

# AAPL Newsletter

American Academy of Psychiatry and the Law



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## 2013 Presidential Address

### Charles Scott MD: *Believing Doesn't Make It So*

Sohrab Zahedi MD

The 2012 Annual Meeting of the American Academy of Psychiatry and the Law (AAPL) was kicked off by Dr. Resnick's entertaining introduction of the organization's 38th president, Charles Scott, MD, through a presentation of Dr. Scott's impressive biography spiced with catchy photographs.



Before medicine, Dr. Scott's interest and talents were geared towards music. A gifted piano player—he performed before an audience of ten thousand at age 12—he majored in Baroque Music History in college.

Dr. Scott's medical career began at the Emory School of Medicine. He completed residency at Walter Reed Hospital, and a child and adolescent psychiatry fellowship at UCSF. After a brief period of military duty, Dr. Scott continued his training with a forensic psychiatry fellowship at Case Western Reserve University with Dr. Resnick as his mentor. Dr. Scott then joined the Tulane University faculty before becoming the director of the UC Davis program in forensic psychiatry. An active member of AAPL and a leader in forensic psychiatry, Dr. Scott was welcomed to loud applause and a standing ovation.

Anyone who has attended a lecture by Dr. Scott is aware of his effective but lighthearted and humorous approach to teaching. However, in looking to chart a future course for the organization, Dr. Scott purposefully traded in humor for a serious tone.

On March 12th 1968, Jonas Rappeport, MD, started what is now known as AAPL with the simple idea of bringing forensic psychiatrists together to advance the field's body of knowledge. This advancement remains the primary mission today, just like it did at AAPL's birth. However, despite significant organizational growth, the search for scientific truth has been, and remains, a challenge. For example, some among the AAPL membership remember that the annual meeting of 1982 was marked by a guest lecture given by Dr. Alan Stone. Emphasizing the lack of scientific basis in forensic psychiatry, Dr. Stone delivered a stinging critique to the organization. The AAPL leadership took measures—with changes in fellowship teachings and educational material for the membership—to boost the objective aspects of forensic psychiatric assessments. However, as critics

continued to point out, objective standards paled when compared to those of bench scientists.

Among recent events, none has been as powerful a force in the call for improvements in the forensic sciences as the Madrid bombing attacks that took place on March 11th 2004. In an international effort to bring the responsible individuals to justice, input from the Federal Bureau of Investigation's fingerprint-matching experts led to the false accusation of an American citizen. It turns out fingerprint technology is not as accurate as once thought. Subsequent lawsuits prompted Congress to call on the National Academy of Sciences (NAS) to evaluate the state of forensic science in the United States.

NAS produced a 2009 report titled "Strengthening forensic science in the United States: A path forward." The good news for forensic psychiatry is that despite being poorly defined, it is a recognized forensic field. Therefore, the NAS' recommendations for improving the forensic sciences apply to forensic psychiatry as well.

NAS' first recommendation was establishment of reliable methodolo-

*(continued on page 2)*



Incoming President Debra Pinal bids Charles Scott farewell from office with President's award.



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## COVER STORY

### Presidential Address

*continued from page 1*

gy for the active analysis of evidence. While Dr. Scott acknowledged the diversity of assessments in forensic psychiatry (malingering, custody assessments, etc), he focused on that of violence risk as an illustrative example. Two hundred years ago, the German physician Dr. Gall relied on phrenology to predict dangerousness. Fortunately, the search for valid methods of assessment continued. By mid 20th century, Dr. Meehl illustrated the superiority of actuarial methods over clinical assessments in the prediction of violence. In 1981, Dr. Monahan's landmark study revealed the glaring deficiency of psychiatrists' and psychologists' power of dangerousness predictability—we were wrong in 2 out of 3 cases. Even if *Barefoot v. Estelle* established the legal arena's willingness to accept such a standard of uncertainty, Dr. Scott challenged AAPL to do better by advancing a proposal that the organization and fellowship training sites educate the membership with a select group of vetted structured psychological tests.

In 2011, Drs. Skeem and Monahan reviewed the mainstream array of structured psychological modalities, including VRAG, COVR, and PCR, used to assess violence risk. These instruments are no panacea and do not replace the clinical interview. They have both strengths and limitations that if used correctly carry the potential for strengthening objectivity. Dr. Scott pointed that even if forensic psychiatrists disagree with use of the psychological instruments, familiarity is essential for ongoing basic research, which in turn would support AAPL's mission in establishing validity of forensic psychiatry as a science. Without this knowledge, the reliability of methodology will be left to the field of forensic psychology. From a socio-political perspective, the present trend is for statutes that require these instruments for clinical assessment. Legislation in Canada, California and Texas speak to this trend. Even though forensic

psychiatrists may become prompted to administer such tests, they are not, in general, qualified to do so as standard forensic psychiatry training doesn't provide adequate training in this area.

The second NAS recommendation was to study and mitigate bias. Applicability of structured evaluation methods is prone to various forms of biases that the forensic assessor brings to the table. The notable example comes from the knowledge that African Americans are more likely to be diagnosed with a psychotic condition compared to white Americans. This holds true even when the evaluator is African American. In short, discovery and application of valid modalities in the search for forensic truth is contingent upon the professional minimizing the subjective aspects of assessment.

In conclusion, in his presidential address, Dr. Scott challenged AAPL to establish a robust scientific basis in advancing its body of knowledge. Following the NAS guidelines, the research for this knowledge should be based on valid scientific principles, and measures in mitigating assessment bias should be adopted and researched. Beyond scientific research, Dr. Scott challenged the AAPL membership and Institute on Education and Research with the task of incorporating gained knowledge into AAPL's mission of educating its participants. This knowledge will advance the field as the membership looks to educate future generations of fellows and rise in standing in academic, administrative and clinical arenas.

In introducing Dr. Scott, Dr. Resnick, a modern icon of forensic psychiatry, described his former mentee as one who has exceeded his fellowship director but not Dr. Resnick's expectations for him. In the same measure, Dr. Scott challenged the membership to exceed the expectations of AAPL's 38th president in advancing the science of forensic psychiatry. If the applause and standing ovation that he received is any indication, Dr. Scott will not be disappointed. ☯

## AAPL in Montreal

Charles C. Dike MD, MPH, MRCPsych



The last time AAPL had her annual meeting in Montreal, Canada, in 2005, urgent family commitments made

it impossible for me to attend. To make matters worse, I had never been to Canada, and had been looking forward to the meeting as a gentle way to introduce myself to Canada; alas, it wasn't to be. Incidentally, that was the only AAPL annual meeting I have missed since I became a member of AAPL over a decade ago.

So, this time, I was ready. As it came to me, I thought, why not kill two birds with one stone - why not visit the capital city of Canada, Ottawa, as well, before swooping into Montreal, especially since both cities were not too far away from each other? Easy decision. Suddenly the AAPL meeting, which is usually exciting all by itself, had become even more so, with the added adventure of discovering and exploring new places, a hidden passion of mine.

The weekend before the AAPL meeting, I rented a car and drove up, with my family, to Ottawa from CT. Upon learning of the purpose of my trip to Canada, the agent at the border happily informed me that she had attended to a couple other visitors from the US who were also going to the "conference of psychiatrists in Montreal." There couldn't have been any other conference of psychiatrists from the US in Montreal other than AAPL Annual Meeting. Or could there?

As soon as we crossed into Canada, the measurement of distance changed immediately to Kilometers from Miles, forcing me to reach way back into my early student days in Nigeria to understand what that meant. I had to do quick mental cal-

culations to understand how far I still had to go to get to Ottawa.

Ottawa is a lovely, modern and vibrant city, with nice, helpful and welcoming residents, all of whom seemed happy, relaxed and easy going to me. After a tour of the Governor General's Mansion (equivalent of the White House in the US, I was told), visiting endless beautiful parks of Ottawa, and the Pink River which is actually usually green (don't ask me), sadly, it was time to depart for Montreal. Of note, the whole city of Ottawa was in celebratory mood, and was decorated in bright colors with statues and pictures of patriots from the American war of 1812; it was the 200th anniversary of the war, and many residents of Ottawa proudly declared to me - once they knew I was from the US - that they had won the war. I was surprised there had been no mention of the war across the border in the USA before I left and when I came back. Is there a message in that? Is the war something better forgotten about around here? I wonder...

The train ride from Ottawa to Montreal was sheer bliss. I swear I must have had two to three appetizers before the main meal! All I now recall is the food just kept coming, and for a while, I thought I was on an airplane flight in 1995 when they fed you liberally. The two hour journey ended too soon; I was having too much fun.

And then, Montreal. What a pleasant surprise! I thought I had been catapulted back to early France with cobble stone and narrow streets. It seemed like every day was a party day for some of the locals; lots of young people brightly dressed, and young at heart who moved in groups and appeared to be either coming from or going to a party. It was a relaxed atmosphere indeed! I wondered if Halloween had something to do with it. I was particularly impressed by how easily people switched from French to English and

back again. It seemed everyone could speak both languages. I was jealous. For more than a second, I considered moving my children to Montreal for a couple of years to immerse them in French. I am still thinking...

The AAPL meeting was in full swing. In attendance were lots of international participants and psychiatrists who enriched the meeting. Two luncheon speakers, David Kaczynski and Brigadier General Stephen Xenakis, MD, had electrified the audience on consecutive days with their gripping personal stories; Kaczynski, about the ravages and well known consequences of his brother's psychotic illness, and Gen. Xenakis, about army psychiatrists working in Guantanamo Bay and involvement in torture. The stage was now set for the third luncheon address, The Psychopath Test, by Journalist and writer, Jon Ronson. But it was not to be. Predictions of massive devastation from Hurricane Sandy, which was about to make landfall, poured in quick and fast. The airwaves were abuzz with anxious anticipation and panic. The anxiety quickly became contagious. The third luncheon speaker suddenly cancelled; the airways, and in fact, most other means of transportation, were no longer safe. Thankfully, Dr. Philip Resnick gallantly rose to the challenge and rescued the third and last lunchtime address by giving a presentation on paranoia and violence on short notice. It was vintage Dr. Resnick, with punch and pomp. The meeting was saved.

Sandy, however, continued to bear down ominously around the Eastern US. As much as Hurricane Irene had struck AAPL with an upper cut the year before in Boston, Sandy was promising to do even more harm. Meeting participants living in the East Coast of the US began to scramble to get home. It was "déjà vu all over again." Two consecutive devastating Hurricanes during an AAPL annual meeting in two consecutive years! What are the chances? Regardless, the AAPL Meeting was a huge success. And... I love Montreal. ☺

## Privilege and Opportunity: Helping AAPL Take the Next Steps Forward

Debra A. Pinals MD



It is with a great sense of privilege that I write my first column as the 39th President of the American Academy of Psychiatry and the Law (AAPL). The organization, established in 1969 with its first President, Jonas Rappeport, MD, has seen a long line of distinguished forensic practitioners, forensic scholars, forensic teachers, and forensic leaders at its helm. Each of these individuals has taken AAPL forward in its development, and I am honored to be among them.

In this first column as the organization's President, I wanted to describe my experience with AAPL, to perhaps call upon other members, including our younger members, to become involved and to grow with the organization. AAPL means so much to so many people. In looking ahead, my goal is to continue to maintain AAPL's strengths and its presence as a professional home.

The main goal of AAPL has been from its beginning to provide education to its members. The recent Annual Meeting in Montreal is a perfect example of the outstanding educational opportunities that this organization is able to provide its members, and Program Chair, James Knoll, IV, MD did a terrific job putting it together. Educational sessions at the Annual Meeting included opportunities for case-based learning, audience participation and feedback, as well as well-researched content on topics such as community forensic services, specialty courts, veterans, ethics, sleep disorders, and civil forensic evaluations.

At the recent meeting, our prior President and my close colleague, Charles Scott, MD, charged us with staying abreast of the current literature and forensic science behind our

work, and I hope to see opportunities for us to meet this goal. We have two strong Program Chairs, Barry Wall, MD, and Stuart Anfang, MD, to develop our meeting in 2013 in San Diego. They are busy lining up luncheon speakers and looking for interesting ideas for a mock trial or special presentation for the Thursday evening slot. I hope to see many people there, including representatives from the international community.

In addition to the meeting activities, another goal for this year is to see that AAPL continues to develop Maintenance of Certification and other educational products. With the help of many members, we have built

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*“Although education is a key priority, as I have noted, AAPL is much more than just an organization for education. It is and can be one’s professional home.”*

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a multiple choice question bank and are looking at web-based exam templates from which we will be able to offer Online Self Assessment CME credits. We have also developed a Performance in Practice patient feedback form and two clinical modules (on disability and competence to stand trial assessments). A new set of Practice Guidelines is in development, and updates of our existing guidelines are underway. In addition, the AAPL Institute for Education and Research is actively reviewing proposals for training and research that will help move our agenda forward. The Journal and Newsletter continue to provide vehicles for peer-review publication and creative professional

journalism. We welcome input, submissions, and feedback for any of these activities.

Although education is a key priority, as I have noted, AAPL is much more than just an organization for education. It is and can be one's professional home. In years past, when I went to my first AAPL meeting in Seattle in 1995, I did not know many of the attendees other than my mentor and my co-fellow. Having previously attended other professional meetings, I found the AAPL meeting refreshing. As it turns out, my first AAPL meeting was the last one when I knew only a small group of people. The meeting was full of enthusiastic participants, interesting meeting choices and a content-rich forensic review course. In addition, the tone of the attendees was notably friendly. The same was true at each and every subsequent conference, so much so that over the years, AAPL has evolved into a time of reunion with colleagues from across the country.

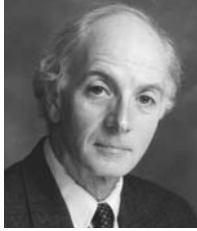
The warmth I have felt extends to people like Mary Cimiluca, of Audio Transcripts, who was given the Amicus Award this year in recognition of her devoted service and numerous contributions to the organization. I began purchasing audio recordings of the proceedings at my first meeting, after being so impressed with the content. I thought at the time and over the years that the woman who sold the audio recordings was so helpful, and it is only fitting that an organization like AAPL recognized Ms. Cimiluca's efforts. It was a great pleasure to speak with her in Montreal and to hear her walk down memory lane as she expressed her appreciation of having received this honor. This is just another example of how AAPL truly represents a place where we can mingle amongst friends, get CME credits, obtain curbside professional consultations with just about every expert on any subject in forensic psychiatry, and find one's intellectual self feeling satisfied.

