of the stresses on ourselves. It is also important to have a support network, or supervi-

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Kindertransport: Southern Italian Style

Stephen P. Herman, MD, LFAPA, DFAACAP

Reggio Calabria sits on the edge of Italy's "boot," the Strait of Messina separating it from Sicily. The region has a 3,500-year history, first inhabited by Phoenicians, Trojans, Mycenaeans, and other peoples. It was an extremely important region when under Greek rule. Under the Romans, it was called "Rhegium Julium," a noble city. At different times, it was ruled by the Byzantines, Arabs, Spanish, Turkish Ottomans, and Napoleon and was overrun by Barbary pirates, who enslaved its inhabitants in Tripoli. Earthquake-prone, the region was destroyed several times throughout its history and was victim of a deadly British air raid during World War II. It has a Mediterranean climate and is famous for its oranges, gardens promenades and . . . the "Ndrangheta", the local Mafia. And therein lies our story.

The "Ndrangheta" (pronounced n-DRAHN-ghe-ta) specializes in a multitude of crimes, from selling "protection," to shops and other businesses, to drug-dealing and infiltrating every aspect of government. According to an article in *The New York Times* (Feb. 10, 2017), 11-year-old children are lookouts during murders, witness drug deals, attend mob "brainstorming" sessions and are trained in using Kalashnikov assault rifles.

What could be done? Magistrate Roberto Di Bella had an idea some have considered brilliant, and others Nazi-like. Why not remove these vulnerable children from their culture and allow them to grow up to be decent, law-abiding citizens? The Magistrate said, "Sons follow their fathers, but the state can't allow that children are educated to become criminals." Minors are removed after committing such crimes as gang violence or fire-setting. Some are even novice Mafia members.

Since 2012, he has removed over 40 children from their families, with only about 25% transported with their mothers. The rest are placed in foster care. According to Di Bella, none of those children has committed a crime. Now, the Italian Justice Ministry has applied this proposal to all of Italy! Authorities must prove that the children are at risk for psychological and physical harm by their criminal families.

The radical proposal has been praised and damned. Even the Magistrate has been ambivalent at times, but reported mob fathers have thanked him. One father expressed his gratitude for giving his children "[a chance] to live in a taintless environment and to live in legality." He continued, "I am proud to grant my children a different future."

The "Ndrangheta" is one of the world's most successful criminal enterprises. It spans most of Italy and its claws extend to South America and Australia. In Italy, young adolescents receive many gifts for their participation and are encouraged to spend more time with the mob than on their education. Thus, Italian authorities have argued, the children need to be forcibly removed from this environment. Otherwise, they will end up like their lost comrades, imprisoned for convictions ranging from minor offenses to murder.

This policy has been both attacked and defended by Italian mental health professionals and others. Psychologists and social workers are tapped to help these children recover from the trauma of being removed from their families and to allow them a "normal" childhood. When they are 18, these young adults are free to choose where they want to live – even if it is back in Reggio Calabria.

Mr. Di Bella has asked for government funding to hire more specialists to help with the project, now very popular with the Department of Juvenile Justice at Italy's Ministry of Justice. It is assumed – without scientific, valid research - that the program is a success. There are only anecdotal reports that some of the children do very well, that is, they apparently do not turn to a life of crime, like their fathers.

Critics argue the answer is not to remove the children but to improve mental health services and socioeconomic conditions in this very poor region. For example, out of 83 towns, only two have a social worker.

Most of us in this country, I surmise, would find this undertaking appalling. It brings to mind the infamous decision by Supreme Court Justice Oliver Wendell Holmes, Jr., in *Buck v. Bell* (274 U.S. 200 (1927), as cited in *Imbeciles: The Supreme Court, American Eugenics, and the Sterilization of Carrie Buck*, by Adam Cohen.

Buck was the victim of the test of the legality of Virginia's Eugenical Sterilization Act of 1924. Her mother and daughter were also diagnosed as "imbeciles." Bell was the superintendent of the Virginia Colony for the Epileptic and Feebleminded, in Lynchburg. Opened in 1910, it was the largest asylum in the United States.

The case moved up the judicial ladder, reaching the U.S. Supreme Court. On May 2, 1927, the Court upheld the Virginia law, 8 to 1. Justice Holmes wrote: "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind." He concluded with, "Three generations of imbeciles are enough."

Carrie Buck was forcibly sterilized four and a half months later.

The Nazis became fascinated with the American pseudoscience of eugenics, and the rest is history.

Is this comparison to the Italian plan too outrageous? It is not. When the State becomes involved in the private lives of families, the question is who determines how much and how long? In the U.S., we empower child protective services to remove children from their home if they are abused or

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Forensic Psychiatrists' Roles in Horror Films

By Susan Hatters Friedman, MD, Fernando Espi Forcen, MD, PhD, J.P. Shand, MD, and Praveen Kambam, MD

Serial killers, "homicidal maniacs," stalkers, the demonically possessed, Frankenstein and zombies are but a few of the characters that cause us terror; however, all of these characters have something in common: an abnormal (or "Abbey Normal" – from Young Frankenstein) brain. Losing control of our thoughts and behaviors is one of our ultimate fears. As such, its embodiment has become a staple in the horror film genre. To rival such abnormal brains, we must have the heroes who can render their power impotent – enter the forensic psychiatrists.

Movie portrayals of forensic psychiatrists have been categorized as: Dr. Evil, The Professor, The Activist, The Hired Gun, and the Jack of All Trades.[1] Dr. Evil uses his intellect and psychological knowledge to harm others. Although the prototype Dr. Evil is Dr. Hannibal Lecter from *Silence of the Lambs*, many earlier characters fall into this category. In the 1920 *Cabinet of Dr. Caligari*, the titular Dr. Caligari himself is an asylum director who is murderous by proxy.[2,3] In the 1933 *Testament of Dr. Mabuse*, the so-called psychiatrist is a hypnotist who uses his powers to commit crimes and later goes "insane." Even in more recent films, we can see Dr. Evil characters, such as *Shutter Island*'s Dr. Cawley (played by Ben Kingsley), a forensic psychiatrist at the Ashecliffe Hospital for the Criminally Insane.[1]

In contrast, the Professor is portrayed as an omniscient expert, who may behave condescendingly or use junk science to explain human behavior. In Alfred Hitchcock's classic *Psycho*, the forensic psychiatrist Dr. Fred Richmond gives a lengthy explanation of Norman Bates' "mother" overtaking Norman's personality as a dissociative reaction and an explanation for his murderous behavior. This use of Dr. Richmond's (fictional) expertise puts him in the realm of The Professor.[1]

Turning to the category of The Activist, here the forensic psychiatrist inappropriately uses a forensic case to advance what he or she personally sees as justice. The Hired Gun offers to sell his or her opinion to the highest bidder, while the Jack of All Trades, like *Alex Cross,* engages in practices way outside the scope of a real-life forensic psychiatrist.

Halloween (1978) is the story of Michael Myers, who after killing his sister when he was age 6, is held in a forensic psychiatric facility for decades thereafter. Myers is in the care of Dr. Loomis, a psychiatrist who in the end saves the day…by hunting and eventually shooting his patient. This forensic psychiatrist who also serves the role of hero, detective and marksman is a fine example of a Jack of All Trades.

Following the success of *Halloween*, a number of similar "psycho-killer" horror films were released. In these films, sexually active teenagers are gruesomely slaughtered by a masked murderer. In *Friday the 13th,* the hockey masked and machete wielding villain kills sexually active teenagers.

Wes Craven's *A Nightmare on Elm Street* also tells the story of a group of teenagers who have nightmares about a sexually violent predator who is a burn victim turned "homicidal maniac" named Freddy Krueger. This "psycho-killer" has the special ability to turn dreams into murderous reality.[4] In a sequel, *Dream Warriors* (1987), Dr. Neil Gordon is a child and adolescent psychiatrist who takes care of the last survivors of Elm Street at the Westin Hills Asylum. Dr. Gordon is the only one to identify the commonality of all the adolescent inmates: nightmares about Freddy Krueger. In this film, a nun appears in a dream-like fashion to the psychiatrist. This nun turns out to be Amanda Krueger, the mother of Freddy Kruger who was raped by 1000 psychopaths resulting in the evil spawn. This juxtaposition of good and evil is again exaggerating the idea of this black and white duality. This splitting of good and evil psychiatrists is also what we often see in the character of forensic psychiatrists – either all good or all bad.

Horror films may also be used to chastise psychiatrists. In the 2003 film *Gothika,* Halle Berry plays Dr. Miranda Grey, who works at a psychiatric hospital. Dr. Grey becomes possessed and requires inpatient treatment by her former colleague Dr. Graham. Dr. Grey's husband (who is secretly a serial rapist) is viciously murdered, leaving Dr. Grey as the prime suspect. While hospitalized, Dr. Grey befriends a former patient who claimed she had been raped at night. Dr. Grey learns the rapes—ignored by the psychiatrists as imagined claims of patients with mental illness—were real. Psychiatry gets schooled. And all along, the real problem (the raping husband) was in the psychiatrist's own home, exploiting public fears about psychiatrists.

Overall, many forensic psychiatrists are portrayed negatively in horror films. We find Dr. Evil and The Professor lecturing about dissociative

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Joseph Penn, MD

Philip J. Candilis, MD

AAPL's new representative to the National Commission on Correctional Health Care (NCCHC) is a former Rappeport Fellow who was inspired to join AAPL by long-time Ethics Committee chair Philip Merideth. Joe Penn himself has served on the Rappeport selection committee at Meredith's encouragement.

Born in Austin and growing up near San Antonio, Dr. Penn completed medical school at the University of Texas Medical Branch (UTMB). International childhood OCD expert and mentor "Henrietta Leonard identified 'forensics' as a career opportunity for me; and I wanted to improve my child forensic expertise, explore child custody and parental rights. She was the one who nominated me for the Rappeport fellowship. Phil [Merideth] took it from there," Penn recalls. "Phil offered me basic organizational advice, fellowship information, deadline alerts, and persistent encouragement." Then the fellowship at Yale beckoned.

