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2014 AAPL Presidential Address

Robert Weinstock, MD:
Is Staying Out of Trouble the Last Word in Forensic Ethics? Resolving Ethical Dilemmas through Dialectical Principlism

Chinmoy Gulrajani MD

The 45th Annual Meeting of AAPL opened at the Marriot Hotel in Downtown Chicago with the presidential address delivered by Dr. Robert Weinstock. In keeping with the broad theme of the meeting, Dr. Weinstock discussed the vitality of ethics in the practice of forensic psychiatry. He highlighted the importance of the discomfort that forensic evaluators experience in the face of an ethical dilemma and called upon forensic psychiatrists to pay heed to this discomfort, for it serves as an alarm to alert the evaluator of potential ethics pitfalls. He asserted that some forensic roles may occasionally seem inherently "wrong," and in many of these situations, even a sanction provided by AAPL's ethics guideline may not help assuage the discomfort of the evaluator. To assist the forensic psychiatrist in such situations, Dr. Weinstock introduced the concept of Dialectical Principlism: a framework for analysis of ethical dilemmas to help the forensic psychiatrist determine the most ethical course of action.

Dr. Weinstock first discussed the concept of ethics in the context of the primary and secondary duties of a forensic psychiatrist. He envisioned ethics as an entity that broadly encompasses professional and personal ethics, societal norms and religious values and cautioned that artificial distinctions between professional ethics and personal morality are counterproductive, since both inherently include consideration of what is right and what is wrong. He asserted that while most cases do not pose ethics dilemmas to forensic evaluators, in a minority of extreme cases the secondary duties might outweigh the presumptive primary duties of an evaluator i.e. to foster justice. For example, not consulting for an organization like the KKK or assisting the prosecutor in a capital case. In doing so, forensic psychiatrists are truly able to equate being ethical with doing what is right by themselves, the profession, and society at large.

Historically, ethics in forensic psychiatry has been a topic of vigorous discourse. Beginning with Alan Stone's criticism some 30 years ago of the role psychiatrists play in court, Dr. Weinstock traced the contribution of various AAPL leaders before him. From Appelbaum's model of fostering justice to Griffith's emphasis on race, and from Ciccone and Clements situational case paradigms to Norko's focus on compassion at the core of forensic practice, Dr. Weinstock briefly touched upon the various approaches that many before him have adopted to assist in the resolution of ethics conflict.

Next Dr. Weinstock laid out the foundation of applying Dialectical Principlism to ethically challenging scenarios, such as those situations in which conflicts arise out of dual agency involvement and those which arise out of a psychiatrist's primary and secondary duties. As the name suggests, the term Dialectical refers to the synthesis of apparently conflicting and competing considerations and Principlism involves the practice of incorporating the weight of ethical, professional, personal and societal values in making an ethical choice.

Dialectical Principlism, he explained, involves identifying and balancing many relevant and conflicting factors. Under the schema of Dialectical Principlism, it is not enough to answer the question hon-

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Incoming President Graham Glancy bids Robert Weinstock farewell with the President's Award

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COVER STORY

Presidential Address

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estly and truthfully, explained Dr. Weinstock; it requires physicians to extract relevant ethical principles and weigh them in the light of a specific context. He compared the similarities between Dialectical Principlism and the principles of bioethics offered by Beauchamp and Childress, reflective equilibrium of John Rawls and the Rosner four step model of solving ethics problems.

To demonstrate the practical application of Dialectical Principlism, Dr. Weinstock provided several illustrative examples. The first one questioned the ethics of providing consultation to the prosecution in a capital crime case where the sole purpose of psychiatric evaluation is to fish for aggravating circumstances that could lead to the death penalty verdict. He argued that even though the AMA and APA both allow for psychiatric testimony on either side, under the analysis of Dialectical Principlism, assisting the prosecution in the sentencing phase of a capital crime case is inherently unethical because in this situation the primary duty of the psychiatrist to foster justice is almost always trumped by the secondary duty of non-maleficence. He opined that even in the rare cases where the defense provides outrageously distorted psychiatric facts, non-maleficence remains severe and outweighs the decision to work for the prosecution whose sole purpose is to chase the verdict of death penalty.