In between meetings, volunteer projects and participation within the organizational infrastructure has

*(continued on page 18)*

# Consensual Sex with a Patient: Does Unethical Equate to Malpractice?

Howard Zonana MD



Psychiatrists having sex with their patients did not enhance the reputation of psychiatry. When surveys in the 1980s indicated that

between 5%-10% of psychiatrists reported having sexual contact with their patients, the American Psychiatric Association responded by clarifying the ethical guidelines and making them more stringent so that even contact with former patients was deemed unethical even if years had past since the original contact.

Although the general prohibition for all physicians was incorporated in the Hippocratic Oath,<sup>1</sup> the ethical guidelines for non-psychiatric physicians was not directly addressed until the early 1990s when the American Medical Association first adopted a guideline that made sexual relationships with current patients unethical in their Ethics Code.<sup>2</sup> This was expanded in 1998 when the AMA issued a report on “Sexual or Romantic Relations between Physicians and Key Third Parties.”<sup>3</sup> For psychiatrists, the ethical prohibition quickly became the standard of care in malpractice litigation. In many states it was also classified a crime by the state legislature.<sup>4</sup>

It was September 2012 when the Pennsylvania Supreme Court first addressed the question whether a medical general practitioner who provides “incidental” mental health treatment to a patient with whom he then engages in a sexual affair, may be held to the particularized “specialist duty” applicable to mental health professionals, that prohibits consensual sexual contact with patients, such that the doctor may be held negligent in a malpractice claim. Their conclusion was surprising.<sup>5</sup>

Mr. and Mrs. T both began seeing Dr. W in 1966. They saw Dr. W for several years and he treated them for

a number of ailments including “libido problems.” The wife was seen for physical ailments, but also symptoms of depression, anxiety, stress, attention deficit disorder and other emotional problems. Mrs. T came to believe that Dr. W had cured her of her problems and told him that he was her “hero” and that she believed she was in love with him. In the spring of 2002, the two began a sexual relationship that lasted for approximately one year. They would meet at the medical center where the doctor maintained an office, in an automobile, and at the doctor’s parent’s residence. Mrs. T became increasingly

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*“... a sexual relationship between a non-psychiatric physician and a patient is outside the scope of the physician’s treatment and is not actionable as malpractice.”*

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anxious and depressed; at one point, she attempted to break off the relationship but the doctor convinced her to continue. She finally ended the affair in January, 2003.

In March, 2003, Mrs. T told her husband about the affair and four months later they filed a lawsuit naming the physician, the medical center and the hospital. The complaint further alleged that the doctor was reckless, negligent, careless and deviated from the “standard of care for physicians under the circumstances” by: instituting and continuing a sexual relationship with his patient; failing to end the sexual relationship; failing to insist the wife find another physician to treat her for her medical and men-

tal/emotional problems; placing his own physical needs and desires before the psychological welfare of his patient and violating the standards of ethics for physicians, among other complaints.

The doctor argued that because he was a general practitioner and not a mental health professional, no “therapist-patient relationship” arose between himself and Mrs. T that could trigger a mental health specialist duty to avoid a sexual relationship. Thus the doctor argued that malpractice allegations were legally unsustainable under Pennsylvania law. The trial court concluded, based on preliminary motions, that the doctor’s conduct may have been unethical but it was not a breach of the duty of care when a “general practitioner engages in sexual relationship with a patient.”

On appeal, a divided three-judge panel of the Superior Court affirmed the trial court’s decision. The Superior Court granted re-argument *en banc*, withdrew the original panel decision, and, in a new 6 to 3 decision reversed the trial court’s decision. The majority opinion held that “a patient does have a cause of action against either a psychiatrist or general practitioner rendering psychological care when during the course of treatment the physician has a sexual relationship with the patient and causes the patient’s emotional or psychological symptoms to worsen.” They also stated: “we believe that there is no reason to distinguish general practitioners from psychiatrists when those general practitioners are treating their patients’ psychological problems/conditions. In both cases the physicians need to maintain the same trust when rendering psychological care.”<sup>6</sup>

The three-judge dissent argued that the allegations did not satisfy the standard applied by an earlier Pennsylvania decision because there was no claim that the doctor *proposed* sexual relations as part of his treatment of Mrs. T. The relationship they felt, was more accurately characterized as a “consensual nonmedical sexual affair between a doctor and a patient”<sup>7</sup> that “does not constitute the

(continued on page 6)

## Consensual Sex

*continued from page 5*

rendering of a medical skill associated with specialized training.” The dissent considered the doctor’s conduct to be unethical but not actionable as medical malpractice.

The Supreme Court of Pennsylvania granted cert. and slightly reframed the question. They asked, “Whether, for purposes of determining professional negligence, a general practitioner who provides mental health treatment to a patient is held to the same higher duty as a specialist in psychiatry or psychology?”<sup>8</sup>

Mr. and Mrs. T, in their briefs, cited their expert’s reference to a study published in the *New England Journal of Medicine* in 2000, which concluded that general practitioners were, at that time, providing more than 75% of mental health therapy for depression. In their view this new reality should mandate that mental health professional’s duty to avoid sexual contact with patient should be imposed on all medical providers who render mental health care regardless of specialty.

The majority opinion first notes that the question of duty in tort cases is “a legal determination, assigned in the first instance to the trial court and subject to plenary appellate review.”<sup>9</sup> They also argue that in addition to Pennsylvania it appears that nearly all jurisdictions in the United States hold medical specialists to some “differentiated or heightened standard of care compared to that governing general practitioners, especially where practitioners hold themselves out as specialists or are board-certified in a specialized field.”<sup>10</sup> But they note that neither the Pennsylvania General Assembly nor the Pennsylvania Supreme Court has yet to recognize that the standard of care governing mental health specialists strictly prohibits mental health professionals from engaging in sexual relations with patients.

They acknowledge that the dominant view among the states that have considered the issue in the case of mental health professionals’ conduct

is that sexual relations with the patient, even if ostensibly consensual, may be the basis for a viable malpractice claim. They also acknowledge that no jurisdiction has rejected the view that a mental health professional’s conduct in engaging in a sexual affair with a patient is actionable in tort. They note, however, that in this case the expert’s testimony did not reflect a sufficiently certain opinion that the malpractice caused the plaintiff psychological injuries. They concluded that Pennsylvania would hold mental health professionals to a standard of care which would include a duty to avoid sexual contact with their patients.

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*“GPs were less likely than mental health professionals to recognize, understand, and employ transference as a conscious therapeutic method.”*

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On the issue of extending the duty to non-mental health professionals the majority felt that the great weight of authority held that a sexual relationship between a non-psychiatric physician and a patient is outside the scope of the physician’s treatment and is not actionable as malpractice. They commented that there was no evidence before them regarding the transference phenomena and therefore would not opine on the general acceptance of the transference phenomenon in the mental health field, but they did note that transference is not a recognized component in the medical treatment of physical conditions. They added there was no evidence on the record that the transference phenomenon was a factor in the instant case.

They also felt that GPs were less likely than mental health professionals to recognize, understand, and

employ transference as a conscious therapeutic method. Second, they felt that imposing the same absolute duty to avoid sexual contact burdens the social utility in general practitioners serving as “first stop medical providers” treating mental conditions that may not be so severe as to require a mental health specialist. Third, they saw the foreseeability of harm stemming from sexual relations as a close call but in the end they viewed this factor as weighing against extending the mental health professional’s duty to general practitioners, even if the general practitioner has engaged in some degree of care regarding the patient’s mental and emotional well-being. Fourth, they felt that holding general practitioners “providing incidental care” to the same standard would have the effect of discouraging general practitioners from rendering what appears to have become relatively routine attention to their patient’s mental and emotional well-being. In sum, they overturned the ruling of the Superior Court and did not extend the tort liability to general practitioners.

There is a strong dissent by Justice Todd. She initially notes that this case is early in the legal process where all the facts have not been gathered, and whether, on the facts posited, Pennsylvania law states with certainty that no recovery is possible. She notes how the majority minimizes the nature of the mental health treatment by calling it first “incidental” and then reframing the question to general practitioners who provide “some degree” of mental health or emotional counseling, or who prescribe “common medications” for depression or anxiety. She feels the pleadings thus far make it unclear as to the exact nature of the treatment and the majority’s conclusion is therefore premature.

She further characterizes that the majority’s concern on placing a duty on general practitioners would create a “absolute duty” in general practitioners to refrain from sexual relations with patients they are treating for mental health issues and would

*(continued on page 18)*

## Annual Meeting: Location, Location, Location

Jacquelyn T. Coleman CAE, Executive Director



When you read this, submissions for the 2013 Annual Meeting will be flooding in. Our location will be the lovely and picturesque Hotel Del Coronado, on Coronado Island off San Diego.

AAPL met once before at “The Del,” in 1990.

I have been asked by the 2013 Program Committee chairs, Stuart Anfang, MD, and Barry Wall, MD, to remind you that civil topics, including child custody and psychiatric disability, are especially encouraged, as well as submissions related to the President’s Theme: Forensic Issues in Public Sector Psychiatry.

This will be our first beach meeting in quite some time.

But let’s linger in the glow of charming Montreal a little longer, and near the end of this article I’ll write more about the science, or lack thereof, in picking meeting destinations.

Our attendees seemed to love the city, and who wouldn’t? Once again a freak storm caused a few of our participants to leave early. I really hope this won’t become a habit!

The 2012 meeting was the third highest attended meeting in AAPL’s history, one attendee shy of the 1998 Orleans meeting.

Meeting attendance was 735, and Forensic Review Course attendance was 220.

There were 95 Canadian attendees and 29 from other non-US locations: Australia, Belgium, Chile, Germany, India, Israel, New Zealand, Norway, and the United Kingdom.

Our lunches were very well attended. The Friday lunch with David Kaczynski, the brother of Unabomber Ted Kaczynski was the best-attended in ten years. Many who attended that lunch remarked about the emotional impact of the talk, the summary of which is printed in this issue.

AAPL is also grateful to Philip Resnick, MD, who reached into his awesome armamentarium to produce a lunch talk for Saturday, when our scheduled speaker, Jon Ronson, was waylaid by the aforementioned storm.

Now on to the topic of how AAPL picks meeting locations and hotels. There are several factors that go into these choices, and since the group of people sitting around the table is different at each stage, people will rank and weigh criteria differently. It always amuses me when I present a list of properties and cities to the assembled group and someone says “How did you come up with THAT one?” And the answer is that the last group of people sitting at the table gave it to us as a priority. The “group around the table” are the Council at either its spring or fall meetings, and the group of officers that assembles early each year as a budget review and strategic planning function of the Academy. It depends on how fast the process goes as to who initiates the choices and who makes the final choice.

As for the speed of our decisions, we want to look at market conditions first of all. We accelerated our timetable for picking meeting sites during the recession because we knew that certain properties we considered very desirable were perhaps no longer out of our reach. On the other hand, when it’s a seller’s market, we will cast our net more widely.

It’s also important to know how hotels make their decisions about whether they find a group such as ours desirable. Each hotel has its own formula for weighing the number of promised sleeping rooms and food and beverage consumption against the amount of space the group is requesting. If we hit the sweet spot combining the space they have available and their desired profit, they will make us an offer. The initial offer will include discounts on sleeping rooms and food and beverage. If we like what a hotel is offering, we then ask to see the layout

of the space they plan to allocate to us.

I have in my mind an ideally sized and spaced hotel. It doesn’t exist, of course. I prefer a large open registration area that can incorporate our posters and coffee breaks and some small side areas for seated conversation. To me, the “buzz” of spirited conversations epitomizes AAPL’s character. I would also like to have every meeting room on the same floor or easily accessible between two floors. I am much less likely to get that wish fulfilled. Also, it’s important to note that we have no bias toward any particular hotel chain. Where we end up, even if we end up at the same hotel chain two or three times in a row, reflects simply the combination of the best space available and prices offered.

A harder function to describe is how we come up with the list of desirable locations. Believe me, there are beach people and city people, and there are resort people and urban people. I think in the end everyone ends up enjoying the place and the meeting, even if they think they are temperamentally suited to another type of place. Also surprising to many people are the number of locations we cannot fit into. Another consideration is how many airport connections people are likely to have to make and how many flights arrive at the nearest city daily. These days with airplanes running full, it’s hard to change flights at the last minute, and the inability to make the necessary change results in having to miss the meeting. That is particularly true of flights outside the contiguous US states.

There also seems to be a desire to avoid the large cities where APA meets, since members get a chance to visit there often. But I also observe avoidance of what I would call middle-tier cities. I don’t think it’s because people have been there and hated them. I think it’s because certain cities have characteristics associated with them that the average AAPL member finds more desirable and those other cities are perceived not to have those characteristics.

So let’s see what you think. Here are our destinations in the coming few years: 2014: Chicago; 2015: Fort Lauderdale; 2016: Portland, Oregon. ☎

## Brigadier General Stephen Xenakis: "We Wear the White Coat at All Times"

Maya Prabhu MD, LLB

It is a pleasure to present a synopsis of the first lunchtime speaker at the 2012 AAPL Annual Meeting, Brigadier General Steven Xenakis. Currently director of



Child and Adolescent Psychiatry at the Psychiatric Institute in Washington, Dr. Xenakis retired from the US Army in 1998 at the rank of brigadier general. He is best known for his work since then calling for the humane treatment of detainees in US custody and speaking out against the involvement of medical personnel in abusive interrogations. Dr. Xenakis' talk in Montreal seemed most timely, coming shortly after the return of Omar Khadr to Canada, after a decade in detention in Guantanamo Bay, Cuba. As Dr. Xenakis went on to describe, he had evaluated Khadr's physical and mental health as part of his defense for his military trial (though Dr. Xenakis did not testify) and had found himself in the news again, now part of the Canadian debate about Khadr's repatriation. While Dr. Xenakis framed his remarks in terms of the role of the psychiatrist in 21st century warfare, the story he ultimately told was a deeply personal one, informed by the work with Khadr and others and emphasizing this message: that despite tremendous political and institutional pressures, physicians ought not to let themselves be part of the degrading treatment of prisoners, and that clear guidelines for psychiatrists' conduct are needed to protect prisoners and physicians alike.