"After I had done adult and child training," Penn continues, "I was ready for a real job, with my two toddlers. My wife encouraged us to go back to Texas." A faculty position opened up at Brown, heading the development of child and adolescent forensics and juvenile corrections. After practicing for ten years in juvenile corrections, Joe assumed the role of mental health director for the UTMB CMC, a medical school-university partnership providing health care to incarcerated adults in Texas and in its expansive juvenile corrections system. It is the largest state correctional system in the US, with 150,000 inmates, 108 facilities, two specialty 550-bed inpatient psychiatric prison units, several women's facilities, two units for those diagnosed with intellectual disabilities, substance abuse programs, and its historic death row. "Constitutional-level health care is provided onsite and via telemedicine to offenders statewide and across the lifespan," Joe says; "to juveniles sentenced as adults, pregnant women, offenders with medical conditions (e.g., requiring dialysis), sex offenders, and those with geriatric and neurocognitive disorders."

"Forensics helps us understand roles," Penn says, "allowing us to see inmates as patients not just offenders. It is a vulnerable population with a constitutional right to health care." His challenge, he asserts, is getting inmates what they need, not simply what they want.

> *"Forensics helps us understand roles," Penn says, "allowing us to see inmates as patients not just offenders."*

Dr. Penn works proactively to recruit and retain psychiatric staff, set up multidisciplinary policies and procedures, teach at the medical school, improve statewide telemedicine and EMR, and utilize CQI and Lean Six Sigma processes to improve health care delivery to the prison system. Because Joe's mother is from Mexico, Spanish is his first language. Family still resides in the old country. Because the DOC and UTMB are both ethnically diverse, he is clear that the system values his cultural upbringing and sensitivity to the community and its incarcerated population.

Joe identifies a number of areas for AAPL and NCCHC to address in the near future. The focus is not simply the disturbing reality that prisons have become the nation's default mental health treatment centers. Restrictive housing, gender dysphoria, HIV, Hep C, offenders with serious mental illness, and an aging inmate population provide growing challenges. "If we don't maintain standards," he says, "poor outcomes and lawsuits will follow. We need system-knowledgeable professionals who know the local community for the best results. For all of us, there is a fine line between good constitutional care and care that doesn't break the bank." As an examiner for the ABPN and principal author of AACAP's juvenile corrections guideline, Joe brings an academic as well as administrative perspective to that tension.

Joe is most proud of his two sons, both currently in college. Oliver, a senior, is a recording artist, singer and song-writer based in Providence. Elliot studies history and archeology at Maine's Colby College. He is an avid fisherman and Civil War re-enactor. Joe himself challenges them to competitive tennis matches, and subjects his family to his aspirations as a "wannabe DJ." The home playlist is apparently a bone of contention.

After ten years as AACAP's representative to NCCHC, and more recent chairman of its board, Joe's broad experience and training make him the ideal AAPL ambassador to corrections. The Newsletter wishes him well in his challenging mission.

Kindertransport

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neglected, but then there is court oversight of that removal, and, in most states, attempts at reunification. Children are not automatically removed because of their parents' political beliefs or criminal behavior, as long as they are safe and well-cared for. Sons and daughters of prisoners often visit their fathers and this is not *ipso facto* considered a bad influence upon them.

In Italy, alleged mob fathers are not necessarily convicted before their children are removed. The decision is made by judges. There seems to be a presumption that removal will assure their psychological safety, when in fact, it may cause irreparable damage. Would such a draconian plan ever be instituted in this country? Let's hope not.

Terrorism: Uncommonly Common? Awareness, Approaches & Theories

Kavita Khajuria, MD

In 2016, the Globe and Mail displayed a tidy timeline of disturbingly frequent terrorist attacks. A dozen attacks had occurred in less than a month. It ranged from the Orlando attacks by a lone gunman, followed by multiple suicide attacks elsewhere, then by a shootout, stabbings and standoff in Bangladesh, followed by a series of suicide bomber attacks in other countries. What could possibly motivate one to conduct such activity and sacrifice one's life?

Despite the increased frequency of terrorist attacks over recent past years, terrorism is not new.

In fact, the history of terrorism is as old as that of mankind.[1]

It is difficult to precisely define terrorism, given its complexity. It originates from the Latin term **terrere,** which means to frighten.[2] Definitions include "Violence or the threat of violence against noncombatants or property in order to gain a political, ideological, or religious goal through fear and intimidation"[1], or, "Acts of violence intentionally perpetrated on civilians with the goal of furthering some ideological, religious, or political objective"[3]

Theories

A number of theories attempt to explain terrorism, and range from early abuse and hostility towards one's parents, to frustration and aggression, low serotonin levels, an inability to generate nonaggressive solutions to conflicts, and a perceptual hypersensitivity to interpersonal cues.

Motives, Ideology and Pathways to Radicalization

The need for identity, belonging, and a sense of perceived injustice are prevalent factors.

An overwhelmed adolescent may seek to define his/her identity through group membership. A quest for personal meaning may push an individual to adopt a role without consideration.[3] Frustrated, rejected youths may be particularly vulnerable to joining a substitute family.

Not all agree with this. Another expert found that some tend to be well educated, from middle or upper class professional backgrounds, married, and with children.[2]

Many believe they have been victimized by state authorities and thus seek revenge.[2] The initial attraction is often to the group, rather than an abstract ideology.[3] Many recruits live in foreign countries in cultural isolation. Group relations and eventual solidarity can create a situation where one may follow another's commitment to terrorism.[2] Some believe that modern communication has brought disrespectful foreign influences, and that their religious commitment justifies their extreme actions.[2]

Most involvement results from gradual exposure and socialization towards extreme behavior which occurs in stages (i.e. Stage 1: It's not right; Stage 2: It's not fair; Stage 3: It's your fault; Stage 4: You're evil.)[3] An initial sense of dissatisfaction then breeds resentment which eventually finds a target onto which to direct the frustration.

Suicide Attacks

Suicide attacks have increased and the attackers view their act as martyrdom. Families and communities may see the act as heroic and support the behavior.[3]

Suicide attackers tend to display a heightened sense of purpose, group allegiance, and task focus.[2]

Relation to Mental Illness

Mental health experts have long tried to explain deviant behavior.

In reality, psychopathology has proven to be only a modest risk factor for general violence, and all but irrelevant to understanding terrorism.[3] Suicide bombers exhibit few signs of the mental problems such as depression that are typically found in people who choose to take their own life.[2]

It is also difficult to study the prevalence of psychopathology in terrorists, as the only persons accessible would include those captured or referred for an evaluation.

Research has been fairly consistent in finding that serious psychopathology or mental illness among terrorists is relatively rare, and not a major factor in understanding or predicting terrorist behavior. Scholarly reviews by experts indicate that terrorists are not pathological, rather, their evidence suggests terrorist "normality", and that violence is perpetrated by rational people with valid motives.[3]

Martens (2004) notes that not all terrorists have ASPD, yet individuals who become terrorists and persons with ASPD share certain characteristics. These include social alienation, disturbed early socialization processes, action-oriented stimulus hunger, narcissistic attitudes, early damage to self-esteem, defensive attitudes, shame, fear of dependency, omnipotent denial, escalatory events, particularly confrontation with police, intolerance of criticism, arrogance, disdain, superiority, justification of their violent behavior, and moral disengagement by dehumanizing victims.[3] Core deficits in psychopaths would likely impair their effective functioning in a terrorist role. Terrorism, like any other serious undertaking, requires dedication, perseverance, and a selflessness, many qualities of which are lacking in the psychopath.[3]

Personality Abnormalities & Profiling

"The outstanding common characteristic of terrorists is their normality"[1] and "Most terrorists are 'normal' in the sense of not suffering from psychotic disorders".[1] There is no terrorist personality, nor is there any accurate profile. Despite the lack of significant psychopathology in the perpetrators, the psychological effects are far reaching, thus attempts to understand and address this phenomena will likely continue.

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The Goldwater Rule: The Tide Is Rising

Matthew P. Lahaie, MD, JD

On January 28th, 2017, US News & World Report quoted psychologist John D. Gartner's professional opinion that President Donald Trump has "malignant narcissism," an incurable condition different from narcissistic personality disorder. Dr. Gartner stated that although he had not personally examined the president, he had made this diagnosis by deriving his conclusions from observed behavior. Although he recognized the ethical standard of the Goldwater Rule, Gartner stated the case of the president warranted a departure from it.

This episode is the most recent in a season littered with mental health professionals making statements about political figures' mental health. With so many of our colleagues having recently proffered professional opinions publicly, has the Goldwater Rule lost its relevance?

The Goldwater Rule originated from the 1964 presidential election, when *Fact* magazine surveyed over 12,000 psychiatrists about GOP candidate Senator Barry Goldwater's psychological fitness for the presidency. While some psychiatrists protested that a response would be unethical and others offered nuanced political views without psychiatric opinions, over 1,100 respondents indicated that Goldwater was unfit to serve as president. Some claimed Goldwater had severe personality defects, including paranoia and grandiosity. Others opined that he had a psychosis or that he was striving to prove his "manliness." Although the American Psychiatric Association (APA) had no relevant formal policy in place at the time of the survey, it objected to the publication of the survey. Despite the APA's opposition, *Fact* magazine published the article. An upset Senator Goldwater subsequently sued the magazine's publisher for libel, ultimately winning $75,000 in damages.

In response, the APA in 1973 adopted Section 7.3 in the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, which states:

> On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.

Yet, many psychiatrists and psychologists have offered diagnoses and psychological profiles of public figures, both past and present. Those discussed have included past American presidents, such as Lincoln, Johnson, Nixon, and Clinton. More recently, psychologist William Doherty at the University of Minnesota in June 2016 posted an online manifesto to oppose the president's election, which was signed by many mental health professionals. Psychiatrists Dr. Steven Buser and Dr. Leonard Cruz published their book "A Clear and Present Danger: Narcissism in the Era of Donald Trump," which they argued did not offer any specific diagnoses, but rather discussed the traits of the president's projected image. Given the public discourse, Dr. Maria A. Oquendo, President of the APA, in August 2016 published a reminder to the field that "breaking the Goldwater Rule is irresponsible, potentially stigmatizing, and definitely unethical."