In the second example Dr. Weinstock considered the situation where a treating psychiatrist is called upon by Social Security Administration to predict the ability of a currently disabled individual to work in the future. He professed that in this scenario the primary duty of the clinician lies towards his patient and that the forensic duty is secondary since it is a temporary ancillary role thrust upon the doctor. And even though the primary duties do not entail lying to benefit the patient, in this scenario the best informed opinion is based upon speculation on part of the evaluator.

Extrapolating from these examples, Dr. Weinstock promulgated that it is inherently wrong and therefore unethical to provide consultation in assistance of agencies that do nothing to promote the benefit of society, even if the consultative role is aligned with the primary duty of fostering justice. Referrals to forward the cause of tobacco companies that manufacture harmful products and of the KKK, which is an extremist organization, he said, are examples of such agencies where application of Dialectical Principlism will lead the forensic psychiatrist to conclude that refusal of the referral is the most ethical course.

To end, Dr. Weinstock clarified that Dialectical Principlism could lead to different decisions for different psychiatrists based upon the weight they give to their primary and secondary duties. Further, he clarified that he was not calling for a change in current ethics guidelines and was in no way promulgating that psychiatrists should only take cases where the outcome is clear from the outset. He conceded that there will be a small number of psychiatrists who want only to meet the minimum ethical standards and blind themselves to the consequences of their work. But for the rest, he hoped, that Dialectical Principlism will offer a viable framework for resolving ethical dilemmas.

Dr. Weinstock's speech was greeted with a vibrant response from a full house and the question and answer session that followed led to an engaging discussion of the current state of ethics in forensic psychiatry across the nation.

Forensic Review Course
October 19-21, 2015

46th Annual Meeting
October 22-25, 2015

Marriott Harbor Beach Resort
Ft. Lauderdale, FL

Cultural Incompetence

Charles C. Dike MD, MPH, FRCPsych

I saw the movie Divergent recently, and it got me thinking. The star of the movie is a young woman who is beautiful, smart, brave and fearless. Coming off the heels of another hugely successful movie, Hunger Games, featuring another beautiful, smart and brave young woman, it struck a chord. These women showed superior intellectual skills as they outmaneuvered all men. They also showed that women can be equally as physically endowed as men, if not more, and can make tough decisions. Ironically, the views run counter to US public opinion. The recent decision by the US Army to allow women into the frontlines of combat was greeted with horror in some quarters. As members of the "weaker sex," women, after all, are not physically strong enough to withstand the rigors of frontline combat. In fact, as the same beliefs go, women are too emotional and generally too indecisive to make good political leaders, as proposed by some men in reference to the presence of strong women politicians in the US political landscape. Is it surprising then that in the over 200-year history of the USA there has not been a woman president? Are these cultural beliefs or reality?

Interestingly, cultures where women have traditionally been described as inferior, subservient, unintelligent, and passive, for example, Africa and Latin America, have supported women warriors and rulers; the fierce all women warriors of Dahomey, in West Africa, is a prime example. Even India and Indonesia with a strong male dominant culture, have had a female ruler! Culture, therefore, is not quite simplistic, is it?

On Christmas Day 2014, the case of two Saudi Arabian women detained in jail for driving a car was referred to the Terrorism Court. The message? Only a woman terrorist would drive a car! In supporting the pre-existing ban on women driving, a leading Saudi cleric, Sheikh Saleh Al-Loheidan, warned, in 2013 (not in 1500 A.D.!), that "it (driving) could have a negative physiological impact ... Medical studies show that it would automatically affect a woman's ovaries and that it pushes the pelvis upward." He continued, "We find that for women who continuously drive cars, their children are born with varying degrees of clinical problems."

In November 2013, Saudi Arabia's Grand Mufti, Sheikh Abdul Aziz bin Abdullah al-Sheikh, opined that the matter of women driving should "be considered from the perspective of protecting society from evil." Those organizing campaigns against the driving ban were accused of seeking "to undermine the social fabric (of the Saudi society), and they are platforms for malice that promote misleading doctrine." (http://rt.com/news/saudi-driving-women-ban-474/). This in a country where women have excelled in medicine, banking and finance, science, media, and all walks of life; of the top 50 Arab women in 2013, ten are Saudi Arabians, including two of the top three spots!

So then, are these beliefs cultural, religious, personal opinions, tools of oppression, or reality?