Dr. Xenakis began his talk with an overview of how psychiatrists and other mental health professionals were drawn into the center of the war on terror since 9/11/2001. He described this as being the result of a shift in military focus from the broader battlefield to the individual combatant ("soldier-centric"). As AAPL mem-

bers who recall the APA and AMA discussions of 2006 will already know, as part of this heightened scrutiny of the "high-value individual," military psychiatrists and forensic psychiatrists were actively recruited to interrogation teams at Guantanamo and elsewhere. Dr. Xenakis detailed how prisoners were subjected to sleep deprivation, extraordinary sensory overload, and solitary confinement, not to mention harsher techniques to "break down resistance;" mental and medical professionals were then called upon to diagnose and

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*"In a presentation which did not mince words, it was impossible not to share Dr. Xenakis' feeling of being "unsettled" with the reminder that physicians, close to home, had strayed so far from their original therapeutic roles."*

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treat the resulting conditions. The US government then relied on forensic evaluations by these practitioners for prosecuting cases before its Military Commissions and federal courts. Thus, for Dr. Xenakis, the role of mental health professionals in the new warfare had become both tactical, at the level of individual engagement, and strategic, as their professional opinions had a deep systemic impact.

Dr. Xenakis expressed profound dismay about the ways he felt that psychiatric opinions had been distorted – from the failure to document physical signs of abuse, to the avoidance of appropriate psychiatric diag-

noses, such as PTSD, which would draw attention to the experience of abuse, to the misuse of psychiatric authority to characterize political or cultural beliefs as pathological. In an anecdote about Khadr, and a second about another young detainee, he observed that even the prisoners themselves were able to grasp the distorted dynamics in which their mental health professionals operated. Dr. Xenakis described how his review of many such evaluations had caused him to be concerned that the work of psychiatrists could drift towards becoming a tool of coercion as it had, historically, in repressive regimes. He expressed amazement that in the "span of one generation," the United States had travelled from condemning medical officers at the Nuremberg trials for their collusion with torture to the current involvement in the name of obtaining intelligence.

In thinking about the command structures and operational settings in which medical personnel were "caught," Dr. Xenakis recognized the very real problem of "dual loyalty": the tension between fulfilling one's role as medical practitioner with the imperative to "do no harm," and the obligation to support the demands of the military mission. He characterized this as the most "elemental" of conflicts and the source of deep resistance to his stance, both within and without the military. Notwithstanding these complexities, citing the work of Human Rights First, with whom he and a coalition of retired generals and admirals advocate for the respectful treatment of prisoners, Physicians for Human Rights, and even experienced FBI interrogators, he called for a firm renunciation of the idea that torture is effective, necessary or even "American." He rejected it as an expression of conviction or a useful tool for gathering reliable intelligence. And he called for AAPL, among other organizations, to continue to affirm the core principles of good clinical practice. In perhaps the most heartfelt moment "between colleagues," Dr. Xenakis made a point of thanking AAPL for its position statement on interrogations in

*(continued on page 14)*



## The Unabomber and His Family

Brian Cooke MD



AAPL attendees were privileged to listen to a luncheon address given by David Kaczynski entitled, “The Unabomber and His Family.” David is Executive Director of New Yorkers for Alternative to the Death Penalty and the brother of Theodore Kaczynski, the so-called Unabomber. Although many in the audience were probably familiar with the story of Theodore and his involvement in a series of bombings that caused three deaths and numerous injuries over 17 years, few know the story of “Ted” from the perspective of a brother who truly loved him.

Ted, we learn from his brother, was brilliant. He skipped two grades and graduated from high school at the age of 15. His IQ was measured at 165. He was the first person in the family’s community to receive a full scholarship to Harvard. Despite these gifts, there were a number of concerning developments in Ted’s life that may have contributed to his later actions. David provided a series of these snapshots told through a lens of hindsight and often coupled with the suggestion that perhaps there could have been an earlier intervention to prevent the tragedy that later ensued.

David was aware by a young age that his brother was “special.” Ted was different than other children, because he was always alone. Their mother explained to David that when Ted was 9-months-old, he was hospitalized for two weeks with a rash. His parents were only allowed to visit him in the hospital for several hours a week. When Ted came home, his mother felt he was different. For his mother, this was a crucial event in Ted’s development.

David described another “piece of a perfect storm” in Ted’s life. While in college, Ted volunteered for a psychology research project studying personality in which he endured a

weekly attack on his belief systems for three years. The family never completely understood the purpose or ethics of this project. Ted later told his family that this was “one of the worst experiences of [his] life.”

Later, while he was working on his PhD in mathematics at Michigan, Ted had a psychotic break. He wrote over 30,000 pages of diary entries, which later showed his brother “an inner world of torture.” The writings carried themes of referential delusions and paranoia, but no one in the family

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*“Despite the FBI spending 17 years of searching for the Unabomber, spending millions of dollars and committing dozens of federal agents to the search, it was David’s wife who first knew that his brother was, in fact, the Unabomber.”*

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quite understood the significance. At some point, Ted sought services at the University’s mental health clinic, but he “shut down,” could not explain his distress to the clinician, and did not receive any treatment. Later, it was learned that at that time Ted had had a realization that he could be happy if he killed a psychiatrist or a scientist.

Another important turning point came while working as a professor at the University of California, Berkley, when Ted wrote a letter to his parents notifying them he intended to quit his job. David initially admired this decision, because it was the ‘60s – a period of “drop out and go back to nature.” Their mother, however, was

worried. Ted then spent the next 25 years living in isolation in a cabin in the woods in Montana.

Ted’s withdrawal from his family continued and contact with them was only through letters. Ten years after leaving Berkley, he sent a 25-page letter to his family describing his realization that his life-long unhappiness came from a lack of love from his family. He had developed a fixed belief that his parents were cruel and unloving. This accusation left his parents confused and asking, “What did we do wrong?” The family still did not suspect mental illness but continued to think of Ted as “eccentric” and “unusual but very bright.”

David naturally served as the liaison between his brother and his parents. In the fall of 1986, he visited Ted in his cabin and they spent two weeks backpacking together.

Although David felt that Ted was acting “a little peculiar,” he was unaware that he had killed someone with his first bomb approximately six months earlier.

Eventually, it was David’s wife who helped him see that Ted had a mental illness. They took his letters to a psychiatrist and asked the question that haunts many family members, “What can we do?” The family felt as if they were “grasping for straws” to reach out and help him. As a desperate attempt to show love and support, David sent his brother the money he requested when Ted wrote letters asking for \$1000 and later \$2000.

There continued to be extensive media coverage of the search for the so-called Unabomber. One fateful night, David’s wife asked if Ted could be the Unabomber; he told the audience the question “took my breath away.” As excerpts from the Unabomber’s “Manifesto” were released to the public, David and his wife spent many painful hours comparing the writing in that document to the letters received from his brother. Despite the FBI spending 17 years of searching for the Unabomber, spending millions of dollars and committing dozens of federal agents to the search, it was David’s wife who first

*(continued on page 14)*

## Phillip Resnick MD: Paranoia and Violence

Reena Kapoor MD



After a last-minute cancellation by Jon Ronson, author of *The Psychopath Test*, Dr. Phillip Resnick gave a lecture on the rela-

tionship between paranoia and violence during the luncheon on Saturday, October 27. Dr. Resnick, whose many contributions to AAPL and accomplishments as a forensic psychiatrist need no introduction, began with the outline of a case:

*A 32-year-old steel worker in Youngstown, OH was brought to the emergency department of a local hospital because he was becoming more paranoid after an argument with a coworker. He was married and had 3 children. Despite his wife's concern about his mental health in the preceding weeks, he had refused to see a doctor prior to the night he was in the emergency room. When evaluated by a psychiatrist that night, he was noted to be paranoid, but he denied any homicidal ideation or violent intent. He was prescribed Mellaril, and the doctor recommended voluntary hospitalization for further evaluation. However, the patient refused. After a conversation with the patient's wife, who begged the doctor to send the patient home and assured him that she would watch over her husband until an outpatient follow-up appointment could be arranged, the doctor discharged the patient from the emergency room. That same night, the patient stabbed his wife to death while she was asleep in their bed.*

Following this case history, Dr. Resnick polled the audience about whether the emergency room psychiatrist had fallen below the standard of care when he discharged the patient home. Approximately 30% of the audience believed that a deviation from the standard of care had occurred, with the remainder of the

audience stating that the doctor had acted appropriately. Those who believed that the doctor should have hospitalized the patient took the position that a first episode of psychosis always warrants an inpatient admission, regardless of the patient's wishes. Those who believed the doctor acted appropriately cited the patient's statements that he was not homicidal and had no intent to harm anyone, thereby indicating that he did not meet involuntary admission criteria. This difference of opinion served as

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*"... clinicians should not surrender their professional judgment to family members in cases such as this one, where the wife promised that she would keep the patient safe at home."*

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the starting point for Dr. Resnick's examination of the relationship between paranoia and violence.

Dr. Resnick outlined his main teaching points about the case example. First, he stated that a building crescendo of paranoia creates a high risk of violence. Additionally, he reminded the audience that clinicians should not surrender their professional judgment to family members in cases such as this one, where the wife promised that she would keep the patient safe at home. Finally, he articulated an important rule about violence risk: "Posing a threat is not the same as making a threat."

Several types of delusions have been linked with violence: erotomanic, misidentification (Capgras delu-

sions in which the patient believes that people have been replaced by imposters), threat/control-override, and persecutory delusions. Dr. Resnick noted that paranoid people are twenty times more likely than the general population to have received threats in the past. Their hypervigilance about being harmed often begins as a "normal" response to real threats, but gradually they develop excessive sensitivity to the negative emotions of others—paranoia.

Dr. Resnick noted that violent acts carried out by paranoid people are usually a pre-emptive strike against the perceived threat, and they are often well planned. Common motives for paranoid violence include self-defense, defense of children, defense of the world, and defense of manhood. In response to paranoid fear, individuals typically react with 4 strategies: avoidance, protection of their loved ones, decreased visibility in the community, and enhanced vigilance. Projection is a key psychological defense mechanism in paranoia. Dr. Resnick noted that a common thought process found in individuals who commit violence against romantic partners in defense of their manhood is, "I love you," followed by, "I hate you," followed by, "You hate me."

Dr. Resnick concluded the lecture with some strategies for managing paranoid patients. First, he stated that a therapeutic alliance with the patient is crucial. This alliance can best be achieved by listening to the full paranoid story that the patient is telling without challenging the delusions or appearing skeptical. A non-judgmental stance is very important. In addition, Dr. Resnick noted that paranoid patients often feel threatened by expressions of caring or intimacy, which they perceive as intrusive or duplicitous. Maintaining distance, both physical and emotional, can be very helpful in making the paranoid person feel more comfortable in the therapeutic relationship. Ultimately, strengthening the therapeutic alliance can be an important protective factor for future violence. ☪

## Forensic Aspects of Gay Conversion Therapy

Stephen P. Herman MD



Should certain “therapies” be made illegal? The State of California thinks so. In January 2013 a law went into effect making so-called gay con-

version or reparative therapy illegal. The basis of the law, signed by Governor Jerry Brown, is that there is no scientific evidence supporting this kind of therapy and that, in fact, it can cause serious harm to patients. A federal judge is scheduled to hear from conservative groups who claim the law is an infringement on free speech, religion, and privacy.

And in New Jersey, four gay men once enrolled in this process have filed a civil suit against a center called Jews Offering New Alternatives for Healing, or JONAH. Its co-founder, Arthur Goldberg is an ex-convict imprisoned for financial fraud committed in the 1980s. His partner, Alan Downing, has called himself a “life coach.” The group claims it has worked with Jews and non-Jews to correct their same-sex attractions. The suit was brought for deceptive practices under the New Jersey State Consumer Fraud Act. Neither of the men are licensed therapists, so they are not subject to professional censure.

One of the plaintiffs had been referred to JONAH by a rabbi when he was 18. He attended weekend retreats at \$650. He was in a group and also had private sessions. He finally quit the “therapy” after Downing had him remove his clothes, touch himself and reconnect with his masculinity! He is claiming severe psychological distress from his experiences with the group. He consulted with a licensed psychologist who has been helping him develop comfort and confidence in his sexuality. He knows he cannot change that and has

claimed JONAH had him believing all kinds of nonsense about his past.

The dean of the law school at UC Irvine has stated that government can prohibit healthcare practices that are ineffective or harmful.

There are gay conversion centers all over the country, attended by men and teenagers distraught by their same-sex attractions. They are given to believe that their homosexual urges can be replaced by “normal” sexual attraction to the opposite sex, provided by these “back to masculinity” centers. But many of these boys and men have suffered from the sham therapy and have developed serious symptoms of depression, anxiety and self-loathing.

The American Psychiatric Association, in 2000, issued a position statement, *Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)*. The APA noted other organizations, such as the American Psychological Association, the American Psychoanalytic Association, the National Organization of Social Workers and the American Academy of Pediatrics have all cited the harm caused by these therapies. The position statement concludes: “Therefore the American Psychiatric Association opposes any psychiatric treatment, such as reparative or conversion therapy which is based upon the assumption that homosexuality *per se* is a mental disorder or based upon the *a priori* assumption that the patient should change his/her sexual homosexual orientation.”

Advocates of conversion therapy tend to be fundamentalist Christian and right-wing organizations. The main organization promoting secular forms of this therapy is the National Association for Research & Therapy of Homosexuality (NARTH).

As challenges are brought to the California law, and more civil suits are filed throughout the country,

forensic child and adult psychiatrists will undoubtedly be called upon as expert witnesses. Their responsibilities will be two-fold: to bring to the court a clear understanding of what gay conversion therapy is supposed to be and why it has been almost universally condemned, and to make known findings in the plaintiff which might elucidate his/her psychiatric distress and diagnoses from participating in such unproven therapy. That could mean opining that therapists had a direct duty to the plaintiff, were negligent in that duty and caused damage. There is much in the psychiatric literature to support such findings.