Proponents of the Goldwater rule argue that it continues to serve important interests. Namely, it prevents the direct impact on a non-consenting individual of a publicly made diagnosis. The rule prevents diagnoses that are inaccurate or without sufficient basis, as these diagnoses may be made without conducting an evaluation and typically are based solely on information in the public domain. Further, professional discussion of public figures' mental health may erode the public's expectation of confidentiality and confidence in psychiatry as a field. Such diagnoses may further stigmatize mental illness and discourage individuals with mental health issues from fully participating in civic and political life. By avoiding making such diagnoses, practitioners avoid the pitfalls of parsing their political and professional views.

Advocates of reconsidering the rule argue that ethical principles may conflict, such as the interest in public service and education versus respect for a public figure, and in some circumstances the "duty to warn" may override other considerations. Rather than diagnose the "whole person," assessments may be limited to the public persona and public behaviors of an individual. Given the modern media's abundance of primary sourced information, the public domain may offer sufficient information to draw reasonable conclusions about an individual's public persona. Direct evaluation may not be necessary in many circumstances. Finally, advocates for reconsideration note that psychiatrists, like others, should be able to participate in civic and political life, and that commenting on the strengths and weaknesses of a public persona may be a part of this.

Psychiatrists and psychologists as citizens have the right to comment on elections and candidates, while avoiding statements regarding diagnostic impressions. But does the Goldwater Rule leave us with enough guidance? Is it fatally flawed? Are other existing ethical tenets sufficient? Should we dispense with the rule as our col-

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Asia Pacific IALMH

Jagannathan Srinivasaraghavan, MD

The first Asia Pacific conference of the International Academy of Law & Mental Health (IALMH) was held in Bangalore, India from December 15-17 2016. There were 46 presentations spread over three days of the conference. The first day was devoted to continuing medical education program for psychiatrists, psychologists, social workers and other mental health professionals. Appropriately the first day the meeting was held at the MVJ Medical College. The next two days of the meeting was held at the National Institute of Mental Health and Neurosciences, a premier institution in India. There were 584 delegates mainly from India and there were some from Vietnam, United States, Ireland, Canada and Australia. The conference was organized by Dr. Gopalakrishnan and his colleagues who excelled in their hospitality and taking care of the international speakers.

The conference was inaugurated by Honorable Justice Gopala Gowda, Retired Judge of Supreme Court of India. In his inaugural address, he traced mental health legislation since 1912 until the recent Mental Health Act and stressed the importance of human rights of the mentally ill. The co-sponsors of this conference namely, The World Psychiatric Association (WPA) represented by Prof T.V. Asokan (Zonal representative), The Indian Psychiatric Society (IPS) represented by Prof G. Prasad Rao, The World Association for Psychosocial Rehabilitation (WAPR) represented by Prof T. Murali, National Institute of Mental Health and Neuro Sciences (NIMHANS) represented by Prof. S.K. Chadurvedi (Dean) and The Indian Psychiatric Society, Karnataka Chapter, represented by Dr. Mahesh Gowda, were present and offered felicitations. I was humbled by the honor of a silk shawl and a Maharaja turban (headgear) for representing the IALMH and arranging all international speakers for the conference. A special supplement of the Indian Journal of Psychiatry indexed with PubMed and covered in Science Citation Reports (JCR) and Theme-Forensic Psychiatry Update was released by Prof. Phillip J. Resnick at the inaugural session.

AAPL was well represented among the speakers. Professor Resnick delivered two lectures, one on training in forensic psychiatry and another on child homicides by parents, Steven K. Hoge presented on competence to stand trial, Charles Scott on malingering (video), Navneet Sidhu on death penalty, Manish Pozdar on neuroscience and forensic psychiatry, Angeline Stanislaus on risk assessment in sex offenders and Jagannathan Srinivasaraghavan on boundary violations. Further US-based Anand Pandurangi and Antony Fernandez (AAPL member) who were alumni of NIMHANS also presented. In fact, presentations by AAPL members brought a lively discussion about the possibility of starting a Fellowship in Forensic Psychiatry (In India it is mentioned as super specialty).

Brendan Kelly of Ireland talked about mental illness and human rights. Julian Gojer of Canada presented on neuropsychiatry of sex offenders. There were excellent presentations by Indian psychiatrists, psychologists, lawyers, journalists as well as other stake-holders. The five member Vietnam delegation gave a brief overview of the mental health laws and services in Vietnam. Trainees had ample opportunities to interact with the speakers. One evening there was fabulous fusion music of classical Indian instruments and keyboard describing a bipolar patient in a musical depiction followed by dinner.

The valedictory session at the conclusion was presided by a High Court judge and the speakers included the Health Minister of Karnataka. There was a lot of interest expressed about further developing this field as well as forming an interest group. The conference was covered in press and a YouTube video is also made. The organizers Drs. Gopalakrishnan, Chandrasekar, Sudhakar and the postgraduate students deserve a lot of credit and if forensic psychiatry becomes a specialty course in India, AAPL can be proud to have played a significant role.

Traditional honoring of Dr. Van

Anand Pandurangi, Ashok Van, Phil and Lois Resnick (photos submitted by Dr. Van)

Ethics at the Women's March

Philip Candilis, MD, Navneet Sidhu, MD, Ethics Committee

As we return from the Women's March on Washington, we reflect on the state of feminism in our community and our profession. Among the rolling cheers, festive atmosphere, and colorful signs were issues from across the country and across constituencies. Groups from Alaska, Maine, Florida, Ohio and elsewhere represented university women, human rights advocates, social workers, psychoanalysts, and physicians. Republicans and prolifers attended alongside Planned Parenthood and the National Organization for Women (NOW).

A sense of humor was evident in the seriousness of the day: Dumbledore's Army had a presence, as did a "congregation" citing Fallopians 1:2. One man walked quietly carrying a sign proclaiming simply, "My wife is pissed." But it was a theme from the dais and NOW that caught our attention most of all.

Trans advocate Janet Mock spoke to the crowd of an intersectional movement that included persons from all sectors of society – even those who are not oppressed by societal mores. Those unaffected by aggressive political trends can still fall victim to a kind of rigid thinking that perpetuates inequality and social injustice, she said.

"It was important to recognize that discrimination intersected the lives of many people..."

At the same time, NOW brought signs saying only, "intersectional feminism." In the crowd, a professor from Florida spoke with us about what that meant.

Intersectionality is about more than a single group's identity or politics; it moves beyond gender and individual rights. This inclusiveness recognizes oppression wherever it exists, whether among persons with disabilities, persons of color, or any non-dominant group mistreated in court or in legislation. However, it also advances the classic dominant-nondominant distinction to a language of humanity in general – toward an understanding of inequality that covers all those who are or may become marginalized. Because we forensic practitioners work consistently with marginalized and stigmatized groups, intersectionality should resonate strongly for us.

Coined by law professor Kimberle Crenshaw in 1989, the term "intersectionality" was an effort, in her words, "to make feminism, anti-racist activism, and anti-discrimination law do what I thought they should — highlight the multiple avenues through which racial and gender oppression were experienced so that the problems would be easier to discuss and understand" (*The Washington Post*, Sept. 24, 2015). It was important to recognize that discrimination intersected the lives of many people, particularly because even social movements could leave some groups behind.

This is an approach that has been evident in forensic psychiatry since Ezra Griffith's cultural formulation provided a more inclusive view of our professional mission. Although the view of dominant and non-dominant groups may ultimately give way to the importance of perspective in general, it is this broad inclusiveness that moves our field toward a more unified professional vision.

Recognizable in AAPL President Michael Norko's search for truth, in Alec Buchanan's work on human rights in forensic practice, or in Rick Martinez' and my claim that we serve social justice rather than justice alone, intersectionality again aligns us with movements that are apparent on the world stage. If human rights and truth weren't quite concrete enough to unify our professional mission before, perhaps intersectionality at marches across the globe provides a goal that is both tangible and topical.

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Sex Offender Registration Requirements

Megan Testa, MD

As a forensic psychiatrist who provides outpatient psychiatric care to people with mental illness who are on probation and parole, I care for many individuals who are required by law to register as sex offenders. When I sit with my patients and hear about the effects that the stigma of sex offender designation has had on them as they have been working to put together lives for themselves in their communities after release from jail or prison, I often wonder about the fairness of the current system that requires automatic classification of individuals convicted of "sexually oriented offenses" as sex offenders.

In 2015 the Ohio Supreme Court became the first state Supreme Court to consider whether their state's sex offender registry violated an individual's constitutional rights by violating the Eighth Amendment's protection against cruel and unusual punishment.

Travis Blankenship was a 21-year old man when he began chatting over social media with a 15-year-old girl. After developing a relationship online, Blankenship met the girl in person and engaged in consensual sexual intercourse on two occasions. He was fully aware of her age at the time of the acts, and legal charges followed. Blankenship was charged with engaging in sexual acts with a minor between the ages of 13 and 16, in violation of ORC 2907.04, a sexually oriented offense. Because he was more than four years older than the minor, his charge was a felony of the fourth degree. In addition to punishments such as incarceration, fines, and community control, Blankenship was subject to automatic designation as a sex offender/child-victim offender in the state of Ohio. In Ohio's automatic tier-based system, Blankenship would automatically be designated a Tier II Sex Offender if found guilty of the offense, without any evaluation of his risk of reoffending, as courts are not permitted any discretion to apply sex offender designation in a case-by-case manner.

During pre-sentencing investigation, Blankenship was ordered to participate in a psychological evaluation. After interviewing Blankenship, the evaluating psychologist opined that Blankenship "lacked the characteristics of what he considered to be a sex offender," and that he posed a low risk of sexual reoffending. After the evaluation was completed, but before his sentencing hearing, Blankenship contacted the victim of the offense and was dishonest with the evaluating psychologist about having done so. The psychologist reevaluated Blankenship. He did not change his opinion after the second evaluation, and the court moved forward with sentencing.

Blankenship was sentenced to six months in jail followed by five years of community control. He was released after serving twelve days of his jail sentence. Upon release, Blankenship was automatically designated a Tier II Sex Offender by the state of Ohio. State law required that upon release from jail Blankenship register at his local Sheriff's office. He was required to make his home, work and school addresses publically accessible on the sex offender registry, and to verify his identity and the accuracy of this information in person with the sheriff every six months for the subsequent 25 years. Blankenship appealed his case, stating a claim that Ohio's Tier II sex offender registry requirements violated his eighth amendment constitutional rights.