A Thomson Reuters Foundation poll in 2011 found that practices harmful to women earned Pakistan the dubious distinction of being the third most dangerous country for women, after Afghanistan and Congo. More than 1,000 women and girls are victims of "honor killings" every year (Pakistan's Human Rights Commission), and 90 percent of women face domestic violence. Physical and sexual abuse are rampant but the victims of rape are afraid to report them for fear of not only tarnishing their families' honor and dignity, but also of being seen as worthless, "used" women, too damaged to be anyone's wife. This unfortunate situation presents a double tragedy for the raped victim who must now fight hard to conceal the abuse and defend the perpetrator, or risk being ostracized or even killed by her family members in order to defend the family's honor! To maintain this tight control over women, some groups in the society expend tremendous energy to discourage female education as evidenced by the near fatal shooting of the then-15-year-old Malala Yousafzai in 2012.

Ironically, Pakistan also holds the distinction of having the first female Prime Minister of a Muslim country in the person of Benazir Bhutto, who ruled from 1988-1990, and again from 1993-1996. How that could happen in a culture described above is striking. As progressive as the USA is, no woman has ever achieved such a feat.

Similar tilted views regarding the role of women are also prominent in psychiatric hospitals in the USA, especially dangerous forensic environments. In casual discussions, male mental health nurses' assistants have been overhead bemoaning the presence of their women colleagues in environments such as maximum security psychiatric facilities, worrying that the women will be of little help (or worse still, a liability) when a violent patient "goes off." Even prior evidence that such violent men have responded positively to interventions by women staff whom they had seen as nonthreatening compared to male staff have not diminished these beliefs. It is therefore, a matter of great irony that most of the nurses who supervise the nurses' assistants are women.

As cultural competence becomes increasingly recognized as a crucial element in psychiatric evaluations and treatment, it is becoming clearer that the cultural determinants of behavior are complex. A careful exploration of a specific individual's response and reaction to his/her culture is perhaps more important than global statements about the perceived influence of culture on him/her.

Forensic Psychiatrists as Educators

Graham B. Glancy MB, ChB, FRCPsych, FRCP(C)

I am humbled to commence my tenure as President of this august organization. After 30 years of membership, during which time I have made efforts to contribute to the organization, it is a great source of pride to be recognized by the members with this leadership. I have chosen to focus on two particular themes for my tenure. The first is education. This includes the education of medical students, residents, and fellows, as well as, and primarily, continuing medical education (CME). The second theme I wish to focus on is Correctional Psychiatry.

In this article I focus on the first of these: medical education. The AAPL mission statement states that, as forensic psychiatrists, we are committed to the three pillars of practice, teaching, and research, with particular emphasis on teaching. One of the main achievements of our organization has been to sponsor educational programs. Our focus has been on CME, the jewel in the crown being the annual conference. This conference has received positive feedback and has been well attended. Many of us return year after year and consider the meeting vital to our continuing professional development. Now is the time, I believe, to take the next step and improve the delivery of these programs.

Those familiar with Dr. Larry Faulkner, a past president of this organization, will know that CME represents a structured approach to lifelong learning. Dr. Brian Hodges, who will be one of our keynote speakers at the AAPL annual conference in 2015, notes in a recent book that the concept of competence has become central to medical education.[1] In recent years it has become increasingly clear that, like all doctors, we can no longer bury our heads in the sand regarding our participation in CME activities. We therefore need to actively participate in and document our efforts in defining, developing, and maintaining professional competency. As practitioners, we are required to continually learn about and maintain our competencies, not only to maintain our licenses in many jurisdictions, but also for our own professional well-being. Doing work of the highest possible standard increases satisfaction and enhances our professional reputations. Perhaps most importantly the forensic psychiatrist role comes with an ethical obligation to maintain and improve our expertise and skill level. This entails performing work of the highest possible standard, and continually striving for excellence. This in turn will enrich our professional experiences and make our professional lives more satisfying.

Despite the importance of CME, our profession still places insufficient emphasis on CME strategies. This is a state of affairs that AAPL can help improve. Throughout our careers, daily work routines provide a wide range of learning opportunities, some of which present particular challenges or new areas with which we have been hitherto unfamiliar. These experiences provide opportunities to regulate and update our skills and gain new information, thereby maintaining and improving our expertise. It is a worrying fact (to some of us) that it has been shown that we start to incrementally lose medical knowledge after the mid-50s; so those of us who tell our fellows in jest that we have forgotten more than they have ever learned are maybe telling the truth.