There will always be new and intellectual challenging roles for the forensic psychiatrist. Debunking the myth of gay conversion therapy and supporting plaintiffs who may have been hurt in such programs will be another novel and necessary role for such physicians. ☯

## Nominations for AAPL Sought

The Nominating Committee of AAPL will be presenting a slate of Officers and Council candidates at the Semiannual Business Meeting in May, 2013.

Any regular AAPL member who would like to be considered for a position should send a letter to the AAPL Office with a statement regarding his/her interest in serving and a brief summary of activities within AAPL.

Open officer positions are: President-elect (one year); Vice-President (one year); Secretary (one year); Treasurer (two years). Councilors serve for three years. Attendance at both the Annual and Semiannual Council Meetings is expected of all officers and councilors.

Please send statements of interest and activity to Debra Pinals, MD, Chair, Nominating Committee, AAPL, P.O. Box 30, Bloomfield, CT 06002 by March 31, 2013. ☯

## Forensic Psychiatry and Eating Disorders: Encompassing my Past, Present, Future

Patricia Westmoreland MD



When applying to a Forensic Psychiatry Fellowship Program, I stated that my interest in forensic psychiatry began during the five years

I worked for the Iowa Department of Corrections. I enjoyed working in a correctional environment and was looking for a fellowship program where I could further my knowledge of correctional psychiatry and my interest in criminal forensic evaluations. I espoused the view that I knew far less about the civil than the criminal arena, and did not have much experience in civil forensic practice. However, I later realized that my interest in forensic psychiatry began far earlier than I had originally suspected, and had begun with a civil forensic experience.

As a resident in a combined internal medicine and psychiatry program, I treated psychiatric patients who were medically ill. On one such occasion, I was working on the Eating Disorder Unit when I admitted a young woman in her early teens who was in dire need of treatment for anorexia nervosa, restricting subtype. She weighed approximately 60% of ideal body weight, and was seriously ill. Her parents, at first eager to have her admitted to the hospital, had second thoughts about our recommended course of treatment (which included having their daughter eat a variety of foods, some of which they feared she may not like). They considered removing their daughter from the treatment program. Concerned that she was gravely disabled due to her psychiatric illness, and because her illness was life threatening, I petitioned the court for involuntary treatment, over the objections of the patient's parents. At the committal hearing, the patient's parents testified that, although they wanted their

daughter to be discharged from the Eating Disorder Unit, they did not have an alternative treatment plan. The patient was civilly committed and offered no resistance to treatment. Several months later, she completed the treatment program and was discharged after attaining (and then maintaining) her goal weight.

Several years later, a social worker involved with the case sent me a newspaper article featuring my former patient. She had won a national academic scholarship and was about to begin pre-med studies at an Ivy

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*“Although eating disorders are the most lethal of psychiatric illnesses, mental health professionals are often reluctant to petition the courts for involuntary treatment.”*

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League college. She was also recognized for charity work in her community. It was five years since she had been treated for anorexia, and she had not been re-hospitalized. I realized that treating this patient's eating disorder, despite resistance from her family, was not an exercise in futility.

Years later, as part of my forensic fellowship, my course work included case law involving civil commitment. Aware of my interest in eating disorders, my fellowship director suggested that I investigate the status of civil commitment for patients with eating disorders in Colorado. At the time, there were no facilities in the state that were able to provide treatment

for patients with eating disorders on an involuntary basis. However, a private facility specializing in the treatment of patients with eating disorders had applied to the Colorado Department of Human Services to be designated as a facility for patients who are civilly committed. A facility with this capability was sorely needed in Colorado. Denver is home to the ACUTE Center for Eating Disorders at Denver Health, a unit providing medical stabilization for critically ill patients with eating disorders. The facility applying for involuntary status (Eating Recovery Center) had the expertise to treat the very severely ill patients once they left ACUTE and is reputed to treat some of the sickest eating disorder patients in the United States: patients who are critically medically ill and close to death who meet the standards for civil commitment.

Involuntary treatment of patients with eating disorders is a complicated process. In many states (including Colorado) guardianship laws do not extend to treatment of mental illness. Although eating disorders are the most lethal of psychiatric illnesses, mental health professionals are often reluctant to petition the courts for involuntary treatment. The reasons for this are multifold and belie the complexity of the illness. In patients with eating disorders, competence is usually suspect only in the narrow area of self-nutrition. Patients often provide rational explanations for their behavior and don't express intent to die. Eating disorders are chronic illnesses, and (with the exception of patients with dangerously abnormal electrolytes) the danger of death may not be thought to be imminent by the courts (Gutheil 1986). There are often frank mistruths regarding eating disorders. For example, some believe that mandated treatment is futile, chronicity is inevitable, and eating disorders are indistinguishable from culturally normative weight concerns (Andersen 2007). However, patients who are civilly committed gain weight at the same rate as those who sign in to treatment voluntarily (Wat-

*(continued on page 14)*

## Is Institutional Psychiatry Incompatible With Being a Parent? Ask a Mensch.

Stephen Zerby MD



Any form of correctional or institutional psychiatry must take into account the fact that there is no opportunity for the forensic

psychiatrist to practice independently. All such work takes place in institutional settings often with formidable management structures in charge of Byzantine policies and procedures.

I truly wish I never had to ask the question in the title but correctional/institutional psychiatry has made me wonder, sadly. To even ask such a question would seem ludicrous to a child psychiatrist or pediatrician, but I question whether our domain of psychiatry and parenthood really mix. In normal work settings (I've worked in other job settings) having a sick or possibly sick child typically elicits some form of sympathetic or at least semi-sympathetic response from colleagues. Many adjectives can be used to describe the experience of seeing a tough boss put aside his or her tough persona for just a bit while expressing sympathy for your sick child: surprising, heartwarming, relieving, heartening, etc. There is so much to be said for such a crucial moment in the employer/employee relationship that managers should take note: this could be a crucial once-in-a-job golden opportunity to build morale and thereby enhance performance, but far too often it is squandered through morale-crushing bureaucratic nonsense.

My forensic fellowship was one trying year for me on a personal level highlighted by the sudden death of a parent. Not long after the burial, I recall going for supervision with a famous forensic psychiatrist who was known for asking pressing and pointed questions and never ever smiling during supervision: it was serious

business discussing research plans and cases, and so forth. When I had interviewed with him for the fellowship spot, I remember crawling out of his office thinking, "Man that was one brutal interview." It had felt like a mental workout – but the good kind of mental burn/pain. So, while still acutely mourning and dragging myself into supervision, he asked me how things were going and I replied that I was really dragging, it was hard to focus, my energy level was low, and so on. He appeared surprised and asked me why I felt that way. I said

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*“Leadership is not simply about enforcing protocols and giving orders: motivating people to go above and beyond in their efforts and reach their full potential is also critical ...”*

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something like, “you know, my mom just died,” assuming he already knew, but the expression on his face told me otherwise. But then – and I'll never forget this moment – something magical happened. The serious, grim-faced persona suddenly and unexpectedly vanished as he put his hand to his jaw asking me in ever so gentle a manner, “What happened?” Immediately the same question came into my head albeit slightly altered: “What happened to Dr. Grim? He's become – well – *Dr. Mensch*” (as a trainee, my child division director wisely taught me of the virtues of Menschdom; a *mensch* is in essence “a good person”). What followed was

one remarkable hour of supervision with Dr. Mensch - who was not listed or promoted in the fellowship brochure but really should have been. It's difficult to explain how much or why that helped, but afterward, my morale boost propelled me to work like a dog the rest of the fellowship, which I completed and did a pretty good job, I think. This taught me that there is such a thing as a “make-or-break” moment. Dr. Mensch had performed brilliantly by revealing his true persona at a critical time and deserves praise for having the wisdom and good heart to do so. In fact – and this is the most impressive part of the story – to this very day I still feel a sense of loyalty to Dr. Mensch and his department, all resulting from that one all-important hour. Be a *mensch* toward someone and his or her enduring hard work and loyalty may be the result – and the supervisor's reward.

Now we turn to large institutions to monitor their *mensch*-levels. The result? Hovering around zero, in my opinion. Facing a somewhat similar situation but now involving my sick child, I've been looking for another Dr. Mensch to jog my morale a bit but unfortunately the *mensch*, like so many other desirable things these days, seems to be in short supply, at least in these types of settings. Never taking into consideration that institutional cutbacks would include compassion, this past year has been one of empathy and humanity deficits. After proceeding through medical school, residency, fellowships, and then working in various clinical settings, never in a thousand years would I have expected those in healthcare professions to conduct themselves as such, with empathy and humanity deficits. Without going into details, imagine the above Dr. Grim vignette but with a twist: instead of kindly asking, “what happened?” he had replied, “It is against the law for a supervisor to ask a supervisee personal details. I don't care about your family. Have your reports been on time and of adequate quality?” There is little doubt in my

(continued on page 31)

## The Unabomber

*continued from page 9*

knew that his brother was, in fact, the Unabomber. The turning point came one morning when David awoke with a feeling of “crushing depression” and finally realized that there was at least a 50-50 chance that his wife’s suspicion was correct. This led to painful questions of, “Who is my brother? Is he evil?” David and his wife struggled with the dilemma of what to do next, because any decision they made could possibly lead to more tragedy.

Soon, David informed the FBI of their suspicions, and then he realized he would also need to tell his mother that Ted might be the most wanted man in America. His mother handled the news with grace. In April 1996, Ted was arrested without further incident. David’s luncheon address did not focus as much on the developments of Ted’s legal case, because it had received much attention from the media. At some point while incarcerated, Ted made a suicide gesture, which he explained was because he did not want to be labeled as a “lunatic.” He was found competent to stand trial but later denied to proceed *pro se*. Ted refused to pursue an insanity defense. Almost two years after his arrest, he pled guilty to all of the government’s charges to avoid trial.

What happened next, David said, taught him the meaning of restorative justice. On the night Ted accepted a plea bargain, David and his mother were invited to meet one of the victim’s families. The family wanted to personally thank them for turning in their own family member. David cringed when his mother told the widow, “It’s not really my son. It was his mental illness.” With anger, the widow replied, “He knew what he was doing.” (This exchange also illustrates commonly held conflicting perceptions regarding mental illness and insanity.) David’s mother realized her comment was hurtful and said, “I really wish he had killed me instead of your husband.” With this, the widow knew that David’s mother was

in as much pain as she was and said, “It’s not your fault.” This moment showed David that despite great loss, indeed, “Healing is possible.” Just as many families suffered from the actions of the Unabomber, Ted’s mother had lost her son, and David had lost his brother. The impact on AAPL attendees was probably best summed up by the remark from one audience member that David Kaczynski’s address was “one of the most inspiring luncheons in the past 30 years.” ☪

## Eating Disorders

*continued from page 12*

son 2000) and they are often (in retrospect) grateful for this treatment (Guarda 2007). Patients are at a critical stage for being receptive to such treatment when they are in their teens or twenties, and early, intensive treatment is essential if patients are to recover and remain illness-free five years later (Strober 1997), as in my patient.

At the time I completed forensic fellowship, Eating Recovery Center had been granted the pre-requisite status, and was able to treat patients with eating disorders on an involuntary basis. I began a clinical practice at this facility and a part-time private forensic practice that focuses on involuntary treatment of patients with eating disorders and other psychiatric illnesses that cross the medical/psychiatric divide. This is a far cry from the correctional career I had envisioned, but a perfect mix of my experience and training, together with my aspirations to make a difference in this relatively uncharted area of civil forensic practice.

*Patricia Westmoreland MD completed her Forensic Psychiatry Fellowship at the University of Colorado, Denver in August 2012. She is now attending psychiatrist at Eating Recovery Center, consulting psychiatrist at Denver Health ACUTE, clinical instructor in psychiatry at the University of Colorado, and has a forensic psychiatry practice in Denver.* ☪

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## White Coat

*continued from page 8*

2006: he explained that such civilian engagement with military practice was a welcome support to him and like-minded colleagues at a time when they were isolated and marginalized.

In a presentation which did not mince words, it was impossible not to share Dr. Xenakis’ feeling of being “unsettled” with the reminder that physicians, close to home, had strayed so far from their original therapeutic roles. Not surprisingly given the subject matter, Dr. Xenakis’ presentation provoked lively questioning, both supportive and critical, but was ultimately met with a lengthy standing ovation. While challenging questions remain, Dr. Xenakis’ talk was a plea to remember that, “the white coat is worn at all times,” even if there is a military uniform underneath.

*For a succinct review of issues with regard to the role of health professionals in interrogations, both direct and indirect, including references to important opinion pieces and professional resolutions, see “Commentary: It’s About the Fundamentals,” J Am Acad Psychiatry Law 34:4:479-481 (December 2006), Young, J. MD.* ☪

## Ask The Experts

Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send 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. The 2013 columns will address a variety of questions submitted by readers regarding the attorney-expert relationship, including common problems and potential solutions. Dr.'s Kaye and Sadoff have conferred on the advice being provided.

**Q.** What can I do to make sure I get paid for my time and work product? How do I deal with a lawyer who wants more time for a deposition than was allotted? What about the billing issues?

**Kaye:** Most forensic psychiatrists set up a fee schedule based on an hourly rate. Those of us with web sites will post our fees along with a list of services on the websites (eg.: www.courtpsychiatrist.com). At the same time, it is permissible to charge a flat rate or case rate. It is not permissible to charge a fee based on any outcome of the case (contingency). Requiring a retainer is the best advice and the retaining party can be billed as needed should the retainer be insufficient.

Mandating the lawyer sign a contract making her responsible for all fees incurred by either side is the recommended. Ideally, you should be paid in full prior to releasing any report to the retaining party. There is a tendency to be too nice to a lawyer in the belief that such "customer service" will be rewarded with future referrals. Also, if a lawyer or firm or insurer has used you in the past, there is a temptation to believe that they can be trusted to treat you fairly in the future. All of us have made

this error.

At the beginning of a deposition, when people are introducing themselves, I generally try to remember to ask that the record reflect who is paying for my time and if there is any additional charge, to what address I should send a bill. This formal record of financial responsibility carries significant legal weight should a dispute erupt later.



I have not yet met a seasoned forensic psychiatrist who has not had a billing dispute. There can be significant pressure brought upon you to accept payment at a later date. Insurers may not want to "pre-pay" and will argue that you don't know how many hours you will use and are sure you will inflate your billings to match your retainer. Some governmental agencies are not allowed to pre-pay and require billing after the fact. Most of us start out being strict, then ease up until we get burnt, and then get strict again, reasoning that "one bad apple can spoil the whole bunch."