By seeking to convince an appeals court that his sentence constituted cruel and unusual punishment, Blankenship's attorneys faced a high burden. In order to succeed with their claim of Eighth Amendment violation, they had to prove that the punishment that was imposed was so extreme that it was grossly disproportionate to the crime, or shocking to a reasonable person.

Blankenship's appeal to higher courts rested on the court-appointed psychologist's opinion. Blankenship argued that he had been evaluated by a professional who stated that he was not a sex offender. He argued that because he was engaged in a "caring" relationship with the victim of his crime and a psychologist had opined that he presented a low risk of reoffending, imposing Tier II registry requirements on him was "grossly disproportionate to the nature of the offense and the character of the offender," thus constituting cruel and unusual punishment.

Blankenship's case was heard by the Second District Court of Appeals. In a 2:1 decision the court affirmed the trial court, deciding that Blankenship's sentence did not violate the constitution. Blankenship then appealed to the Ohio Supreme Court. The Ohio Supreme Court heard Blankenship's case. An opinion was issued on November 12, 2015. The court affirmed the lower courts in a 4:2 decision.

The majority opinion was written by Justice O'Connor. Justice French concurred, and Justices O'Donnell and Kennedy concurred in judgment only. Justice O'Connor acknowledged that sex offender designation was a punishment, rather than a civil requirement, as applied by the state of Ohio. She stated in her opinion that, simply as a matter of law, Blankenship's conviction itself made him a sex offender, regardless of the opinion of any mental health professional. She noted that Blankenship's reliance on the psychologist's opinion was improper because Ohio law applied sex offender/child victim offender designation as an automatic consequence for individuals convicted of crimes that were statutorily defined as sexually oriented offenses. She stated that the Tier II registration requirements did not rise to the level of severity required to find the punishment cruel and unusual. Finally, she stated that Ohio's sex offender registry had penological justification as a

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PHOTO GALLERY

Jennifer Piel and Deborah Kushner

Kip Thompson and Britta Ostermeyer stop for a chat

Lt. Barton, Gregg Dwyer, Karen Rosenbaum, and Paul Federoff at their Internet Crimes Against Children presentation

Dick Krueger, Mike Norko, and Rocksheng Zhong (2106 Rappeport Fellow) enjoy their meal

Judy Faulkner, Renee Binder, Larry Faulkner, and Jackie Coleman catch up

Charles Scott, Richard Frierson, and Peter Ash catch up over a glass of wine

PHOTO GALLERY

AAPL members enjoying the reception

John Young (center) and Charlie and Barbara Meyer

Rick Martinez and Saul Faerstein at the reception

Philip and Nancy Margolis with friends

Learning at the AAPL meeting

Photo Credits: Eugene Lee, MD and Andrew Kaufman, MD

Nathan Kolla catches up with Eugene Lee

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Transgendered Patients and the Law: An Update

Aimee Kaempf, MD, Gender Issues Committee

Rough estimates are that about 0.3% of the US population, or almost 700,000 individuals, identify as transgender. As there grows awareness of the needs of transgender individuals in terms of health care, and legal protections, states and government have moved to institute policies – some protective and some discriminatory. Given all the recent changes, this article will summarize the up to date information.

The three primary topics that legislatures and government entities are addressing are 1) general discrimination statutes, 2) bathroom access, and 3) treatment options/payment for medication and surgery for transition to the identified gender.

General Discrimination Statutes

The Civil Rights Act of 1964 and Title IX substantiate the federal laws regarding discrimination in the workplace and education, respectively. The Civil Rights Act of 1964 dictates that it is illegal for an employer to "fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions or privileges or employment, because of such individual's race, color, religion, sex, or national origin."[1] Title VII of the Act created the Equal Employment Opportunity Commission (EEOC) to implement the law.

Title IX of the Education Amendments Act of 1972 states that "no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance."[2]

Although these laws clearly state that discrimination based on sex is illegal, there are no federal laws that extend this protection from sex to gender identity. However, 22 states have laws against discrimination based on gender identity. While it may not be illegal to discriminate against a transgender individual, depending on the state in which you reside, many organizations have policies that prohibit discrimination based on gender identity, and violations of policy could result in termination from one's job.

Bathroom Access

In 2016, North Carolina's governor signed House Bill 2, commonly known as the "bathroom bill." The bill specified, among other things, that people must use public accommodations based on the biological sex that is identified on their birth certificate, meaning that transgender people cannot use the bathroom of the sex with which they identify, even if they no longer physically resemble the sex on their birth certificate. Not only was the signing of this bill controversial among residents of North Carolina, but it led to more consequential action. The Department of Justice advised Governor Pat McCrory that HB2 likely violated the Civil Rights Act of 1964. President Obama said HB2 violates Title IX and issued guidance that students in public schools should be allowed to use the bathroom corresponding to the gender with which they identify. The federal government sued North Carolina, and North Carolina then sued the federal government.[3] The NBA All-Star Game was set to be held in Charlotte but was moved to New Orleans in protest of HB2. Several large companies, including PayPal, halted plans to expand in North Carolina after the bill was signed, Bruce Springsteen canceled a major concert, and the state lost other NCAA and ACC college sports events. Economists predict that HB2 has cost North Carolina upwards of $400 million in lost revenue and legal fees.[4]

Other states have followed North Carolina and have similar legislation in varying stages of progress: Kentucky, Missouri, Minnesota, Washington, South Carolina, Virginia, and Texas. Of these states, the Texas State Bill 6, is thought to be the most likely to make it from a bill into law given the political climate in Texas at this time. Kentucky's bill is similar to Texas' bill, and the Virginia bill has a unique stipulation that would require school officials to "out" any students who came out as transgender at school to their parents.[5]

Treatment Options and Payment for Gender Transition

The process of transitioning can be expensive. Treatment, as recommended by organizations such as the World Professional Association for Transgender Health, includes hormone medication, living in one's gender role, and mental health counseling. While coverage for hormonal and mental health treatment has been more prevalent, recently gender transition surgery is getting the green light from government and private entities as a covered and medically necessary treatment. For example, the US military began to provide this for its active duty members as of October 2016. The Pentagon spokesperson, Ben Sakrisson, was quoted in September as stating, "The Secretary of Defense has made clear that service members with a diagnosis from a military medical provider indicating that gender transition is medically necessary will be provided medical care and treatment for the diagnosed medical condition."[6]

Similarly, earlier this month, a California prison inmate was the first to undergo gender reassignment surgery, paid for by the state. This came about after a settlement between a transgender inmate, Shiloh Quinne, and the Department of Corrections. The terms of the agreement, which occurred in 2015, included the fact that prisoners seeking gender reassignment surgery would be evaluated by medical and mental health experts and present their cases to a committee, who would vote on

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Transgendered

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whether the surgery was warranted. Individuals would also have to live for a year in their preferred gender roles and undergo hormone therapy.[7]

For private citizens, certain companies (Google, for example) and private insurance companies are beginning to offer this option. A number of foundations have funds set up to help individuals pay for this treatment. Some states have begun making changes as well to their Medicaid programs, following a ruling in 2016 by President Obama and the Department of Health and Human Services that pressures insurance companies and federal programs like Medicare and Medicaid to cover gender reassignment surgery.

A spokesperson for the Department of HHS stated that "The final rule does not require covered entities to cover any particular procedure or treatment for transition-related care, including gender reassignment surgery. However, it does bar a covered entity from categorically excluding from coverage or limiting coverage for all gender transition-related services."[8]

For example, in November, a Minnesota district judge ruled that a prohibition on the use of public funds for sexual reassignment surgery is unconstitutional. Because Medicaid is administered by states, the regulations are as different as there are different states. Yet for many transgendered individuals, gender reassignment surgery remains an expensive and often out of reach medical treatment and it is unclear how these provisions and regulations will change moving forward with the new administration.

Concluding Thoughts

Overall, it appears that there is mixed progress with respect to legal protections and health care access for transgendered individuals in this country. It will be important to maintain awareness and see the direction this moves in the new administration.

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Ask the Experts

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sion, or a team approach, where one can voice and share these concerns and symptoms. It is also important to attempt to diversify one's practice to decrease the dosage of exposure. Additionally, the usual modes of self-care, involving avoidance or reliance on alcohol or drugs, healthy eating and sleeping, and living a balanced lifestyle are a *sine qua non* for maintaining one's equilibrium. It is also important to use resources, possibly in the form of mindfulness and meditation, or possibly psychotherapy, and even pharmacotherapy if necessary. In the particular case above, I realize that the questioner only raised the fact that he found the material grueling. I have used this as a springboard to discuss more serious manifestations of workplace stress, with vicarious PTSD the extreme version of the spectrum.

Take Home Points:

Early intervention is vital so we must give credit to the insightful colleague who raised this issue, prompting this article. We would encourage all of our colleagues to be so honest and open, so that early recognition, acknowledgement, and help seeking will avoid more serious mental health issues.

Horror Films

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identity, and The Jack of All Trades shooting his own patient. As well, forensic psychiatrists can be seen to have lessons of their own to learn, and to be causing danger to society by being ignorant of dangers in their own home. Concerns have been raised about horror films increasing stigma towards people with mental illnesses, [3] but these films also negatively portray forensic psychiatrists. On the bright side, the Jack of All Trades can save the day, unlike those of us real-world forensic psychiatrists…

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What's in a name? Deciphering the meaning of the word "addiction"

Elie Aoun, MD, Adam Fusick, MD, Ryan Wagoner, MD, Addiction Committee

Today, people all over the world search for the definition of words in different ways, from the classic paper dictionary to electronic search engines. However, in the field of forensic psychiatry, words can often have different meanings based on the context, particularly if a legal definition is required. This can become even more challenging when a clear legal definition is difficult to find, as in the case of the word "addiction." The multitude of descriptive terms referring to individuals with maladaptive patterns of alcohol or drug use include: *addiction*, *substance use*, *substance dependence*, and *substance use disorders*. These terms are often used inconsistently in legal settings, which further complicates an already murky issue.