Maintenance of competency (MOC) programs, such as the Royal College of Physicians and Surgeons of Canada (RCPSC) MOC program, are designed to facilitate continuous practice-relevant learning and improvement. The RCPSC MOC program emphasizes ongoing assessment as a means of identifying emerging professional needs in the areas of knowledge, skills, competency and performance.[2] The main point here is that the commitment to identifying new challenges, problems, and needs, and acquiring new skills and knowledge to address them is career spanning. Hence, over time, the profession as a whole and the individual members of it, should be reflective about professional competence and how it can be bolstered to meet the dynamic changes of an evolving field.

An interesting article by Van der Vleuten[3] applies Miller's pyramid of learning, to the concept of clinical performance at, distinguishing between the does level, and the knowing how to do level. The idea here is that expertise consists of not just knowing how to behave optimally in general but in *excellent performance under real conditions*. In other words, an excellent practitioner is not just someone who *knows how to* do things well, but who *actually does them well* when it counts. Implied in this model is that high level competence is, to some extent, always context specific – what works well in one circumstance may not work so well in another. Given that the contexts in which clinicians work are variable and dynamic, practitioners need to reflect on and adapt to new and unforeseen conditions and challenges throughout their careers. Hence it is important for us to focus not only on the skills and knowledge we already know we must possess, but also to actively and reflectively engage with contexts that are novel and challenging. As members of a dynamic and evolving field, it behoves us to commit to this continuous professional learning and development.

I would like to turn now to reflect upon the modalities that AAPL can offer for the continuing education of our members. AAPL already offers excellent opportunities and I would like to urge us to consider evolving even better approaches in an incremental fashion. Although our annual meetings have always been of a high caliber, we should not rest on our laurels. We need to continue to develop and evolve, to serve and educate our members, so as to develop increasingly better learning opportunities. We need to consider what may be the best strategies for continually main-

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Participating in AAPL's Governance: How to join the AAPL Core

Jeffrey Janofsky MD

Most members experience AAPL through our Annual Meetings which occur Thursday through Sunday in October, our *Journal* and our *Newsletter*. What some members may not be aware of is AAPL's organizational structure, which allows AAPL's educational mission to move forward.

AAPL governance structure is outlined in Bylaws which vest executive authority in a Council consisting of a President, two Vice Presidents, a Secretary, a Treasurer, the Immediate Past President and nine Councilors. The Bylaws also outline a Committee Structure. AAPL now has more than thirty Committees. Committee Chairpersons report to Council. Committees write articles for our Newsletter and submit presentations for our Annual Meetings, as well as advise the Council on topics specific to their Committee.

AAPL Committees and Council meet on the Wednesday before our Annual Meeting and at AAPL's Semiannual Meeting, held the Saturday before the American Psychiatric Association meeting in May. A Committee dinner, free to Committee members, is held on the Wednesday evening of our Annual Meeting.

All AAPL members are invited to attend the October Annual Business meeting. There AAPL officers and staff report on what has happened during the past year, and give a forward looking appraisal of AAPL's future goals.

The first step to becoming involved in AAPL Governance is to join a committee. A listing of current committees can be found at: http://www.aapl.org/committees.htm . You might consider phoning the Chair of a committee you are interested in for more information, or just dropping into a committee meeting held at the Annual or Semiannual meeting. Once you have identified which committee interests you, let the Committee Chair know and then send an e-mail to AAPL's current President and ask to be placed on that committee. Once placed on a committee please try your best to help with committee work, and try to attend as many of the committee meetings as possible.

The "entry level" position on the AAPL Council is the Councilor Position. Councilors hold three year terms and two new Councilors are elected each year. Councilors and officers are expected to attend AAPL Council meeting in October and May, and to also be available for consultation by email or phone when necessary.

> *"What the applicant has done for forensic psychiatry outside of AAPL (APA, ABPN, child psychiatry, home university), and what the applicant hopes to accomplish on the Council are also useful for the Nominating Committee"*

Councilors and Officers are initially selected by a Nominating Committee consisting of the President, the two Immediate Living Past Presidents, the six Councilors whose terms do not end at the time of the election for which the Committee selects nominees, and two ad hoc members appointed by the President who do not hold office at the time of their appointment.

The Nominating Committee meets at AAPL's Semiannual Meeting in May. Prior to that meeting a request for applicants will be sent to AAPL members, requesting that any member interested in a Councilor or Officer Position inform the Nominating Committee of their interest.