Lastly, a cleared check should be required prior to entry into court. That allows you to testify with no fear of being "stiffed" if the case goes against the retaining party and allows you to tell the jury that your testimony is unhampered, because you have already been paid.

**Sadoff:** It is important to have an agreement with the attorney about the hourly fee or set fee for a particular case. Some attorneys prefer to have a fee agreement signed by both parties. Some forensic psychiatrists prefer to have everything in writing as well. I have not had a problem with attorneys with whom I have worked as long as there was an established verbal agreement at the outset.



I do not see *pro se* individuals; I

insist on working with an attorney. I require a retainer fee in civil cases when working with a plaintiff attorney or in criminal cases when working with a defense attorney. I have never had a problem with being paid by a prosecutor or a district attorney and have had few problems with defense counsel in civil cases so I may extend them the courtesy of being billed.

It is best to charge by the hour rather than a flat case rate as one can't know in advance how many hours it will require to review records, examine an individual, or to speak with other involved parties/witnesses. I usually set a base of 5 hours for the retainer fee with the understanding that if I work more, I will bill for the balance before releasing my report. I also return any unused funds promptly.

Depositions can pose problems as they are mostly requested by the non-retaining attorney, who has no particular obligation to me, since she works for the other side. That makes it extremely important to have a retainer fee for the deposition paid in advance. It is best to have it paid several days in advance to assure the check clears your bank prior to the deposition. Should the non-retaining attorney request more time for the deposition than was originally agreed to, I always request from the non-retaining attorney a fee for the time she estimates the deposition will take. Knowing that depositions may run beyond the allotted time, I usually do not schedule anything after a deposition, allowing me some flexibility. I insist that the attorney bring a blank check to the deposition to pay for any additional time used. It is up to the retaining attorney to assure her adversary brings the check in order for the deposition to go forward. If the attorney needs more time and doesn't have a check with her, I insist on ending on time and rescheduling with prepayment. I will offer the retaining attorney the opportunity to guarantee payment in order to negate the need to reschedule.

(continued on page 28)

## PHOTO GALLERY



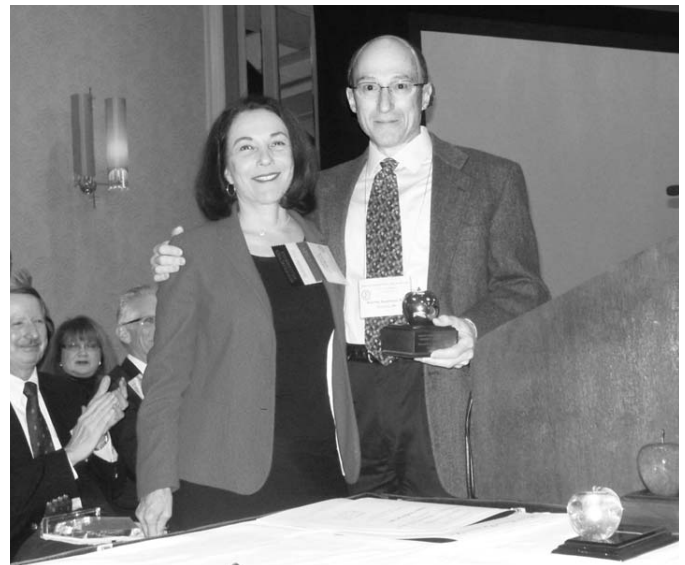
Larry Faulkner receives the Seymour Pollack award from Renée Binder.



Conference venue. The Sheraton Hotel, on the right.



AAPL staff welcoming members to the conference.



Ken Applebaum receives Golden AAPL award.



Steve Noffsinger receives Best Teacher award.



Committee chairs presenting reports to council.



# PHOTO GALLERY



Emily Keram honored with the Red AAPL award.



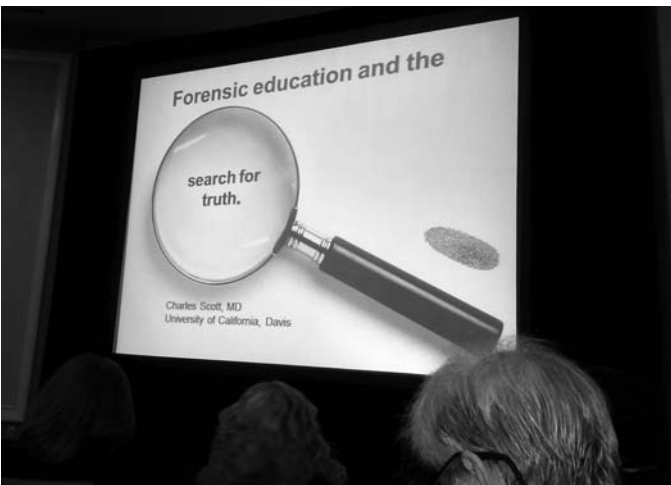
Dr. Trestman honors Tara Collins with the Young Investigator award.



Here they are! The next group of Rappeport Fellows pose with Susan Hatters Friedman and Britta Ostermeyer.



AAPL Medical Director, Howard Zonana, being recognized for years of meritorious service to AAPL.



Forensic psychiatric practice under a magnifying glass.

Photo Credits: Steve Berger MD; Roni Seltzberg MD; James Wolfson MD



AAPL members take time to explore and enjoy old Montreal!

## Next Steps Forward

*continued from page 4*

allowed me to also stay connected, while moving ideas and agendas forward. By continuing with many of the themes of prior Presidents and building our pathway brick by brick and member to member, I aim to continue to build AAPL as a “go-to” professional home for many years to come. Many of our members already help with this goal through their participation in the organization through Committees and other aspects of governance. I have had the chance to meet with Committee Chairs, and they all enthusiastically participate in the organization infrastructure. Based on these discussions, we have asked Committee Chairs to provide a brief description of their work so that we can put together a compendium of our Committees. The goal is to share this compendium widely to help inform members more about our Committee structure and to encourage further participation of additional members. Although our membership has been stable over the years, we need to continue to build on efforts like these to enhance opportunities for membership to grow. I believe by continuing to provide meaningful contributions to the members’ professional lives, the organization will maintain its current vitality.

As we look at these exciting growth areas, it is important to take a moment to also thank several individuals. There are too many to name in this newsletter column, but I am indebted to our incredible management staff, including Jackie Coleman, our Executive Director, Marie Westlake, Associate Executive Director, Kristin Loney, Executive Assistant, and Sara Elsdon, Journal Editorial Coordinator. They work hard each day to keep our organization on track and I have appreciated all their support over the years. Thank you also are extended to our Medical Director, Howard Zonana, MD, as well as Ezra Griffith, MD, our tireless and thoughtful Journal Editor, Michael Norko, MD, Associate Editor of the Journal, and Charles Dike, MD, our

Newsletter Editor. There is much to be proud of as we look back to the founding of the organization and all it has accomplished over the years, and I am grateful and honored to help AAPL take its next steps forward. ☪

## Consensual Sex

*continued from page 6*

create a per se cause of action.” She argues that the “absolute duty” to refrain from sexual relations with patients is no different than the “absolute” ethical duty currently imposed upon physicians with which they must abide. Licensure boards, she notes, are already authorized to take disciplinary action in these cases. “Thus, based on the universal condemnation of sexual contact between a physician and a patient, in my view, the social utility of the physician’s conduct at issue favors recognizing a duty of care.”<sup>11</sup> She also felt that the additional burden of argument to turn general practitioners from treating mental conditions is not credible especially in light of the already existing prohibition on this conduct.

In my view, the dissent got it right. In general, ethical violations are not always the standard of care for malpractice purposes. In the case of sexual contact between physicians and patients however, the ethical guidelines have generally been interpreted as the standard of care. Licensure boards have been increasingly harsh on these violations, frequently suspending a physician’s license to practice when sexual contact is proved. While we prefer not to see expansions of liability in general, this area has such a bad outcome for both patients and for the profession that strong deterrents are needed. ☪

### References

1. “...I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons...” Campbell, M. The Oath: an investigation of the injunction prohibiting physician-patient sexual relations. *Perspect. Biol. Med.* 1989;

32; 300-308

2. AMA Code of Medical Ethics- Opinion 8.14 Sexual Misconduct in the Practice of Medicine, Adopted Dec 1990 (*JAMA* v. 266: 2471-2475, 1991)

3. AMA Code of Medical Ethics- Opinion 8.145 – Sexual or Romantic Relations between Physicians and Key Third Parties, Adopted in June 1998.

4. E.g. See Conn Gen. Stat. Sec. 53a-71. Sexual assault in the second degree: Class C or B felony.

(a) A person is guilty of sexual assault in the second degree when such person engages in sexual intercourse with another person and: ..... (6) the actor is a psychotherapist and such other person is (A) a patient of the actor and the sexual intercourse occurs during the psychotherapy session, (B) a patient or former patient of the actor and such patient or former patient is emotionally dependent upon the actor, or (C) a patient or former patient of the actor and the sexual intercourse occurs by means of therapeutic deception; or (7) the actor accomplishes the sexual intercourse by means of false representation that the sexual intercourse is for a bona fide medical purpose by a health care professional....

5. Thierfelder v. Wolfert, 52 A. 3d 1251 (September 28, 2012)

6. *Ibid.* at 1260

7. *Ibid.* at 1261

8. *Ibid.* at 1261

9. *Ibid.* at 1264

10. *Ibid.* at 1266

11. *Ibid.* at 1285

## Future AAPL Meeting Dates

October 24 – 27, 2013  
Hotel Del Coronado  
San Diego, California

October 23 – 26, 2014  
Marriott Downtown  
Chicago, Illinois

October 22-25, 2015  
Marriott Harbor Beach  
Ft. Lauderdale, FL

October 27-30, 2016  
Hilton Portland  
Portland, Oregon

## Suicide Risk Assessment: Augmenting Clinical Skills with Structured Instruments

Hal S. Wortzel MD, Suicide Committee

Dr. Charles Scott, during his President's Address at the 43rd Annual Meeting, issued a compelling charge to our members: enhance our self-efficacy by identifying and learning structured assessment tools to augment our clinical evaluation skills. Two specific areas of assessment were explicitly discussed, violence risk assessment and symptom validity. For instance, rather than rely upon colleagues from other disciplines to perform structured violence risk assessment, the forensic psychiatrist may learn to use the HCR-20 in conjunction with his/her own clinical risk assessment to more robustly and systematically identify risk factors for violence and stratify level of risk. Similarly, the forensic psychiatrist might learn to administer the Test of Memory Malingered (TOMM) to help assess the validity of purported memory impairment rather than call upon a neuropsychologist to deploy this tool. The advantages of being able to combine clinical evaluation skills with structured assessment tools seem self evident.

In the spirit of this compelling charge, it seems appropriate to suggest an additional important area of assessment wherein clinical evaluation skills may be appreciably augmented by the addition of structured assessment tools: suicide risk assessment. Suicide may be conceived of as a self-directed form of aggression. In fact, the preferred nomenclature for suicide and self-injurious behaviors currently in use by both the Center for Disease Control, Veterans Health Administration, and Department of Defense is described under a self-directed violence classification system.<sup>1-3</sup> A theoretical model offered by Kerr et al.<sup>4</sup> posits a crucial role for aggression in driving suicidal behaviors. Just as violence risk assessment benefits from combining clinical and structured assessment techniques, assessing risk for suicide and self-directed violence

also may benefit from this combination of skills. While a thorough clinical evaluation remains the standard of care in suicide risk assessment, unstructured clinical examinations carry the potential to miss some aspects of risk assessment when not combined with more structured assessment tools. Additionally, as suicidality may be difficult for some individuals to disclose, a combination of clinical interview and structured assessment tools, including self-report measures, yields more avenues and opportunities for unearthing thoughts of suicide.

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*“Just as violence risk assessment benefits from combining clinical and structured assessment techniques, assessing risk for suicide and/or self-directed violence also may benefit from this combination of skills.”*

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Three examples of useful suicide risk assessment tools include the Beck Scale for Suicidal Ideation (BSS),<sup>5</sup> the Lifetime Suicide Attempt Self Injury Interview (L-SASI),<sup>6</sup> and the Reasons for Living Inventory (RFL).<sup>7</sup> The BSS is a 21-item self-report inventory based on the original Beck Scale for Suicide Ideation, which is the clinician-administered version. Each item on the scale may be responded to with a range of 0-2, 0 representing lowest and 2 representing highest in terms of severity. The total scale generates a score ranging from 0-38. Two of the

items refer to past suicide attempts and do not factor into the score generated. The L-SASI is a brief survey of lifetime intentional self-injurious behaviors. Behaviors are categorized into suicide attempts and non-suicidal acts. The L-SASI also assesses characteristics of self-harm behaviors, including intent, method, treatment received, and lethality. The RFL is a 48-item measure of barriers against suicidality, based upon reasons individuals may give for not killing themselves when they were thinking about suicide. Items are rated in terms of their importance as a reason for living on a scale from 1 (*not at all important*) to 6 (*extremely important*). Six domains are assessed: Survival and Coping Beliefs, Responsibility to Family, Fear of Suicide, Fear of Social Disapproval, Moral Objections, and Child Related Concerns.

More information about these and other assessment tools may be found at the website for the Veterans Integrated Service Network 19 Mental Illness Research Education and Clinical Center ([http://www.mirecc.va.gov/visn19/research/assessment\\_tools.asp](http://www.mirecc.va.gov/visn19/research/assessment_tools.asp)). Tools should be thoughtfully combined to capitalize on the respective strengths of each instrument. The combination of the three suggested above is a good example. The BSS, as a self-report measure, provides the opportunity for the individual to acknowledge struggles with suicidal thoughts in writing, and provides an overall sense regarding the acuity of suicidality. The L-SASI provides a more detailed historical perspective on prior self-directed violent behavior. The RFL is helpful in identifying potential protective factors that might be augmented or capitalized upon in helping to mitigate long-term risk.