The term "addiction" comes from the Latin verb *addico*, meaning "giving over." In Roman law, the related term *addictus* was used to refer to individuals who failed to pay their debts and were given over as bond slaves. Its application to illicit substances and substances of abuse dates back to the 1800's, in the midst of increasing anti-opium rhetoric.[1] Today, it comes up in multiple areas of the legal system, including both criminal and civil cases. For example, in criminal cases, a person with an addiction can sometimes be diverted to specific services available for treatment. In civil cases, this term can be a factor in litigation, running the gamut from personal injury to child custody to product liability.

The psychosocial and scientific progress in understanding the phenomenological and neurobiological aspects of addictions may provide some insight on the perceived inconsistencies in definitions. *Addiction* is listed as *Alcoholism (addiction)* and *Drug addiction* in the first edition of the DSM and included in the personality disorders section under the *Sociopathic Personality Disturbance* heading.[2] This set of diagnoses were defined by their undesirable consequences to the functioning of society and the individual's inability to conform with cultural norms. The term was dropped from DSM-III and further revised in DSM-III-R, presenting a different model of addictive disorders that did not include the term *addiction*, by introducing a distinction between *substance abuse* and *substance dependence* diagnoses.[3,4]

The DSM-5, released in 2013, eliminated this distinction in favor of a single substance use disorder diagnosis, with the severity determined by the number of symptoms present that meet criteria.[5] The DSM-5 comments that the term *addiction,* while not a diagnosis, is commonly used to describe severe problems related to compulsive and habitual use of substances.

Although the clinical definition of addiction has evolved over the years, the legal definition has moved at a more varied and inconsistent pace. One major problem with diagnosing an individual with an addiction is that it is not a clinical term defined in the DSM-5. Furthermore, the courts and legislatures have been reluctant to provide a clear definition of addiction and have instead relied upon varied methods for clarifying the meaning. These different methods result in criteria that often vary from state to state and can be based on a multitude of factors, including severity and/or duration of symptoms, presentation or behavior and even the type of substances used. Illinois, for example, specifically excludes alcohol use when the state defines the term *addict* and instead lists separate criteria that must be met for an individual to suffer from *alcoholism*.[6] New Jersey, on the other hand, uses the term *dependence* instead of *addiction,* but employs uniform criteria for all substances an offender could use and does not specifically exclude alcohol.[7] These distinctions play an important role, as an offenders disposition or a plaintiff's case can hinge, at least in part, on a finding of an addiction.

The legal distinction between *addicts* and *non-addict drug users* often assumes a model of varying degrees of substance use severity, which was previously paralleled in the *substance abuse/substance dependence* dichotomy. Several states previously conflated the term *addiction* with *substance dependence,* which was a well-defined clinically recognized diagnosis.[8]

The previous scheme used by some states is now hampered by the changes in the DSM-5. When substance dependence is no longer a diagnosis, what clinical definition do you use and how does it is interact with the term *addiction*? One proposed model has been to relate substance dependence and certain levels of substance use disorder.[8] This idea is based on epidemiological research showing greatest concordance between the old and new classification.[9] One method would include setting *severe substance use disorder* as the equivalent to the previous diagnosis of *substance dependence,* as this would likely result in higher interrater reliability and validity for expert opinions.[10] Another consideration would be to use *moderate* and *severe* when equating the new definitions to *dependence*. However, roughly one fifth of individuals who used to meet substance dependence criteria would not meet the moderate to severe substance use disorder diagnosis[11] and would not benefit from certain legal protections in some states. The National Institute of Drug Abuse (NIDA) and other agencies use a narrower definition of addiction represented by severe substance use disorders only,[12] which would exclude even more individuals previously diagnosed with substance dependence. With either model, the previous practice of equating *addiction* and *substance dependence* is no longer as easy as it once was.

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Legalizing It: New Marijuana Laws and Adolescent Mental Health

Marc Heiser MD, MPH

In the November 2016 elections, voters in California, Maine, Massachusetts, Nevada, and the District of Columbia passed ballot measures that legalized the production and use of recreational marijuana. This followed similar legislation enacted in Colorado, Washington, Oregon, and Alaska. As a result, a total of 26 states and the District of Columbia now allow for marijuana use in some form, either recreationally or medicinally. Despite this, the federal Controlled Substances Act classifies tetrahydrocannabinol (THC), the main psychoactive ingredient in marijuana, as a Schedule I substance, meaning marijuana is illegal to produce and possess. Under President Obama's administration, the federal government generally did not enforce these regulations and override state marijuana laws, and it seems unlikely that the new administration will attempt to eliminate a now $6.8 billion industry that has the support of most Americans (60% of Americans support legalization, according to a 2016 Gallup Poll). Although these laws prohibit cannabis use by minors (most prohibit use by those under 21 years of age), the impact of the legalization of recreational marijuana for adults on use by children and adolescents remains unknown.

Marijuana is already the most widely used illicit drug in the United States with 44% of people age 12 or older reporting lifetime use.[1] According to the 2015 National Survey on Drug Use and Health, 7% of 12-17-year-olds and 19.8% of 18-25-year-olds report use in the past month. Most teens also view marijuana as safe and easy to obtain.[2] Although there is much concern that legalization of cannabis for adults will lead to increased use in teenagers because of increased availability and perceived safety, very preliminary data from states that legalized recreational use in 2012 suggest this may not be the case. In Colorado, pooled data comparing use among 12-17-year-olds in 2012-13 (pre-legalization) to 2014-15 (post-legalization) demonstrated a small decrease in past-year use (20.81% to 18.35%, p=0.092) and a small but not statistically significant decrease in past-month use (12.56% to 11.13%, p=0.265). However, these rates were among the highest in the country (1). Rates of use among transitional age youth (18-25) were unchanged during this period (~31%) while adults' rates of use increased (12.45% to 14.65%). It should be stressed that this data is very preliminary and the true impact of these laws on marijuana use in adolescents remains to be seen.

One major concern is that these laws essentially create a for-profit industry that will benefit from heavy use that begins at an early age and that will therefore market marijuana to youth and encourage the social normalization of regular use (a strategy utilized by the tobacco industry).[3] It is easy to imagine the appeal of various edible marijuana products (such as lollipops) to youth, and there has already been a significant increase in emergency department visits by children in Colorado for ingestion of THC-containing edibles.[4] Adolescence is a critical period of structural brain development, and environmental exposures, such as cannabis use, may alter the course of this process and ultimately have behavioral and psychiatric implications. Acute psychiatric symptoms of use can include anxiety, panic attacks, and psychosis.[5] Studies have demonstrated that heavy cannabis use during adolescence and early-adulthood is associated with significant alterations of brain anatomy and physiology.[6,7] These alterations, in turn, have been associated with poorer performance on cognitive tasks, including long lasting effects such as lower IQ, and poor performance on tests of attention, memory, and executive function.[5, 8, 9] Many of these decrements in performance were correlated positively with the lifetime amount of cannabis use and were more pronounced in those persons who began use earlier in life.

There is mounting evidence that adolescent cannabis use is associated with the development of psychiatric disorders and worse socioeconomic outcomes in adulthood. Meta-analyses of longitudinal studies have confirmed that there is an increased risk of psychosis in people who have used cannabis, with a "dose-response" effect apparent and an earlier age of onset of illness.[10-12] A number of longitudinal studies also suggest that adolescents who use or have used cannabis are more prone to develop depression and anxiety than adolescents who do/have not.[13-15] Although these studies indicate that cannabis use during adolescence is associated with an increased likelihood of mood, anxiety, and psychotic disorders, it is not currently known whether cannabis use causes the disorders or whether the disorders (or early manifestations thereof) predispose children to use cannabis. Adolescents are also more susceptible to becoming dependent on marijuana than adults.[16] Finally, multiple longitudinal studies indicate that more frequent use of cannabis during adolescence is correlated with an increased likelihood of leaving school without a degree, a lower income, greater dependence on welfare and unemployment, and lower life satisfaction as an adult.[5, 17-19] Together, these data demonstrate the importance of limiting the exposure of adolescents to marijuana and of monitoring the effects of recent marijuana laws on adolescent use.

Along with the risks associated with changes in marijuana laws come opportunities. More attention is being paid to research on potentially beneficial components of marijuana. Of great recent interest for clinical researchers is cannabidiol (CBD) a non-intoxicating component of marijuana. Studies suggest that CBD may be useful for the treatment of psy-

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A Primer on Kratom

Joseph C. Cheng, MD, PhD, Ryan C. W. Hall MD

A substance of abuse that has recently been gaining national attention is the plant kratom (*Mitragyna speciosa*; aka Thang, Kakuam, Thom, Ketum, and Biak).[1] The plant is indigenous to Southeastern Asia and Africa, but is consumed throughout the world for its psychoactive properties.[1-4] At low doses, kratom has stimulant effects causing users to feel more alert, energetic, and talkative; and at higher doses, kratom has analgesic effects and may cause sedation or euphora.[5] In fact, its history parallels that of cocaine in that kratom was originally chewed or brewed by laborers in Asia for enhance work productivity.[6,7] It has also been reported as a folk remedy for malaria, cough, hypertension, diarrhea, depression, fever reduction, and opioid withdrawal.[7] The leaves of this plant are typically brewed into a tea, chewed, smoked, or ingested in capsules.[1]

Although the National Institute of Drug Abuse has identified kratom as an emerging drug of abuse, the general medical community is not familiar with this substance.[1] Kratom use in the U.S. emerged in the early 2000s[6] and its increasing popularity in the U.S. is evidenced by a ten-fold increase of kratom-related calls to poison control centers from 2010 to 2015.[1] In December 2016, a PubMed search for the term "kratom" yielded only 86 articles. However, subsets of the general public seem much more aware of the substance and its uses. A YouTube search also done in December 2016 yielded 36,000 videos, most featuring laypeople or alternative substance "experts" discussing how to use kratom and the positive or euphoric effects one can expect from it. In addition, there are many non-medical-based websites, such as Erowid, Sage Wisdom, and Reddit, that publish similar information on achieving a "legal high" with kratom. Kratom is available through the Internet, in convenience stores, gas stations, and head shops.[7] Vendors usually advertise by potency, vein color and country of origin. However, claims of potency based on these parameters have not been substantiated.[7]

One of the authors of this newsletter article has seen one patient who, through recreational use of kratom, had a severe manic episode, which resulted in legal difficulties. However, given that the individual had bought the substance legally at a smoke shop, it did not occur to them to initially disclose that they were using kratom when they started seeking medical treatment since it was an "herbal tea." When it was finally recognized that the person had been using kratom few treaters counseled him on stopping its use because they did not know what kratom was.