I have served as a voting member of the Nominating Committee on five occasions. From my perspective it is important that the letter expressing interest be well thought out, outlining what the applicant has done for AAPL in the past. Information about the applicant's committee participation, presentations at Annual Meetings and Journal and Newsletter articles are important. What the applicant has done for forensic psychiatry outside of AAPL (APA, ABPN, child psychiatry, home university), and what the applicant hopes to accomplish on the Council are also useful for the Nominating Committee

After sometimes very difficult deliberations the Nominating Committee presents its slate of candidates during AAPL's Semiannual business meeting, which occurs just before the Guttmacher Lecture at the May APA meeting. Assuming there are no additional nominations from the floor at the Business Meeting, a very rare occurrence, the slate is closed. The slate of Councilors and Officers are formally voted into office at the AAPL Annual Business Meeting which occurs on Saturday Morning during our October Annual Meeting.

I have had the opportunity to serve on numerous AAPL committees and the AAPL Council since I joined AAPL in 1986. I found such participation a useful way to meet other forensic psychiatrists in a small group setting, share common scientific interests, and put together ideas that eventually became presentations at AAPL and other scientific meetings. Committee and Council membership also helped me begin ongoing social and professional relationships with AAPL members that have continued for more than 28 years. Participation has also allowed me to "pay it forward" to help make AAPL a more useful organization for forensic psychiatrists.

I hope you consider joining AAPL governance yourself.

Forensic Psychiatrists as Educators

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taining, demonstrating and improving the competencies of AAPL members.

One potentially fruitful strategy involves using computerized self-assessment during our Annual Meetings. This will involve assessment before and after the meeting and could even be linked to specific teaching sessions.

Another strategy involves tapping into our strong tradition of peer review. The meeting provides opportunities for peer review of individual members by the Peer Review Committee. It is one of the great strengths of AAPL that the doyens of forensic psychiatry practitioners, whom we all know and respect, will contribute their valuable time and expertise for this worthwhile work.

The second contribution by the Peer Review Committee is the organization of the video feedback session, wherein the membership as a whole can give feedback to one brave member. This is set up as a demonstration, enabling both participants and observers to learn from this feedback.

A relatively new development undertaken by our organization has been the institution of "performance in practice" modules (PIPs). Specific performance-based competencies such as assessment of competency to stand trial can be targeted in this type of module.

This type of learning may represent the most up to date learning in our field. It is hoped that we can develop a full range of these PIPs to enhance the skills of our members.

The forensic psychiatry practice guidelines, which have increasingly become a focus for AAPL, also represent educational opportunities. While the signs and symptoms of schizophrenia for example, can be learned from a textbook, texts are of limited value in specifying the optimal *procedure* for assessing patients.

In addition to aiding practitioners in doing real-world tasks, practice guidelines can be used as frameworks for evaluating professionals' competency in fulfilling these tasks. We presently have guidelines for assessing competency to stand trial, assessment of insanity[5] and several other professional functions. By using them, members can be informed about what they should be doing, and can be assisted in delineating what skills they require in order to be competent in these specific areas. In other words, they inform us of the competencies we need to develop and assist us in developing them.

Forensic psychiatrists repeatedly have to demonstrate their competency, often in a very public manner, in the court room. As we all know, this can sometimes be quite anxiety-provoking, because feedback often comes in the form of rigorous cross examination. Competency in these circumstances implies not only knowledge but the ability to demonstrate knowledge in a professional manner in the face of the vicissitudes of cross-examination.

In connection with this particular aspect of competency, I would like to discuss a strategy I believe to be particularly promising for the preparation of trainees: simulation. Simulation training is widely used in the education of physicians and other medical professionals.

Certain specialties within medicine lend themselves in particular to teaching through the use of simulated practice environments. This can be organised using standardized patients, programmed mannequins, or simulated scenarios in emergency situations. Specific feedback can then be provided by faculty members or peers, to improve skills for future practice.

The use of simulated practice environments, in the form of mock trials, is a common component of many legal education programs. In forensic psychiatry we have also used this approach for years. However, I believe that this format holds great potential that has not yet been tapped.

I would encourage members to carefully think about how mock trials and other simulations can be used at both the fellowship level and in CME. In my own examination of the fairly small body of literature on mock trials I could find very little discussion of their appropriate learning goals, their optimal structure and appropriate feedback methods.