Collectively, this battery, when combined with a clinical examination, will provide a robust picture of risk and protective factors, and put the clinician in the best possible position to accurately estimate acute and chronic risk for suicide. The information yielded will also guide treatment in identifying risk factors to target for extinction, and protective factors to

*(continued on page 28)*

### AMA Meets in Hawaii

*Robert T.M. Phillips MD, PhD, Delegate; Barry Wall MD, Alternate Delegate; Ryan Hall MD, Young Physician Delegate; Howard Zonana MD, Medical Director*

The American Medical Association's (AMA) Interim Meeting focuses on advocacy issues. Your AAPL delegation participated in the November 2012 AMA Interim Meeting, held in Honolulu, Hawaii.

The meeting began two days after the national elections, and Florida's electoral votes were not certified until several days into the meeting. The meeting tone was subdued, and national policy resolutions were light, due to the election's prior uncertainty. Our delegation expects more advocacy related to the Affordable Care Act at the Annual Meeting in June.

In spite of relatively light Federal advocacy activity, the AMA House of Delegates voted to leave advocacy to expand Medicaid eligibility (to 138% of the federal poverty level) to states and state medical societies, rather than to support such advocacy at the Federal level. It also voted to preserve, rather than cut substantially, the Prevention and Public Health Fund, which is needed to promote wellness, prevent disease, and protect against public health emergencies. AMA will also study whether to oppose antitrust exemption status for health insurance companies via calling for repeal of the McCarran-Ferguson Act.

Psychiatric highlights include the following:

- Ethical Opinions on Continuing Medical Education: The Council on Ethical and Judicial Action issued a report amending ethical opinions on CME. The report pertains to individuals attending CME, not for those who provide it (that opinion was issued last year). The report is located at <http://www.ama-assn.org/resources/doc/ethics/cejaj-1112.pdf>.
- Atypical antipsychotics in pediatric patients: As anticipated, the Council on Science and Public Health issued a report on the use

of atypical antipsychotics in pediatric patients. It summarizes recently developed guidance on such use; the report is located at <http://ama-assn.org/resources/doc/csaph/i12-csaph1-atypical.pdf>.

- Psychiatric populations: The House also passed a resolution encouraging the NIMH and local health departments to examine national and regional variations in psychiatric illness among immigrant, minority and refugee populations. Other meeting highlights include the following.
- Physicians as employees: With the increasing number of physicians entering into employment arrangements, the House of Delegates approved principles for physician employment. These principles identify and address some of the unique challenges to professionalism and the practice of medicine arising in the face of physician employment. It is located at <http://www.ama-assn.org/resources/doc/hod/ama-principles-for-physician-employment.pdf>.
- Medical Staff autonomy: The House spent considerable time debating medical staff autonomy and due process rights when physicians are terminated. A report on this topic will be issued in the future.
- Push back of the ICD-10: The

House again voted to push back implementation of the ICD-10, citing numerous encumbrances and costs associated with learning and installing a new coding system. Onerous codes cited in ICD-10 include specifying burns occurring while water skiing, and injury while attending the opera.

One position is available for a young physician to serve in the AAPL AMA delegation as a Young Physician Delegate. A young physician is defined as an individual within the first 8 years of practicing since completing training or younger than 40 years of age. The Delegate will participate at the Annual Meeting of the AMA Annual meeting held every June in Chicago and the AMA Interim meeting held every November at rotating locations. This is a multi-year commitment. Meetings run from Thursday evening to the following Tuesday or Wednesday. AAPL covers expenses for travel, meals, and hotel during the AMA meetings but there is no compensation for time spent on these activities. Applications are due March 1, 2013. Interviews will take place during the American Psychiatric Association meeting in San Francisco on May 18 and 19, 2013. Those chosen for interviews will be notified as soon as possible after March 1, 2013. The AAPL Executive Council makes the appointment. Please contact any member of the AMA Delegation if you have additional questions.

For more information on the actions of the AMA House of Delegates at the 2012 Interim Meeting go to <http://www.ama-assn.org/ama/pub/meeting/index.shtml> ⓘ



## Autism Spectrum Disorders and Criminal Justice

Ken Weiss MD, and Manish Fozdar MD, Developmental Disability Committee

At the Annual Meeting, the Committee sponsored a presentation on Autism Spectrum Disorders (ASD) and criminal justice. The panel included Committee Chair, Manish Fozdar, MD, Committee members Kenneth Weiss, MD and Alexander Westphal, MD, and invited participants, Madelon Baranoski, PhD and Mark Mahoney, Esq. In addition, Committee member Denise Kellaher, D.O. displayed a poster on Asperger's and deviant sexual behavior in a teenaged boy.

Much attention has been directed towards clinical dimensions and legal implications of Autism Spectrum Disorders (Asperger's and PDD-NOS in DSM-IV nomenclature). In higher-functioning individuals, there is ambiguity about capacity for criminal intent, despite intellectual ability in other areas. The presenters shared many examples of adults and juveniles with ASD charged with crimes ranging from possessing pornographic images to gruesome murder. A recurring theme was assessing the subjective state of the defendant in situations where there may not be grounds for a standard defense of insanity.

In Mr. Mahoney's example of child pornography, we had an illustration of how the overdeveloped interests of the person with ASD led the defendant to receiving and possessing unlawful material. The defendant's reason for the behavior was the pursuit of his interest, whereas he was oblivious to the legal and other implications. Mr. Mahoney characterized the intersection of Asperger's Disorder and criminal justice as "the perfect storm." Thus, for example, prosecutorial attitudes toward possession of child pornography include escalation of penalties based on the quantity of images. In the Asperger's case, the defendant's highly developed interest and accumulation was used as evidence of criminality.

Dr. Kellaher reported on a teenaged boy with Asperger's and a highly focused obsession with canine genitalia. He was arrested for publicly masturbating while fondling a neighbor's dog. His lack of insight was striking, as he told of his intent to become a veterinarian. As a concession, he noted that his interest in horses could be problematic.

In Dr. Fozdar's example of homicide, the 21-year-old with ASD killed his mother and 2 half-siblings. "Bobby" showed classic signs of poor

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*"... characteristics of affected individuals in the criminal justice system seemed always to work against them – aloofness, glibness, lack of empathy and remorse, and apparent inability to recognize the wrongfulness of their acts."*

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social development, hypersensitivity to stimuli, and restricted interests. His interests ran towards violent and pornographic videos and knives, which he collected. This was a capital case involving many expert witnesses. Dr. Fozdar showed the difficulty not only in achieving consensus among the experts but also in educating the judge and jury on the nature of ASD and its implications for culpability. Ultimately, the defendant received a life sentence.

There is great resistance in the criminal system against excusing ASD defendants, although the behavior is best explained on the basis of

ASD. The panelists were in accord that characteristics of affected individuals in the criminal justice system seemed always to work against them—aloofness, glibness, lack of empathy and remorse, and apparent inability to recognize the wrongfulness of their acts.

Using examples from cinema and new reports, Dr. Weiss noted the polarization of responses to behaviors by individuals with ASD. In the movie "Adam," the main character had lost his job and was wandering, stopping at a schoolyard during recess. Someone called the police about a suspicious person, and when confronted by police, Adam told the truth: "I was watching the children." One can easily see how the social cognition and communication style of such a person pours gasoline onto a fire of suspected criminal behavior. In the movie, Adam was not charged, but in a serious international case, that of Gary McKinnon, there has been a huge amount of activity. The Briton hacked into the Pentagon "looking for evidence of UFOs," and has been criminally charged in America. As he sees it, he was simply following his interests, not spying. Now a *cause célèbre*, the McKinnon matter has generated great interest, including tabloid coverage and British "save Gary" (from extradition) campaigns.

Examining psychological studies of ASD, Dr. Baranoski underscored the difficulties in assessing trial competency. Among them is the frustration of defense lawyers who know there is something wrong with the client, yet cannot identify it. Dr. Baranoski highlighted 3 key issues: 1) the disparity between verbal capacity and practical reasoning; 2) the odd and yet normal presentation; and 3) the presentation of stubborn disregard for authority, arrogance, and defiance. Judges, the psychologist said, often see defendants with ASD as an annoyance. Among the psychometric findings was the disparity between verbal superiority on vocabulary and deficient verbal reasoning. The obsessive focus on certain words or mean-

(continued on page 28)

## Virtual Reality and Forensic Psychiatry in Quebec

### *The Philippe Pinel Institute of Montreal*

*France Proulx MD and Kenneth Busch MD, Chair of the International Relations Committee*

The International Relations Committee sponsored its 13th yearly site visit at The Philippe Pinel Institute of Montreal during the 43rd Annual Meeting. The site visit was coordinated through Dr. France Proulx who has been a psychiatrist at the Philippe Pinel Institute since 1998. She and one of her colleagues, Dr. Joel Watts, both members of the AAPL, welcomed a group of participants to the AAPL meeting in Montreal this past October.

The history of the facility is strongly linked to forensic psychiatry in Quebec and the Institute now has a global reputation as one of the world's foremost sources of knowledge pertaining to the prevention, assessment and treatment of dangerous and violent behavior. It was founded in 1970 in direct response to the Quebec government's desire to provide appropriate mental health care for a group of patients who were deemed difficult to treat. The Institute was named after the French doctor Philippe Pinel (1745-1826) who greatly influenced the evolution of psychiatry through substantial reforms in French hospitals.

The Institute keeps up with the latest technology in assessment of violent patients. A team of researchers, led by Patrice Renaud, PhD, is developing a virtual reality environment (the CAVE: Cave Automatic Virtual Environment) in order to assess individuals with different profiles of deviant behavior: sexual deviance, impulsivity and aggressiveness, and cognitive deficits. Through this research team, the Institute was funded with a grant of more than a million dollars by the Quebec provincial government agency for economical development and innovation.

Patrice Renaud, PhD and an engineer involved in the research project

presented on the development of tools to be used for the assessments with the CAVE. Avatar, virtual human replicas in 3D, are developed based on specific characteristics of gender, age and appearance. Virtual environments are developed as well. The team is currently working on virtually replicating one of the treatment units of the Institute. As there is no other technological setting like it in the world, a lot of effort and time are needed, and many specialized staff are involved. When the CAVE is ready, the individual to be assessed will be presented with different stimuli, depending on specific assessment needs.

After being presented the CAVE research project, participants visited two inpatient units, a leisure activities area for patients with a game room, well-equipped gymnasium and indoor pool, and the staff library which has a large collection of information on forensic psychiatry and extensive resources available for research on

law and mental health.

The hospital is considered to be a maximum secure facility and has about 290 beds. Inpatient services consist of the following programs: admission and evaluation including the assessment of the level of dangerousness, fitness to stand trial and criminal responsibility; treatment and reintegration program for patients prone to violent behavior; rehabilitation program for chronically dangerous patients; a program for clients from Federal Penitentiaries, including services for sexual offenders; and an adolescent program for forensic evaluation and treatment. The outpatient department offers consultation to clinicians and hospitals regarding violent patients, to community agencies concerned with mental health and legal issues, and to provincial and federal detention centers.

The site visit at the Philippe Pinel Institute was well-received by the participants. It outlined the importance of developing new ways to assess difficult and violent patients, even in these times of budget cuts. We were especially impressed with the enthusiasm and accomplishments of the program and Staff. We thank Dr. Proulx and Staff for being wonderful hosts and for arranging such an exceptional visit. ☺



## School Bullying: Administrators' Responsibilities and Effective Interventions?

Cory Jaques MD, Child and Adolescent Committee

School bullying is a common, problematic behavior that can disrupt children's lives and development and cause significant psychiatric comorbidity. Approximately half of school-aged youth worldwide are affected by bullying.<sup>1,2</sup> Though not a new phenomenon, national attention to the problem of bullying rose dramatically in the 1990s after several highly publicized incidents of school violence (e.g., Columbine). Bullying has become increasingly prominent in the popular media, heightening public demands for action to respond to this public health crisis.

Historically, we have vested the teacher with the responsibility of protecting children in the school environment. Because most bullying behaviors occur during school settings, teachers in the "post-Columbine" era (i.e., after April 1999) are increasingly expected to proactively protect children from harm.

Today, many educators struggle to keep pace with increasing public expectations regarding their roles in keeping students safe. Inevitably, the courts are increasingly involved in the process, resulting in a rapidly evolving legal standard holding school officials accountable for student harm.

In 1999, the U.S. Supreme Court established the current judicial standard for deciding whether or not school officials should be held liable for harm caused by student-on-student harassment. In *Davis v. Monroe*, the Court held that school officials may be liable for student (i.e., peer) harassment when they are "deliberately indifferent to known acts of student-on-student sexual harassment," the alleged harassment is "so severe, pervasive, and objectively offensive that it effectively bars the victim's access to an educational opportuni-

ty," and where "the student harasser is under the school's disciplinary authority."<sup>3</sup>

In applying the deliberate indifference standard, the court acknowledged the practical realities of school officials' ability to respond to student behaviors. In addition to establishing clear limits on schools' liability, this standard has also created a requirement for school officials to respond swiftly to students who report being

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*"In Davis v. Monroe, the Court held that school officials may be liable for student (i.e., peer) harassment when they are "deliberately indifferent to known acts of student-on-student sexual harassment.""*

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threatened or harassed, thereby potentially mitigating the harm to the bullied student.

In recent years, most states have taken affirmative steps to reduce or prevent bullying. Though many state anti-bullying legislation or policies mandate school officials to implement bullying response and prevention programs, they provide little guidance on what constitutes an effective program. Bullying behaviors have been difficult for schools to control despite the currently available interventions,<sup>4</sup> and school officials often lack the time or training to evaluate fully the efficacy of these programs. Though there is an increasingly wide variety of commer-

cial or "research based" prevention programs available and utilized by schools, the evidence base is sparse and often conflicting. In response to this dilemma, school officials struggling to comply with the law and protect students may seek out professional guidance for recommendations on interventions that may decrease bullying behaviors.

Forensic mental health experts can assist schools and parents in decreasing bullying behavior and in mitigating the mental health impact of bullying by providing recommendations for research based response and intervention programs. Additionally, the courts continue to seek out professional guidance for recommendations on interventions that may decrease these behaviors.

Over the past two decades, the research on bullying has grown as investigators explore how to intervene effectively and prevent it from occurring. Because there are few longitudinal studies regarding the impact of bullying behaviors, it is difficult to determine for bullying victims or bullies themselves a long-term prognosis with any degree of certainty. Recommendations for effective, evidence-based programs should be backed by data on empirically-identified risk and protective factors for school bullying, based on findings from prospective, longitudinal research, and incorporate relevant research in other fields.