There are 25 alkaloid substrates that can be isolated from the kratom leaf, but the primary agents of psychoactive effects are mitragynine (stimulant) and 7-hydroxymitragynine (7-HMG; narcotic).[2,7] These agents are thought to act on mu- and delta-opioid receptors as well as alpha-2 adrenergic and 5-HT2A receptors.[6] Like many substances, the amount absorbed can change the pharmacologic effects one experiences from kratom. Taking a dose of approximately one to five grams of raw leaves will yield mild stimulant effects, such as alertness, sociability, and increased sexual desire. However, some report this dose range also produces negative effects such as anxiety or agitation. At 5 to 15 grams, opioid effects will be noticed, such as analgesia and euphoria. Above 15 grams of ingestion, kratom is generally very sedating and risk of experiencing stupor and potential dysphoria increase.[2,6] A panoply of side effects has been reported, including nausea/vomiting, fatigue, weight loss, constipation, insomnia, dry mouth, frequent urination, myalgias, chills, hypertension, hyperpigmentation in cheeks, tremor, anxiety, irritability, agitation, psychosis, seizures, and death.[1,2,6] A withdrawal syndrome resembling opiate withdrawal, (agitation, anxiety, tactile hallucinations, restlessness, insomnia, confusion), has been reported.[6] Effects of kratom can be seen within 10 minutes of ingestion, with full effects occurring at 30 to 60 minutes after adminstration.[1] Effects can last for about five to seven hours. The terminal half-life of kratom is approximately 24 hours.[6]

The complex effects of kratom use have led many to promote its study and use for medicinal purposes, such as treating opiate addiction.[2,3] Opioid abusers report using kratom to manage opioid withdrawal because procurement is easy and legal, and it is less expensive than other opioid replacement therapies, such as buprenorphine.[6] Although many claim kratom has medicinal properties, it is currently banned or regulated in multiple countries: Banned in Australia, Malaysia, Myanmar; regulated in Australia, New Zealand, Sweden, Denmark, Finland, Germany, Romania, Thailand.[7] The first legislative attempts to limit its consumption occurred in Thailand with the Kratom Act of 1943.[4] Although comprehensive assessment has not been conducted, the FDA has banned use of kratom as a dietary supplement.[6] This has resulted in a seizure of kratom products in California by federal marshals from a company advertising kratom as a cure or treatment for various diseases without FDA indication.[5]

The DEA currently has kratom on the list of Drugs and Chemicals of Concern, which contains substances that are not currently regulated by the Controlled Substances Act, but pose risks to persons who abuse them.[1,4] Currently, there is no national law regarding kratom, but Alabama, Florida, Indiana, Louisiana, Tennessee, Wisconsin, and Vermont have passed legislation banning or regulating its sale; other jurisdictions are also considering laws regarding the use and sale of kratom.[1,4,7] In August 2016, the DEA announced plans to make kratom a Schedule I drug.[4] However,

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Legalizing It

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chosis,[20] anxiety disorders,[21] and epilepsy.[22] Though CBD remains a schedule I substance because of its containing small amounts of THC, the DEA recently eased requirements on CBD research. Furthermore, several states have proposed using taxes collected from marijuana sales and production to fund research on medicinal uses of marijuana. California, for example, will use marijuana tax revenue to create the Center for Medical Cannabis Research at the University of California, San Diego. Similarly, states also are using revenue collected from marijuana taxes to fund mental health services. Thus, these laws may indirectly facilitate the discovery of important new treatments for neuropsychiatric disorders and improve mental health care overall.

The recent changes in marijuana laws likely will have far-reaching impacts on adolescent marijuana use and therefore, adolescent mental health. The careful regulation of production and marketing of marijuana, along with monitoring of use prevalence by the public will be critical in detecting any potential increases in rates of regular use by adolescents and associated poor outcomes. Clearly, more time and careful research on the effects of marijuana use and its legalization on the mental health of youth are required for the public to draw meaningful conclusions about this complicated issue.

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Fostering Interest and Mentorship in Research

Andrew R. Kaufman, MD, Jennifer Piel,MD, JD, Douglas Mossman, MD, Research Committee

Young people have ideas… research ideas… good research ideas. This has been a recurrent theme discussed among members of AAPL's Research Committee. The question has always been: How can we capitalize on the youthful enthusiasm of our early career members and facilitate their development in research? The answer to this question is vital to the future of our profession, which will increasingly demand research evidence to support forensic opinions and treatment in the forensic context.

Our profession is relatively young. It is only since 1992 that we have been sanctioned by the ABMS and now have endless MOC requirements to stay credentialed. We are relatively few and, at present, in great demand. Our origins are rooted in legal scholarship and high ethical standards of professionalism. We have become excellent at maintaining a neutral stance in our legal expert opinions. We have learned to navigate the world of courtrooms, penal institutions, administrative entities, licensing authorities, insurers, and others.

However, too few forensic psychiatrists are actively involved in research. Our opinions are strengthened by support of sound research and evidenced-based practices. Our founding father, Jonas Rappaport wrote, "There will be changes because of developments in the 'brain sciences,' as molecular biology, brain imaging, and psychopharmacology furnish a sounder scientific basis for psychiatric opinions."[1] We must be prepared to be experts about these findings and we should be a key source of designing experiments to contribute to this knowledge base.

It makes perfect sense that early career forensic psychiatrists are in the best position to pursue these goals. AAPL's Research Committee has begun the process of helping develop this talent and promoting a model of integrating research effort, be it ten percent, one-hundred percent, or anything in between, into their career trajectories. To aid this effort, the Research Committee has promoted two avenues to increase research participation, particularly among early career members. First is the Research Poster Contest based on poster submissions to the annual meeting. The second is the Young Investigator Award for the best scientific paper submitted for presentation at the annual meeting. Each year it is a pleasure to review the submissions for these contests. Each year the quality seems to improve and the science seems to be more grounded. Yet there is something missing: too many trainees abandon their research projects once their fellowship is complete.

> *"How can we capitalize on the youthful enthusiasm of our early career members and facilitate their development in research?"*

In some cases, residents, fellows, and early career members have inspiring research ideas but lack available mentors or time to carry out their research pursuits. At academic institutions, fellowships are generally small and many lack faculty members with research expertise. Further, the inspired budding researcher needs protected time to conduct the research or the ability to pay an assistant to collect the data. For those who have never written a grant application, the process can be overwhelming. It is practically impossible without appropriate guidance and mentoring.

Our committee has learned these facts, and we want to promote additional avenues to help bright talent develop into successful researchers. One way to do this is to turn to the AAPL Institute for Education and Research (AIER). The AIER offers research grants specifically for projects that will advance our field. The Research Committee encourages all members – particularly those in training and early career – to take advantage of these funds. It is your time to shine and inspire the next generation to join our profession. The AIER selected several projects to fund for this coming year.

Another way to inspire and foster research is through training and mentorship related to research skills. The Research Committee sponsored at the annual meeting in Portland a course focused on research design and development. The panel included some of AAPL's most experienced and successful researchers: Drs. Nathan Kolla, Philip Candilis, Douglas Mossman, Robert Trestman, and Alexander Westphal. The session included a course component focused on core research concepts and strategies, such as research design and methods; statistical analysis; application and approval by institutional review boards; and funding. The course included practical how-to instruction on finding sources of funding and applying for grants.

In addition, the course included onsite research consultation for each participant in the course. At the beginning of the course, each participant shared their research interests and what they hoped to gain from the course. All participants were invited to pitch their research ideas and discuss any current works in progress for direct feedback and consultation of the expert presenters, as well as other course participants. Participants were encouraged to discuss all phases of research, from initial topics of interest, to design, to mentoring, and efforts to maximize chances of success for peer-reviewed grants. What is more, the panelists offered to continue mentoring course participants

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Neurolaw 101: Intro to Neurolaw for Forensic Psychiatrists

Vivek Datta, MD, Neuropsychiatry Committee

Neurolaw – the field exploring the use of neuroscience in general, and neuroimaging in particular, to answer complex legal questions – has established itself as a legitimate field of scholarly inquiry. Scientific meetings devote themselves to neurolaw, learned societies have penned reports on it, journals have dedicated special issues to it, a small library of books on the topic is amassing, and the MacArthur Foundation funds a project on it. At the same time, between 2005 and 2012, over 1585 judicial opinions have been penned that discuss neurobiological evidence used by criminal defendants, and the number of judicial opinions discussing neuroscience in criminal cases more than doubled between 2007 and 2012.[1] This is not to mention the increasing popularity of neuroimaging to bolster expert opinion in civil cases. Despite the rapid ascendance of neurolaw as a field of inquiry and the increasing presence of neuroscience in the courts, neurolaw has been relatively neglected by AAPL. Only 3 non-book review articles published in the *Journal of the American Academy of Psychiatry and the Law* have ever used the term "neurolaw." Though the Forensic Neuropsychiatry Committee regularly presents neuropsychiatric topics at the Annual Meeting, the term "neurolaw" appears only 3 times in the programs of the AAPL Annual Meetings between 2006 and 2015 (twice in 2011, and once in 2012). To remedy this deficiency, the Forensic Neuropsychiatry Committee presented a course at the 2016 Annual Meeting titled "Neurolaw 101: Intro to Neurolaw for Forensic Psychiatrists".

Organized by Octavio Choi, MD, Chair of the Forensic Neuropsychiatry Committee and Assistant Professor of Psychiatry at Oregon Health Sciences University, other speakers featured included Francis Shen, JD, PhD, Associate Professor of Law at the University of Minnesota; Stephen Morse, JD, PhD, Professor of Psychology and Law in Psychiatry at the University of Pennsylvania; Manish Fozdar, MD, a past Chair of the Forensic Neuropsychiatry Committee; and me.

Neural Correlates of Moral Reasoning

Dr. Fozdar presented a survey of the neuroanatomy of moral reasoning. He noted that recent structural and functioning neuroimaging studies exploring morality gone awry did not focus on specific diagnostic groups, but tend to conflate psychopathy, antisocial behavior, and aggression. Nevertheless, current research appears to highlight that dysregulation of neural circuits involved in moral thinking and feeling, may give rise to antisocial behavior. In particular, reduced activity and grey matter volume of certain prefrontal brain structures including the orbitofrontal cortex, ventromedial prefrontal cortex, and dorsolateral prefrontal cortex have been associated with antisocial behavior in numerous studies.