This educational tool has been a particular interest of mine from an academic perspective, so I would like to develop this format to maximize its androgogical effectiveness as a part of my mandate as president. This task fits in with a more general mandate of continuing to learn how best to maximize learning opportunities in order to most efficiently develop and enhance competency.

I look forward to working with the members in continuing to develop our role in medical education. I would like to urge us all to consider the use of new methods and technologies that will help us achieve our mission to improve education and, thence, through education, the practice of forensic psychiatry.

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Laurence Steinberg, PhD:

Should Science of Adolescent Brain Development Inform Legal Policy?

Simha Ravven MD

On October 23, 2014 Laurence Steinberg, PhD, delivered a compelling address at the AAPL Annual Meeting in Chicago, entitled "Should the Science of Adolescent Brain Development Inform Legal Policy?"

Dr. Steinberg is the Laura H. Carnell Professor of Psychology at Temple University and the author of *Age of Opportunity: Lessons from the New Science of Adolescence* (Houghton Mifflin Harcourt, 2014). His lecture examined the relationship between the science of adolescent brain development and legal public policy involving adolescents.

The broad conclusion of his and his colleagues' research is that adolescents are less mature than adults in fundamental ways that warrant differential treatment under the law. He outlined the increased consideration of scientific evidence on adolescent development in decisions about criminal culpability in adolescents.

Dr. Steinberg's research has been cited by the U.S. Supreme Court in its 2005 decision in *Roper v. Simmons* to abolish the juvenile death penalty, its 2010 decision in *Graham v. Florida*, to ban life without parole as a sentence for juveniles convicted of nonhomicides, and its 2012 decision in *Miller v. Alabama* to prohibit states from mandating life without parole for juveniles, regardless of the crime. In each of these cases, the Court concluded that the inherent developmental immaturity of young people diminished their criminal culpability to a degree that protects them against punishments reserved for fully responsible adults who commit the most serious of crimes. In *Graham* and *Miller*, the Court explicitly cited research on adolescent brain development.

The central legal issue in *Roper, Graham*, and *Miller* was whether the application of a particularly harsh sentence to a juvenile—such as the death penalty or life without the possibility of parole—violates the Eighth Amendment of the U.S. Constitution, which prohibits "cruel and unusual" punishment, even if the same sentence is not a constitutional violation when applied to an adult.

> *"... the circumstances under which individuals make medical decisions and commit crimes are very different and make different sorts of demands on individuals' brains and abilities."*

The question in these cases was not whether a juvenile's criminal act should be completely excused because of immaturity — normally developing individuals are assumed to be capable of forming criminal intent by age 7. Rather, the issue was whether the sentence the juvenile received was excessive relative to the degree of responsibility he had for his behavior.

Interest in whether adolescents are as mature as adults has been stimulated in the past decade by the rapid expansion of knowledge about adolescent brain development. Legal and policy discussions and popular culture are increasingly referencing the neuroscience of adolescent development.

According to Dr. Steinberg, the Court's decisions regarding juvenile culpability have been increasingly influenced by findings from studies of brain development that support the position that adolescents are less mature than adults in ways that mitigate their criminal culpability, and that adolescents' diminished blameworthiness makes it inappropriate to sentence them in ways that are reserved for individuals who are deemed fully responsible for their criminal acts. The more recent cases were of course not the first ones in which the Court acknowledged that adolescents and adults are different in legally-relevant ways, but they were the first to look to neuroscience for confirmation of what "any parent knows," as Justice Kennedy put it in his majority opinion in *Roper*.

Dr. Steinberg observed, however, that the same research that was cited in these cases also has been used by those who have argued that youthful immaturity justifies placing limits on adolescents' rights, such as the right to seek an abortion without parental permission.

Steinberg noted that in his dissenting opinion in the juvenile death penalty case, Justice Scalia took the American Psychological Association to task for having opposed the juvenile death penalty on the grounds that juveniles are less mature than adults, since the organization had previously argued in favor of minors' rights to obtain an abortion without parental involvement on the grounds that adolescents were just as mature as adults.

He explained that the circumstances under which individuals make medical decisions and commit crimes are very different and make different sorts of demands on individuals' brains and abilities. State laws governing adolescent abortion require a waiting period before the procedure can be performed as well as consultation with an adult – a parent, health care provider, or judge. These policies discourage impetuous and shortsighted acts and create circumstances under which adolescents' decision-making is in fact just as mature as adults'. In contrast, violent crimes

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Professor Michael Perlin:

Power Greed and the Corruptible Seed: Mental Disability, Prosecutorial Misconduct, and the Death Penalty

Victoria Dreisbach DO

Michael Perlin, Professor of Law at New York Law School, Director of New York Law School's International Mental Disability Law Reform Project, and Director of the Online Mental Disability Law Program gave an intriguing lecture concerning defendants with mental disabilities, the contexts that lead prosecutors to misconduct and inequities in the application of the death penalty, and possible remedies for consideration.