Based on the extant literature, systems-based approaches aimed at changing the culture of the school are the best general interventions to decrease bullying behavior. School-wide systems-based approaches have shown the most efficacy in decreasing bullying behaviors, though not all research supports this.<sup>5,6</sup> Prevention programs that focus on the individuals involved, provide classroom teaching, or incorporate school-wide cultural changes appear to be the most effective in reducing bullying behaviors.

Some interventions, though well-meaning, may actually lead to a

*(continued on page 29)*

## Forensic Psychiatrists and Attorneys on Undue Influence

Sherif Soliman MD, Susan Hatters Friedman MD, Adam Fried JD, Carolyn Dessin JD

Elder financial abuse is a growing crime, currently estimated to cost victims \$2.9 billion annually<sup>1</sup>. Undue influence, broadly defined as “any act of persuasion that overcomes the free will and judgment of another<sup>2</sup>,” is one of the primary mechanisms perpetrators use to exploit vulnerable elderly victims. This exploitation can take the form of *inter vivos* gifts (those given while the elder is living) or testamentary gifts (which are given after the elder has died). The distinction between influence and undue influence is usually based on coercion. A vulnerable person is prevented from exercising their own free will due to domination by another. The testator might be imagined to say: “This is not my wish, but I must do it.”<sup>3</sup>

Forensic psychiatrists are increasingly called upon to provide expert testimony in cases where undue influence has been alleged. Will contests are the most common cases of undue influence, though it is relevant in other settings such as guardianships. In our workshop at the 2012 AAPL meeting, we discussed relevant legal concepts in undue influence, selected case law, and the proper role of experts in undue influence cases.

There are a number of recurring themes in the undue influence case law. These are issues that are raised frequently enough by courts to warrant taking them into account when planning expert testimony.

With respect to the type of evidence needed to support a finding that a person has been unduly influenced, courts frequently note that an ongoing course of behavior must be examined rather than simply looking at the parties’ conduct when a document is being signed. This suggests that a court may find lay testimony about the alleged victim’s conduct over a period of time more convincing than expert testimony that focuses on cognitive ability at the time the

document is signed. It further suggests that an expert might include testimony about how declining cognitive abilities might not be apparent to a layperson.

Courts often suggest that the vulnerability of the victim is an important factor in determining whether he was unduly influenced. Thus, courts often find testimony about how a person’s medical condition could lead to vulnerability persuasive. Similarly,

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*“In will contests, the testimony of a lay witness who knew the deceased testator is often accorded greater weight than the testimony of an expert witness who merely reviewed documents but did not conduct a personal examination.”*

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experts often testify about how dementia can lead to passivity, which can make a person more vulnerable to undue influence.

Undue influence cases are universally recognized to result from conduct that is rarely perpetrated out in the open. Whether undue influence can be demonstrated, therefore, depends on a demonstration of some power differential between the object of the gift and the donor together with elements of control. Practicing attorneys rely heavily on circumstantial evidence and attempt to develop what are commonly referred to as

“red flags” in order to prove their cases. Your opinion will be sought to help the attorney explain the medical and relationship dynamic that were in place and may constitute the exertion of undue influence.

If you are being called to render an opinion, you can bet that the matter is highly contested. Due to the circumstantial nature of these cases, the quality of evidence gathering by the attorneys who retain you is highly important. Indeed, the existence of one critical fact could sway your opinion and defeat your credibility if that fact was not known prior to you rendering your opinion. Therefore, before issuing any opinion on an undue influence case, it would be prudent to assess the quality of the evidence provided and ask questions of counsel to assure yourself that game-changing facts are not lying in wait. Such game changing facts could include legitimate reasons for the disinheritance, and evidence of a controlling beneficiary in the notes of the drafting attorney, just to name a few. If you cannot be comforted by counsel that you have a full and complete factual grounding, then you should be more careful about taking on the case.

Wills are most commonly contested because of changes which are significant or inconsistent with expressed wishes, and/or related to undue influence.<sup>4</sup> This is in keeping with the balance between self-determination and paternalistic protection from one’s own folly that the law holds in regard. Courts look for evidence of harassment and pressure, threats to abandon, and deception.<sup>4</sup>

In will contests, the testimony of a lay witness who knew the deceased testator is often accorded greater weight than the testimony of an expert witness who merely reviewed documents but did not conduct a personal examination. This has been observed since at least the 1800s when Dr. Isaac Ray was involved in the *Pidcock v. Potter*, 1871 Pennsylvania Supreme Court case of a contested will.

(continued on page 29)



## “Least Restrictive Constraints”: Expert Role in the Assessment of Capacity in Conservatorships & Guardianship

Stephen Read MD, Geriatric Psychiatry and the Law Committee

The aging of society is one of the dominant facts confronting the United States and, indeed, the entire world in the coming decades, as a result of increased longevity and lower fertility rates. Life expectancy has increased from 47 years in the United States at the turn of the 19th to the 20th century to today’s anticipated life expectancy at birth of over 80. In the United States, the proportion of the population aged  $\geq 65$  years is projected to increase from 12.4% in 2000 to 19.6% in 2030, with numbers of those aged  $\geq 65$  years more than doubling: 35 million in 2000 up to an estimated 71 million in 2030. More dramatically, the number of persons aged  $\geq 80$  years is expected to increase from 9.3 million in 2000 to 19.5 million in 2030<sup>1</sup>. By 2025, the proportion of the population aged  $\geq 65$  years is projected  $\geq 15\%$  in 48 states (all but Alaska and California), with Florida leading the way at 26%.<sup>2</sup>

Among the results of these dramatic changes, the geriatricians of today, such as the author, who trained in programs for the “elderly” often defined as adults 65 years of age and older, and sometimes 55, are finding these days that those “young-old” are bringing their 80+ and 90+ year-old parents to the doctor. In addition to living longer, we are living better: many are active in retirement, not a few continue to work. One finds that geriatricians are more often focused on the “old-old,” typically defined as those 80 years of age and older. While the potential for further extensions of the life span are of great interest, there are some indications that indefinite lengthening is still beyond our reach: the US Census Bureau prediction of a dramatic increase in centenarians in the 21<sup>st</sup> Century (from 37,000 in 1990 to at least 69,000 in 2000, and up to 160,000 in 2030,<sup>3</sup> has not materialized.

Fear of “Alzheimer’s,” i.e. dementia that brings dependency and loss of

meaningful autonomy, is the greatest concern in this population. What can be expected to add to this fear is the recognition that the Alzheimer’s disease process, as with so many of our chronic “geriatric” conditions, begins many years prior to the onset of identifiable symptoms.

On the other hand, the late recognition of dementing illnesses and conditions results in these persons being exposed to the hazards of financial exploitation and abuse, loss of wealth, and other dangers. Expert opinions about the capacity of elders can therefore be expected to be a “growth

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*“... the late recognition of dementing illnesses and conditions results in these persons being exposed to the hazards of financial exploitation and abuse, loss of wealth, and other dangers”*

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industry” in coming decades, and, increasingly, the questions before the court will not be simple up or down determinations of capacity or lack thereof, but of how much loss has occurred, and how family and courts can best accommodate these losses, while preserving the person’s greatest of autonomy.

Two areas predominate in the practice of forensic geriatric psychiatry: testamentary capacity and the determination of the need for guardianship (in this article referring to court-ordered oversight of a ward; in Idaho, the jurisdiction of the case presented, both

guardianship and conservatorship are used—the one for personal care issues, the other for estate). The core issue in these matters is mental competency or capacity, typically in relationship to concerns about acquired cognitive impairment and/or dependency.

Therefore, the special assessment tools required for forensic assessment of older persons are the cognitive mental status examination and application of the findings of that examination to the issues of competence and capacity and, in addition, to the vulnerability of that potentially impaired person to external influence, i.e. to exploitation or abuse.<sup>4</sup> “Evaluating the Dementing Millionaire,” the panel from the Geriatric Psychiatry and the Law Committee at the Montreal meeting illustrated the challenges in these evaluations, most specifically the issue of how a court crafts rules for a person determined to require guardianship within the mandate for the “least restrictive” loss of autonomy.

Mr. K was a successful entrepreneur in a technically specialized field. Approaching the age of 80, he had comprehensive evaluation of a complex neuropsychiatric disorder. Opinions of severe impairment with poor long-term prognosis led to guardianship and court-ordered succession of the trusteeship of his estate (including his business interests and several properties), with a total worth in the tens of millions of dollars.

Contrary to expectations, however, psychiatric, neurologic, and medical treatment after the imposition of the guardianship resulted in significant improvement in Mr. K’s mentation. The guardian, conservator, and guardian ad-litem appointed by the court to manage Mr. K’s affairs agreed to support a petition to allow Mr. K greater involvement in his affairs.

Among other things, Mr. K wanted to change the designated successor trustees of his trust, including his daughter and a major financial institution, and also to alter the beneficiaries of his estate. The successor trustees in turn did not find persuasive the evidence of improvement and did not support the idea of revising the terms

*(continued on page 26)*

## Constraints

*continued from page 25*

of the guardianship. Several experts were retained to assist the court's evaluation of the proposals. The presentations in the symposium included:

1. A review of the complex history, symptomatology, and initial test findings of Mr. K, with a question of the reliability of etiologic diagnosis of cognitive impairment, even from highly specialized centers, especially as a basis for assumptions about future capacity. The diagnosis of a dementing illness depends primarily on findings of deficits in multiple areas of mental function, which may include neuropsychological testing. The etiologic diagnosis of dementia involves the pattern of those deficits, but also an understanding of the course and evolution of the symptomatology, data that are typically dependent on information from family and close observers. Increasingly, laboratory data and neuro-imaging findings lead to better recognition of specific disorders.<sup>5</sup> Evaluation at UCSF had resulted in a diagnosis of probable Dementia with Lewy Bodies (DLB), with emphasis that Mr. K had an irreversible, certainly progressive dementing process. However, at the time of evaluation, therefore, it was not clear whether the diagnosis of DLB was in fact correct.
2. Presentation of the findings at extended geriatric psychiatric assessment by Dr. Read in relationship to Mr. K's goals and the mandate to craft rules for guardianship that are the "least restrictive" in terms of liberty issues. Dr. Read assessed Mr. K in two extended sessions on a single day after a review of the UCSF findings and records of other assessments and the course of treatments. Dr. Read also conducted an extended subsequent telephone interview to assess Mr. K's specific understanding and appreciation of a later complex negotiation about changing institutional successor trustees. Mr.

K was able to sustain alertness and mental energy and to display an impressive body of knowledge of the technology and the business details of his career at these encounters. Mr. K's cognition had improved dramatically, illustrated by his score on the Mini-Mental State Exam of 27+/30 (from < 20 at UCSF). Mr. K also conveyed his avid interest in the subject of his business as being his "life's work." Dr. Read opined that these findings belied the certainty of the UCSF prognosis of DLB, and, at a minimum, that treatment of the compli-

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*"... treatment of the complicating neurological and psychiatric disorders, including alcohol abuse and dependence, bipolar disorder, and then re-introduction of medications for his Parkinsonian symptoms had led to Mr. K's significant improvement."*

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3. Presentation of findings from neuropsychological test results by Craig Beaver, PhD, focused on the areas of executive function and of

practical reviews of actual demonstrable function on specific tasks by Mr. K.

Dr. Beaver reported evaluations of Mr. K that bracket Dr. Read's assessments in time. Dr. Beaver reviewed the concept of executive functions. He also stressed the value of documenting a subject's capacity to perform specific tasks, using established practical instruments such as the Texas Functional Living Scale<sup>6</sup> to assess a person's actual functional skills. He concluded that while Mr. K's attention and preserved knowledge base were important considerations, persistent deficits in the areas of executive function constrained the extent to which Mr. K's involvement should be allowed to expand.

4. Robert Weinstock, MD, Chair of the Geriatric Psychiatry and the Law Committee and our new President-Elect, discussed the ethical aspects of elderly capacity evaluations. Dr. Weinstock framed his remarks in terms of the fundamental issue illustrated in the case presentation: The challenges facing a court in terms of providing appropriate oversight and protection regarding a person with a dementing illness, while ensuring the "least restrictive" terms as regards a person's liberties, both for the immediate issue and for future care. Issues Dr. Weinstock addressed include the significance of collateral information in both diagnostic and functional assessments, including the possibility that family or other observers can bias the examiner's view of the course of illness, a powerful consideration—whether or not the bias is intentional or inadvertent—as possibly was a factor in the UCSF evaluation. The examiner may therefore be in a position of making judgments about which "facts" are true. There is also, of course, an ethical conflict if an opinion about capacity is requested from a treating physician or psychiatrist—who risks being characterized as acting against his
- (continued on page 27)*

## Constraints

*continued from page 26*

patient's interests or breaching confidentiality. He also said that some people who lack the capacity to make complex decisions still retain the capacity to make more general decisions like who is and is not trying to help him. Challenging as it might sometimes be there may be an ethical obligation to try to clarify this difference. Finally, Dr. Weinstock noted the key role of DSM terminology and concepts in court deliberations. For example the obvious presence of Parkinsonism may have worked against Mr. K, both in his presentation to the court, and in terms of psychomotor effects in neuropsychological testing. Dr. Weinstock also commented on the forensic consequences of the coming DSM-V, specifically regarding the new category of "Neurocognitive Disorders," which displaces the current diagnostic terminology and may thereby increase a court's difficulty in understanding the basis for an expert's recommendations.

The resolution of the case further illustrated that, in addition to the evolution of medical and scientific concepts in the area of brain function and capacity, the law also continues to evolve. The parties appeared headed to a "middle ground," i.e. some expansion of Mr. K's role in the operation of his business, but in the context of maintaining the supervision of the court by means of guardianship. In addition, recognizing his retained testamentary capacity would allow modification of his beneficiaries.

However, during the evaluation/deliberation actions, an interval court decision in Idaho, the jurisdiction of Mr. K's guardianship (for personal and medical issues) and conservatorship (for financial matters), changed the rules: It was held that no change in financial oversight and involvement could be considered for a person simultaneously under guardianship of his personal affairs.