Dr. Fozdar further discussed similarities between developmental and "acquired" sociopathy. Acquired sociopathy refers to antisocial behavior that arises in later life, predominantly due to traumatic brain or behavioral variant frontotemporal dementia. Studies of antisocial behavior of the different etiologies described above all appear to point to the orbitofrontostriatopallidal neural circuits as underlying morality. He then discussed the role of temporal structures, chiefly the amygdala and hippocampus, dysfunction of which have been identified in children with conduct disorder and adults with psychopathy. These brain structures if hypoactive or poorly developed lead to impaired fear conditioning, which is probably why psychopaths have high rates of recidivism: their fear conditioning and thus ability to learn from punishment is impaired. Finally, Dr. Fozdar discussed that at the brain level, moral thinking (knowing that) and moral emotion (feeling that) are distinct, and it is the latter that is impaired in psychopaths. Our evolving understanding of the neuroanatomy of moral reasoning and its dysfunctions may have significant implications for our understanding of criminal responsibility.

Violence Neuroprediction

Next, I discussed neuroprediction of violence recidivism. Neuroprediction refers to the use of neuroimaging to make future predictions. Violence risk assessment is fundamental to the practice of clinical and forensic psychiatry. Determinations of violence risk and dangerousness assume relevance to important decisions including civil commitment, bail, parole, capital sentencing, sex offender registration, and sexually violent predator status.[2] I noted that violence risk assessment has certainly advanced since 1983, when the American Psychiatric Association noted in their amicus brief in the case of *Barefoot v. Estelle* that "the unreliability of psychiatric predictions of long-term dangerousness is by now an established fact within the profession."[3] Despite advances, including the development of a number of structured risk assessment instruments, a recent meta-analysis of structured violence risk assessment instruments concluded, "assigning predetermined probabilities to future violence risk on the basis of structured risk assessment is not supported by the current evidence base."[4] Because of that, the field has turned towards neuroscience in the hope that neuroimaging can improve the reliability of determinations of future dangerousness.

I reviewed the neurobiology of aggression as it pertains to mental disorder, noting that there are differences in the neurobiology of instrumental aggression (as seen in psychopathy) and reactive aggression (e.g. as seen in borderline personality disorder). Mental disorder can lead to

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violence through impairments in top-down processing; that is, the regulation or suppression of impulses, which involve the orbitofrontal cortex and anterior cingulate gyrus; or through impairments in bottom-up processing, through impairments in emotion regulation involving structures such as the amygdala and insula.[5] While a number of psychiatric disorders are associated with violent behavior, the neuroimaging literature has focused on schizophrenia and psychopathy. I also discussed that dysfunction of the anterior limb of the internal capsule and the striatum appear to be involved in psychopathy. The striatum has been implicated in prediction error signaling, which is the mismatch between expected and actual reward or punishment, and important in stimulus-reinforcement learning (modulated by the amygdala)[6]. Impaired prediction-error signaling explains why psychopaths fail to learn from punishment and why psychopathy is a risk factor for violence recidivism. Of particular interest, one study found that reduced grey matter volumes in the prefrontal cortex and increased grey matter volumes in the caudate and cerebellum was associated with psychopathy scores on the Hare Psychopathy Checklist-Revised and violence recidivism risk as predicted by the Violence Risk Appraisal Guidelines.[7]

I briefly discussed some of the ethical issues of violence neuroprediction, including the fact that neurobiological data can be contemporaneously mitigating and aggravating evidence, problems with knowing whether imaging findings are simply correlates or causal, and whether a neurobiological basis for psychopathy means psychopaths are less criminally responsible for their behavior. I also discussed some of the challenges with functional neuroimaging research, such as the recent finding that software glitches may invalidate more than 40,000 fMRI studies[8], and the fact that most neuroimaging studies have small sample sizes and thus lack statistical power to answer the questions they purportedly aim to. Finally we discussed two competing ideas on law, brain and behavior. The first is that if violence is yoked to our neural circuitry, can we be held responsible for our behavior at all? The second is that of "brain overclaim"[9], coined by Stephen Morse, which argues that neuroscience has been (ab)used to provide moral exculpation for behavior when it is not warranted.

Reading the Mind with Machines

Dr. Choi then discussed whether machines can read the mind. The short answer is yes, it is possible, but we're not there yet. The longer answer is that the notion of mind reading is predicated on the idea that mental states map onto brain states and decoding these brain states will allow us to read the mind. In the forensic context, this may have implications for lie detection, memory detection, mental state at the time of the offense, measuring pain, and brain-based detection of implicit biases. We can visualize brain activity using positron emission tomography (PET) and functional magnetic resonance imaging (fMRI). fMRI using blood oxygenation levels in the brain as a proxy of brain activity – bloody oxygenation level dependent (BOLD) signals. The limitations of fMRI discussed include the fact that fMRI measures vascular response to brain activity, rather than brain activity itself; not all brain activity triggers a neurovascular response; lack of standardization of statistical methods; and that statistical packages for fMRI analysis result in a 70% false-positive rate thus potentially invalidating over 40,000 fMRI studies.[8]

Dr. Choi then discussed the category of specific visual areas that have been identified suggesting that we can create maps of the representation of object and action categories across the human brain.[10] He suggested that fMRI could be a powerful lie detector if we scanned a large number of people and essentially used a machine learning approach, multivoxel pattern analysis (MVPA), to "train" the machine to distinguish lying from truth-telling. There are many different types of lies, and he suggested that different kinds of lying would likely be associated with different brain patterns. Currently however fMRI lie detection is not ready for the courtroom because of lack of ecological validity, standards and error rates. Interest in fMRI for lie detection has fallen off since the Sixth Circuit Court of Appeals affirmed a lower court decision to exclude fMRI lie detection in a Medicare fraud case where Lorne Semrau, a clinical psychologist, claimed that fMRI evidence would prove the veracity of his denials of wrongdoing.[11]

Neurolaw and the Aging Brain

Dr. Shen discussed the aging brain as the next frontier of neurolaw. Neurolaw may potentially be most useful in answering legal questions involving the aging brain. There has been increasing attention paid to brain health, with many companies claiming their brain training products can stave off dementia, and these claims have already been challenged in the courts. At the same time, many questions are unanswered, but Dr. Shen suggested that neurolaw may enhance legal determinations of criminal and civil competencies involving the aging brain, as well issues involving contested wills, guardianship, undue influence, elder fraud and abuse. Neuroimaging may allow the early detection of dementia and cognitive decline, and has implications for the aging inmate brain, and the ethics of early detection of dementia. This area coalesces as the interface of elder law issues and the growing use of neuroscientific evidence in the courtroom. In particular, Dr. Shen suggested that there might be significant implications for brain changes identifying the beginning of neurodegenerative disease before the frank symptoms appear.

Indispensable forensic psychiatry

Finally, Dr. Morse gave a more guarded forecast for the future of neu-

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rolaw. He suggested that whatever advances happen in the neurosciences, forensic psychiatry as it stands will remain indispensable to criminal and civil law.[12] With passion and vigor, he communicated that criminal law relies on folk psychological models of the person, and the criteria for responsibility and competency are acts and mental states. He noted that free will, though often mentioned in discussions of neurolaw and responsibility, is not relevant to legal determinations and not a criterion for any legal doctrine.[13] He argued that the "causal theory of excuse", that is behavior is excused if outside of one's control, is "the fundamental psycholegal or psychomoral error." Dr. Morse further argued that nothing can replace careful clinical evaluation of acts and mental states and that neuroimaging is of no help in mens rea, provocation, diminished capacity, or insanity defenses. He ended with some cautious optimism, suggesting that neuroscience may be helpful in individual case adjudication, evaluation of pain and memory accuracy, evaluating folk wisdom and evaluating and shaping policy and legal doctrines.

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The Goldwater Rule

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leagues Jerome Kroll and Claire Pouncey suggest in the June 2016 issue of JAAPL? Or should we consider reformulating and refining it for modern times, such as in the manner suggested by Ronald Pies in the October 7th, 2016 Psychiatric Times?

Despite the closure of the election cycle, there continues to be much discussion of public figures and mental health concerns. Although the Goldwater Rule stands, many continue to disregard it. Perhaps the time is ripe that we embark on a reconsideration of the merits of the current rule. As a field, we should together determine whether refinement or revocation best respects the dignity of our patients, our society, and our profession.

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Pre-Meeting Update

Cheryl D. Wills, MD,
AAPL Representative to APA Assembly

The American Psychiatric Association has grown to represent 37,106 members, an increase of 1.6% in the past year. The Annual Meeting will take place in San Diego, California from May 20-24, 2017. The theme, "Prevention through Partnerships," underscores the importance of psychiatrists collaborating with other healthcare professionals, as well as professionals in community development and education, to implement early identification of and interventions for individuals with mental disorders. The Meeting will offer a diverse selection of programs and discipline-specific tracks so attendees may craft individualized programs in substance use disorders, child psychiatry, geriatric psychiatry, psychosomatic medicine, forensic psychiatry etc.

Attendees may sign up to tour of the U.S. Naval Medical Center of San Diego learn how medical care is delivered at sea. The guest speaker at the Convocation of Distinguished Fellows will be Elizabeth Vargas, who anchors "20/20" on ABC. She has spoken and written about her own struggles with anxiety and alcohol use and wrote the memoir *Between Breaths: A Memoir of Panic and Addiction*.

APA members are encouraged to visit the Innovation Zone that will be located in the exhibit area. The Zone provides a forum for contemplating the future of mental health technology and advancing psychiatric practice. Attendees can engage in discussions with technology professionals and executives. There will be a competition for psychiatrists to present innovative ideas to their colleagues and a panel of technology experts.

In 2012 the APA drafted a Position Statement on Discrimination against Transgender and Gender Variant Individuals. The Federal Government recently delegated policy development regarding transgender restrooms to the states. The APA is ready to assist district branches and other partners in addressing policy development and interested parties should contact Ariel Gonzalez (agonzalw@psych.org).