Mr. Perlin used Bob Dylan's song, *Blind Willie McTell*, to illustrate the sad history of racial inequity and injustice in the United States dating from slavery. He discussed how mental disabilities, like race, have led to unequal application of the death penalty for this class of defendants. He eloquently traced the origins of inequitable treatment that affects defendants through each phase of the criminal justice process, from initial contact, intake, interrogation, prosecution and disposition.

In particular, Mr. Perlin highlighted the prevalence of false confessions related to defendants with mental disabilities. He cited a review of four Innocence Project websites, which implicated mental impairment as the major reason why innocent defendants confessed to offenses they did not commit.

Mr. Perlin described inducements in the criminal justice system that support and reinforce prosecutors and trial judges to seek and impose the death penalty. He described how the influences of seeking election and/or re-election for these positions in districts where citizens favor the death penalty shape the judicial process. As an illustration, he described a Philadelphia prosecutor's "passionate" commitment to capital punishment despite her view that it does little to deter crime, and her use of it more often per homicide in her district than anyone else in the country, to give citizens "a feeling of control demanded by a city." She compared her district's plight to being in Bosnia.

In the case of a defendant with mental illness, the public's misperception and fears create a heightened prosecutorial pressure to seek maximum penalties, and judges to grant them, which further reinforces the stance of being tough on crime, garners public support, and eventually, leads to re-election.

> *"... prosecutors exploit ignorance regarding mental illness by arguing that the flattened affect of a defendant with mental disabilities is further "proof" of lack of remorse, thereby justifying the death penalty."*

These political forces coalesce with fatal effect in defendants with serious mental disabilities. Mr. Perlin discussed the case of a man with serious mental illness who was convicted and executed for the murder of his sons. His defense attorney discovered after his death that documentation existed that the defendant had exhibited symptoms of serious mental illness prior to the instant offense that was not disclosed by prosecution. As a result, the defendant was not given the legal representation he deserved, and died on November 15, 2011.

Incentives and consequences for such prosecutorial misconduct are lacking and are not remedied on appeal. Mr. Perlin reviewed statistics from Louisiana to illustrate that of 150 reported cases where misconduct was found, only 20 convictions were reversed on appeal.

Mr. Perlin asserted that prosecutors may misuse evidence of a mental disorder to exploit the ignorance of jurors to play on their fears and misperceptions. For example, in a report by Amnesty International, American prosecutors exploit ignorance regarding mental illness by arguing that the flattened affect of a defendant with mental disabilities is further "proof" of lack of remorse, thereby justifying the death penalty.

Another way of distorting evidence is by offering experts known to provide baseless evidence of future dangerousness to support the death penalty in defendants with mental disorders. Dr. James Grigson was used in 57 cases between 1995 and 2004 *after* being decertified by the American Psychiatric Association and Texas Society of Psychiatric Physicians for his professional misconduct. No sanctions to date have been levied against prosecutors who chose to use this psychiatrist as an "expert" to juries deciding the fate of mentally disordered offenders.

Mr. Perlin offered potential remedies. Re-evaluation of prosecutorial training programs concerning ethics in capital cases and how to manage the pressures for convictions and death sentences.

Others include suggestions for sanctioning attorneys whose conduct is improper or unethical through limiting future practice in capital cases to being reported to the bar. In short, Mr. Perlin opined that although "ghost of slavery ships" in Dylan's song may remain, its exorcism is still possible.