Negotiations to try to find an agreement that would allow for at least temporary abrogation of the guardianship

failed—consistent with the opinions of all evaluators that Mr. K had not in fact regained sufficient capacity to recommend such action. Further negotiations about the management of Mr. K's trust continued for nearly a year more, during which time Mr. K's condition continued to fluctuate but overall to decline. In the end, Mr. K had some satisfaction: he was allowed to stay in his (remodeled) home in Sun Valley with his long-time caregivers and the daughter he had come to mistrust resigned as successor trustee. However, his business involvement was not increased and his choice to change institutional successor trustees did not proceed.

Responses in the discussion following presentations highlighted the recognition of these issues among audience attendees. The absence of consideration of vulnerability to undue influence was raised. The presenters had chosen not to address this issue on the grounds of time. However, we noted that the deficits in executive function are primarily associated with damage to frontal lobe brain damage, and these are most closely associated with impairment in the ability meaningfully to manage finances and business.

Frontal lobe damage is also associated with impairments in the interpersonal and affective processes subsumed in the concepts of "social brain," concepts that await more precise tools and characterization that will be relevant to an expert contribution to the issue of influence.

We note as well that our colleague Sherif Soliman, MD had organized a thoughtful symposium on the topic of influence earlier in the meeting. We look forward to further contributions on forensic geriatric psychiatry at future AAPL meetings.

In conclusion, Mr. K's case illustrates the magnitude of disputes about capacity issues, as well as the likelihood that law will evolve along with our growing knowledge base. Consideration of wealth distribution by age further suggests the likelihood of a large growth in disputes about finances in elder persons in the coming decades. For example, while the total value of all U.S. household

wealth in December 2007 was \$65.9 trillion, plunged to \$48.5 trillion during the first quarter of 2009 and then recovered partially to \$54.2 trillion by the end of 2009, wealth of those Americans age more than 75 fluctuated much less.<sup>7</sup>

For the importance of inheritance in wealth transfers, a 2010 study estimated that the "Baby Boomer" generation could expect to receive approximately \$8.4 trillion in inheritance overall, with up to \$40 trillion in wealth changing hands by inheritance by 2050.<sup>8</sup> Given the well-known incidence of cognitive impairment and dependency with increasing age, disputes about wills and management of wealth in impaired elders will become more frequent and expert opinion on these matters will be in greater demand. Demand for expert opinion about geriatric issues, and greater expertise in geriatrics, is to be anticipated in coming years. ☞

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## Ask The Experts

*continued from page 15*

While I am aware that some colleagues charge more for the first hour of a deposition, it is my belief that a standard hourly rate is best for all work, including depositions and court appearances.

I usually charge my regular hourly or day rate for travel, since that is time that I would normally spend working. If one must stay overnight, a charge for a full day and partial day for the following day is appropriate. A day rate equal to 8-10 times the hourly rate is customary.

When asked about your rates/billings, it is best to answer as clearly as possible so that it is clear that you have nothing to hide or to be ashamed of, especially if the billing would “shock” a “typical” juror who might earn far less annually.

I explain to the attorney: “your check is my key to the courtroom door.” Being paid in advance not only assures you will be paid, but also eliminates any implication that your testimony is biased or dependent on the outcome of the case. If the case runs longer than planned and I am required to come back to court again, as with a deposition, I ask to be paid in advance for the additional time.

Working with attorneys is a labor of mutual trust. The attorney trusts that the expert will provide an unbiased professional examination, evaluation, and consultation to the attorney, who will provide the agreed upon fee requested by the expert. ☞

## Suicide Assessment

*continued from page 19*

target for amplification. From the medicolegal perspective, such a process would clearly meet, if not exceed, any established standard of care for suicide risk assessment. Hence, the Suicide Committee welcomes the charge issued by Dr. Scott, and respectfully offers these additional tools for optimizing suicide risk assessment. ☞

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## Autism Disorders

*continued from page 21*

ings can throw a wrench into the competency determination. Neuropsychological testing can help to unravel these issues.

Dr. Westphal outlined the complexity of issues in criminal justice. In the social domain, the interactive effects of ASD characteristics—specialized interests, sexual urges, lack of insight, touch sensitivity, aversion to authority, mindblindness, and cognitive rigidity—conspire toward poor outcomes. There has been a spike in literature citations for ASD, Dr. Westphal said, but not in the forensic area. Accordingly, there is still confusion about whether ASD is associated with “malice.” This conflation would tend to augur poorly for the person with ASD accused of a crime. Greater attention must be paid to sorting out the differences between ASD and other offenders. Dr. Westphal, citing Woodbury-Smith, noted that, relative to the non-ASD group, ASD non-offenders were impaired on tests of executive functioning, theory of mind (mentalizing), and fear recognition. Neuroimaging may help us discriminate apparent overlap in behavioral phenotypes between ASD and psychopathy, thus better informing criminal justice. ☞

## MUSE & VIEWS

### Defendant following the judge's order. Sorta....

A man who stole two pairs of underwear after being told he would need clean skivvies to serve weekends in jail may need even more drawers — he's been sentenced to even more time in jail.

Alvin Rogers, 33, of Painter, was sentenced to five years with two years, six months suspended for third-offense shoplifting. Substitute Circuit Judge Glen A. Tyler, presiding in Northampton Circuit Court, noted that Rogers had already paid the \$17.85 in restitution.

Defense attorney Paul Watson told the court late last year that a person checking in for weekends in the Accomack County Jail is required to bring two sets of underwear.

“And that is exactly what he took,” said Watson.

Source: <http://www.delmarvanow.com/article/20130114/NEWS01/130114007/VA-SHORE-Man-gets-jail-time-after-stealing-underwear-way-jail?gcheck=1>

*Submitted by Charles L. Scott MD*

## School Bullying

*continued from page 23*

worsening of behaviors by creating a hostile school environment. These counterproductive interventions include the “zero tolerance” policy, suspension or expulsion of bullies, mediation and conflict resolution with peers, anger management groups, and utilization of student groups to attempt to “police” bullying behavior.

Researchers continue to explore potential interventions for individuals and school systems to mitigate the effects of bullying, as well as programs to prevent this ever-increasing problem. Additional research on the potential long-term comorbidities associated with specific types of bullying is critical to tailoring effective interventions. Without this, school children will continue to suffer from bullying behavior and school officials will face uncertainty in assessing their own liability for responses to this growing societal problem. ☎

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*Dr. Jaques is a third-year psychiatry resident at the Semel Institute for Neuroscience and Human Behavior at UCLA.*

## Undue Influence

*continued from page 24*

Evaluations should consider that undue influence represents a course of conduct, not a single event. In reviewing records, consideration should be given to conditions or medication effects leading to increased vulnerability. Dementia, alcoholism, mood disorder, and psychotic disorder symptoms can make persons more vulnerable to undue influence.<sup>5</sup> Rationale for changes, consideration of how decisions are made, and family tensions are all relevant.

It is important for forensic psychiatric testimony in these cases to be appropriately limited to areas of expertise, to be scientifically grounded in medical and psychiatric principles, and to avoid addressing ultimate issues such as whether undue influence actually occurred. Forensic psychiatrists should request all available information including medical records, nursing notes, financial records, depositions, and access to people who were familiar with the alleged victim. If the alleged victim is living, a personal examination should be sought, though this is sometimes of limited value if the alleged victim's health or cognitive function has deteriorated significantly since the alleged undue influence.

Forensic psychiatric expertise is most relevant to two areas of undue influence: victim vulnerability and relationship characteristics that give rise to or suggest the presence of undue influence. Forensic psychiatrists should look for and explain how certain victim characteristics such as dementia, mental illness, physical illness, or personality traits render victims more vulnerable to undue influence. Forensic psychiatrists can also look for “red flags” of undue influence such as secluding the victim, indoctrinating the victim, and disparaging independent thought in the victim.<sup>6</sup>

Before agreeing to render an opinion in a case of alleged undue influence, it is critical for forensic psychiatrists to understand the legal context in which such cases are filed, the rel-

evant psychiatric issues involved, the relationship dynamics correlated with undue influence, and the appropriate limitations of psychiatric expert testimony in this setting. ☎

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### AAPL Awards Committee Seeks Nominations for 2013

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

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

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

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

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

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

Please send your nominations to Renée Binder, MD, Chair of the Awards committee at [reneeb@lppi.ucsf.edu](mailto:reneeb@lppi.ucsf.edu).

**POSITION OPEN**  
**AAPL Delegate – AMA Young Physicians Section**

One position is available for a new fellow or recent graduate interested in serving in the AAPL AMA delegation as a young physician delegate to the AMA House of Delegates (HoD).

A young physician is defined as an individual within the first 8 years of practicing since completing training or younger than 40 years of age.

It is important for applicants to realize this is potentially a multiyear commitment. Applicants would need to be members of both the AMA and AAPL. The duties of the AAPL young physician delegate would be to actively participate at the annual AMA House of Delegates meeting in Chicago, usually held in June and the Interim HoD meeting usually held in November at rotating locations. Meetings for young physicians usually begin on Thursday evening and run to the following Tuesday or Wednesday. Attendance at both meetings for the full length of time is required. It is expected that the AAPL young physician would actively participate in the YPS debates and leadership structure (e.g. serving on YPS handbook review or reference committees) as well as participate in the psychiatric caucus (APA, AAPL, AACAP). The psychiatric caucus is instrumental in advocating for psychiatric concerns in the house of medicine by helping to develop policy, educating physicians of all specialties about psychiatric concerns, and at times running candidates for leadership positions in the AMA. In addition residents would need to be available (e.g. phone, internet) to participate in pre-meeting planning (e.g. review of proposed policies) with the AAPL delegation, the psychiatric caucus and the AMA YPS. It is also expected that the young physician would come to the Annual AAPL meeting in order to attend the Council meeting with the rest of the AAPL delegation.

AAPL covers expenses for travel, meals, and hotel during the AMA meeting but there is no compensation for time spent on these activities.

**Application letters for this position should state experience and interest in organized medicine and are due March 1, 2013. Interviews, if deemed necessary by the Search Committees, will take place in San Francisco, May 18 and 19, 2013. Those chosen for interviews will be notified as soon as possible after March 1, 2013. Appointments will be made by the AAPL Executive Council.**

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

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

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

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

Contact Information:

Christopher J. Lockey, M.D, Assistant Professor of Psychiatry, OHSU  
 OHSU Chief Psychiatrist, Oregon State Hospital  
[lockeyc@ohsu.edu](mailto:lockeyc@ohsu.edu)

## Ask a Mensch

continued from page 13

mind that the outcome would have been far different: instead of gaining morale and momentum simply by being a member of the *Homo sapiens* club, I would very likely have lost heart and my morale would have plummeted even further. There would have been no way I would still have felt a sense of warmth and loyalty to my program. Truly, it is difficult to think of a more effective morale-killer than the grim response above. Leadership is not simply about enforcing protocols and giving orders: motivating people to go above and beyond in their efforts and reach their full potential is also critical, but there seems to have been a drought in this form of management skill lately.

Dr. Mensch has a special place in my heart after all these years and he has modeled the kind of fellowship director I have tried to be. I have skipped the Dr. Grim persona and just stuck with Mensch, opting to not switch back-and-forth between the two in such a Kleinian manner. But being a *mensch* is far more than performing *mitzvahs* (good deeds). It's also about being the person you would like your residents, fellows, and other supervisees to be. Managers everywhere in our institutional and correctional settings should take heed: when it comes to boosting morale, loyalty, and work ethic, Dr. Mensch is not only the *good* way to go – it's also *smarter*. ☺

### 2013 Annual Meeting Call For Papers

**Submission  
deadline:  
March 1, 2013  
[www.aapl.org](http://www.aapl.org)**

#### Position Description Medical Director American Academy of Psychiatry and The Law

The Council of the American Academy of Psychiatry and the Law believes that the function of Medical Director, while changing in scope over the organization's twenty-five year history, has been useful in promoting the growth and stability of the organization.

Although the executive and administrative functions of the organization are now handled by professional association managers, the Council wishes to have, for an additional period of time, the benefit of perspective unique to medicine as a profession and psychiatry as a specialty. The following job description has been developed based on this philosophy.

##### A. Responsibilities of the Medical Director

1. Assist in the development and implementation of policies adopted by the Executive Council and make regular reports to the executive Council.
2. Serve as a resource for the Executive Director.
3. Coordinate interactions between AAPL and other organizations (e.g. APA, ABPN) based on policies adopted by the Executive Council.
4. Respond to calls from media. This can include referring calls requiring particular expertise to other AAPL members.
5. Provide expertise and support to committee chairs; assist in liaison and management of issues where committees overlap; undertake intensive and specific projects involving committees or publications as requested by the Executive Council.
6. Supervise the development and revision of guidelines, working with task force Chairs to assure consistency and continuity.

##### B. Organizational Structure

The Medical Director reports directly to the President and Council and is supported administratively by the Executive Office.

##### C. Term of Office

Five years with the possibility of reappointment to additional terms

##### D. Remuneration

\$29,630 for 2013. Cost-of-living increases are given in same amount as to staff. A 1099 will be issued for this amount. The Medical Director is not an employee and no taxes or benefits are paid.

##### E. Expenses

Travel and housing for AAPL Annual Meeting and travel and housing for 2-3 nights (depending on travel time) of APA Annual Meeting. Other expenses reimbursed as determined by the Budget Committee. AAPL does not customarily reimburse for meals, nor does it pay for registration fees, e.g. for AAPL, APA Annual Meetings.

#### Application Process

The announcement is being made by postal mail and email and in the Newsletter.

**Deadline for applications is March 1, 2013. Applications must be emailed to the Executive Office [office@aapl.org](mailto:office@aapl.org).**

Letters should consider the following and be accompanied by a full C.V.:

**Vision for AAPL; Goals as Medical Director; Why the applicant is suited for the position.**

**Applications will be reviewed by a Task Force that will determine the candidates to be interviewed by the Council.**

**Interviews will be held on either Saturday evening or Sunday morning at the APA Annual Meeting in San Francisco. No exceptions will be made. Every effort will be made to notify participants in time to obtain reasonable accommodation and flights, but AAPL will not reimburse for travel to the interview.**

Letters of support will not be considered.



**AAPL Newsletter**  
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Charles Dike, MD, MPH, MRCPsych, Editor

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