Discussions about national politics remain a salient topic for APA members and leadership. The organization has always worked across the aisle with both major political parties to promulgate a better understanding of the needs of APA members and individuals with mental disorders. In February 2017 the APA led a group of allied stakeholders in holding several CEO-level meetings with Congressional and committee leadership. The coalition included: the American Foundation for Suicide Prevention, American Psychological Association, Eating Disorders Coalition, Mental Health America (MHA) and National Alliance on Mental Illness (NAMI), National Council for Behavioral Health, and Sandy Hook Promise. The coalition educated our political leaders about how changes in healthcare policy might affect mental health practice and the well-being of individuals with mental disorders. These efforts will continue regardless of how the government chooses to proceed with healthcare reform.

The ability of mental health professionals to comment about the mental health of public figures has been a matter of much debate in the past year. Several psychiatrists, psychologists and social workers have proffered opinions about the fitness of political leaders to govern.[1] Many APA members have questioned the appropriateness of this action. In response, the APA's Ethics Committee revisited the Goldwater Rule which was included in the Code of Ethics in 1973. The Committee affirmed the Rule, which states psychiatrists should not offer professional opinions about the mental state of individuals whom they have not personally evaluated. The practice compromises the integrity of the psychiatrist and the profession and may stigmatize individuals who have mental disorders.

The APA is providing resources and assistance to help members understand and benefit from the Merit-Based Incentive Payment Program (MIPS) and to earn incentives for participating in the Alternative Payment Models (APMs) that are part of Medicare's new "Quality Payment Program." There is an APA Payment Reform Toolkit available at www.psychiatry.org/PaymentReform that contains fact sheets and other information. There also is a webinar, titled "Quality Reporting 101," that is available in the APA learning Center at no charge to members. Additional resources are being developed to aid members.

There is a new APA mobile health (mhealth) webpage that includes a Mobile Apps Evaluation Tool which is designed to help mental health professionals review the efficacy and risks associated with mobile and online apps. The APA Apps Work Group is considering increasing the tool's functionality and expanding its content. The tool is a resource for mental health professionals who recommend apps to patients as part of a comprehensive treatment plan.

The World Health Organization (WHO) is proposing to transfer all diagnoses for dementia - in the beta version of International Classification of Diseases, 11th edition (ICD-11) - from the Mental Health or Behavioral Disorder Chapter to the chapter of Diseases of the Nervous System. The recommended change may prevent mental health health professionals from delivering services to individuals with dementia in the U.S. and other countries; health insurance companies may refuse to reimburse mental health professionals for diagnosing, conducting medical and psychological testing, and psychosocial treatment and pharmacological intervention for individuals with dementia.

APA President Maria Oquendo and Medical Director Saul Levin submit-

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ted a letter to the WHO to formally object to the proposed changes, The letter has been shared with nearly 20 national and international health organizations and many have or plan to formally oppose the changes.

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Sex Offender Registry

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means to protect society. Justice O'Donnell's opinion concurred in judgment only, and he wrote a separate opinion in order to state that he believed Blankenship did not have an Eighth Amendment claim at all because the sex offender registry was a civil requirement. Justice Kennedy concurred.

Justice Pfeifer wrote the dissenting opinion, and was joined by Justice O'Neill, who concurred but also wrote his own dissenting opinion. Justice Pfeifer stated that Blankenship's case exemplified one in which the punishment imposed was disproportionate to the crime and "shocking to any reasonable person." Justice O'Neill expressed, through his dissent, frustration with the "one-size-fits-all mentality that increasingly dictates criminal sentencing in Ohio." He stated that a 21-year-old offender who was opined by a respected mental health professional to present a low risk of reoffending should not be subject to a punishment which would "guarantee an unnecessarily long period of public humiliation only." He stated that the Tier II registry requirements, which would restrict Blankenship's job and relationship opportunities, and "lay shame at the feet of others," clearly represented cruel and unusual punishment.

At this time, Blankenship remains on the sex offender registry in Ohio, along with many individuals who are consumers of mental health services. When I see patients who have been designated as sex offenders, I acknowledge the stigma that they feel. I make sure that my patients understand what their legal requirements are, and encourage them to meet their registry requirements to avoid legal peril. The registry will continue to be a legal issue with implications for community reintegration in Ohio, as well as other states, unless more cases challenging its constitutionality arise.

State v. Blankenship, 145 Ohio St.3d 221, 2015-Ohio-4624

What's In A Name

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So what does a forensic psychiatrist do if asked for a definition of addiction? Unfortunately, there is not a uniformly accepted answer at this time. As with most legal issues, if a legal definition happens to be available in the state or jurisdiction where the question is posed, then that definition may be used. However, in most areas, a legal definition of addiction is not readily available. In those circumstances, the forensic psychiatrist may consider the factors detailed above and reach their own conclusion about how the current substance use disorder diagnosis interacts with the legal term *addiction*. Until a more uniform statement regarding the definition is available, it will continue to part of the individual opinion of the expert, based on their own interpretation of the available literature and their personal knowledge, experience, and training.

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Terrorism

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A Primer on Kratom

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due to opposition from those who felt kratom may have medicinal purposes, as well as concern from politicians about whether or not procedure was appropriately followed, the Schedule I change did not occur.[3] The DEA is currently engaging in a more transparent approach to address these concerns such as having an official public comment period before again considering action.

Use may be higher than previously suspected since many standard drug screens do not detect kratom.[2] Although kratom can have opioid-like effects, it is structurally unrelated to opium and, therefore, many standard urine toxicology screens do not detect it. Sophisticated screening such as liquid chromatography or mass spectrometry needs to be used to detect kratom.[2] There have been some possible urine tests studied, but they are not readily available in most clinical settings.[8]

Given recent DEA and legislative actions involving kratom, difficulty in detecting kratom use either from history or objective screening, and increasing use of kratom as a recreational substance in the United States, it is important for forensic psychiatrists to be aware of its existence and properties.

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Asylum Evaluations

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by professionals to measure features of radicalization, include the Violent Extremist Risk Assessment (VERA-2), Identifying Vulnerable People (IVP), Extremism Risk Screen (ERS), and the controversial, unpublished Extremist Risk Guidance 22+ (ERG 22+). The VERA-2, ERS, and IVP, however, are designed to be used with persons with histories of extremist violence or terrorist offenses. Other tools have been developed for research measures, but have not been spread to general use at this time.[8]

According to a new Cato paper, from 1975 to 2015, the United States accepted approximately 700,000 asylum seekers and 3.25 million refugees. Excluding foreign attacks, four of those asylum-seekers became terrorists and killed four people in attacks in the United States. Twenty of the 3.25 million refugees became terrorists and killed three Americans on U.S. soil.[9] Thus, the forensic evaluator should be aware of the heightened political climate for asylum seekers and refugees, but should continue to focus on a valid and comprehensive assessment. Remember, the final determination of credibility is the responsibility of the trier of fact: the judge.

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Fostering Interest

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after the meeting in cases where this would be helpful.

So, if you are now saying to yourself, "I can't believe it. I've been hoping to find ways to get involved in research," this is your chance. There are several avenues to support entry into forensic research, including those discussed here. Please help our profession move forward and give yourself the satisfaction of testing your idea, using scientific methods.

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MUSE & VIEWS

"Once a man indulges himself in murder, very soon he comes to think little of robbing and from robbing he comes next to drinking and sabbath-breaking, and from that to incivility and procrastination."
- Thamas De Quincey

"It is hard to believe that a man is telling the truth when you know that you would lie if you were in his place."
- H. L. Mencken (1880 - 1956)

"I have the heart of a child. I keep it in a jar on my shelf."
- Robert Bloch

"If it weren't for my lawyer, I'd still be in prison. It went a lot faster with two people digging. "
- Joe Martin, Mister Boff

"A criminal is a person with predatory instincts who has not sufficient capital to form a corporation."
- Howard Scott, Economist

"America believes in education: the average professor earns more money in a year than a professional athlete earns in a whole week. "
- Evan Esar (1899 - 1995)

"Thought: Why does man kill? He kills for food. And not only food: frequently there must be a beverage. "
- Woody Allen (1935 -)

SAVE THE DATES FOR FUTURE AAPL MEETINGS

October 22-24, 2018 – Forensic Review Course
Austin, TX – JW Marriott

October 25-28, 2018 – 49th Annual Meeting
Austin, TX – JW Marriott

May 5-9, 2018 – APA Annual Meeting
New York NY

October 21-23, 2019 – Forensic Review Course
Baltimore, MD – Marriott Waterfront

October 24-27, 2019 – 50th Annual Meeting
Baltimore, MD – Marriott Waterfront

May 18-22, 2019 – APA Annual Meeting
San Francisco, CA

October 19-21, 2020 – Forensic Review Course
Chicago, IL – Marriott Downtown

October 22-25, 2020 – 51st Annual Meeting
Chicago, IL – Marriott Downtown

April 25- 29, 2020 – APA Annual Meeting
Philadelphia, PA

Diversity Committee

In keeping with the plan of Dr. Emily Keram, immediate past president of AAPL, I hereby invite AAPL members to the inaugural meeting of the Diversity Committee of AAPL in October 2017. Dr. Keram's vision is to establish a forum where issues of diversity in all areas of AAPL are explored and discussed, and ultimately presented to the AAPL council. Questions to be addressed include, but not limited to: do all groups represented in AAPL see AAPL as their professional home? Are there factors that interfere with members developing a sense of belonging at AAPL? Do people believe issues regarding their specific group(s) are addressed by AAPL? Do minority groups feel empowered to be all they could be at AAPL? And so on.

For questions or to become a member of the committee, please contact **Charles Dike** at **charles.dike@yale.edu**

The Midwest Chapter of AAPL held its annual meeting in Kansas City, MO, March 31-April 1. The Program Committee for the excellent program was Jim Reynolds, Larry Jeckel, Melissa Spanggaard, and Phil Pan.

Outgoing President Larry Jeckel turning the gavel over to Incoming President Delaney Smith.

MUSE & VIEWS

"Documentation is like sex: when it is good, it is very, very good; and when it is bad, it is better than nothing."
- Dick Brandon

Photo Gallery

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Charles Dike asks a question at the Annual Meeting

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