Gregg Barak, PhD and Judge Donald Shelton, JD, PhD

The CSI Myth and Reality: Jurors', Judges' and Litigators' Expectations for Scientific Evidence

Brian Cooke MD

On a sunny Saturday afternoon, AAPL attendees were presented a three-course meal and a two-speaker distinguished lecture, "The CSI Myth and Reality: Jurors', Judges' and Litigators' Expectations for Scientific Evidence" presented by Gregg Barak, PhD and The Honorable Donald Shelton, JD, PhD. Gregg Barak is Professor of Criminology and Criminal Justice at Eastern Michigan University and the former Visiting Distinguished Professor in the College of Justice and Safety at Eastern Kentucky University. Barak is a two-time award winning author and editor of 15 books on crime, justice, media, violence, criminal law, homelessness, human rights, and related topics. Judge Donald E. Shelton has been a Circuit Judge since 1990. He served as Chief Judge of the Trial Court from 2010 to 2013. Shelton was also the presiding judge of the Civil/Criminal and Juvenile divisions of the Trial Court. He obtained his PhD in Judicial Studies from the University of Nevada. He served as a captain in the United States Army Judge Advocate General's Corps from 1969 to 1974, earning the Meritorious Service Medal in 1974. Judge Shelton recently retired from the bench and is now an Associate Professor at the University of Michigan.

The speakers focused much of their discussion summarizing their research and experience working in the courtroom. Empirically speaking, they emphatically denounced the CSI effect. What is the CSI effect? It has been proposed that it is any of several ways in which the exaggerated portrayal of forensic science depicted in television shows such as *CSI: Crime Scene Investigation* influences public perception. More specifically, the CSI effect is the belief that jurors have come to demand more forensic evidence presented in criminal trials. This, in turn, has placed higher expectations on the prosecution, raising the standard of proof.

For those unfamiliar with the show, *CSI*, which first aired in 2000, depicts a fictional team of crime scene investigators who solve murders in a major metropolitan area. Television shows, such as *CSI*, have influenced jurors to the extent that they expect the hard evidence popular in television to also be presented in real-life criminal trials. The speakers remarked that they have heard some jurors comment, "But where are the holograms?" and, "They didn't even dust the lawn for fingerprints!" As a result of this perceived CSI effect, prosecutors have changed their work (e.g., in *voir dire*, opening and closing statements, or retaining expert witnesses) to counter and minimize impact of the CSI effect.

Fueled in part by media hype, the speakers remarked there is a fascination with the criminal justice process, as evident by the popularity of television shows such as *CSI, Cold Case, Bones, NCIS*, and many offshoots. *CSI* recently began its 15th season.

As a result, Barak and Shelton embarked on one of the largest empirical studies of the CSI effect. In it, they asked if jurors expect the prosecution to present scientific evidence and if jurors demand scientific evidence as a condition for a guilty verdict. Their first study, published in the Vanderbilt Journal of Entertainment and Technology Law (2007), randomly selected 1,627 summoned jurors from Washtenaw County (Ann Arbor). A second study (published in the same journal in 2009) randomly selected 1,219 summoned jurors. The survey examined jurors' television watching habits, expectations for different types of cases, and burden of proof. The results showed that 58.3% of jurors expect to see some kind of scientific evidence in every criminal case, 42.1% expect to see DNA, 56.5% expect to see fingerprints, and 49.1% expect to see ballistics. Strikingly, almost 90% of jurors expect to see DNA presented in rape cases, although (as the speakers reminded the audience), DNA is not relevant in these cases because the issue is a matter of consent and not penetration. Their study also shows that jurors are more likely to find the defendant guilty than not guilty even without scientific evidence if there is testimony from the victim or other witnesses, except in rape cases.

The speakers contend that blaming jurors' television watching is too simplistic. Instead, they argue that an alternate explanation for the changing perception of forensic evidence is what they have dubbed the "tech effect." They explain that this is a broader effect reflecting the changes in our popular culture that might be more likely to account for increased expectations and demands of jurors for scientific evidence. The more sophisticated jurors are with technology, the higher their demands in the courtroom.

Prior to Barak and Shelton's research, they found that 79% of judges, prosecutors, and defense attorneys believed in the CSI effect. Despite their research, which attempts to deflate the CSI effect, the speakers admit that they believe attorneys and judges still believe in it. This is not surprising, given that their alternate hypothesis, the "tech effect," seems closely intertwined with the effect they claim is merely a myth. The technology of our society is in our pockets, our homes, and our offices. It affects us personally, through our children (who also own

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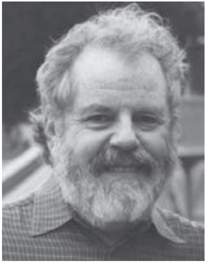
The Bully Pulpit

Stephen P. Herman MD



When I was in fourth grade, Bobby S. had it in for me. I didn't know why at first. He would push me down on the school playground and laugh while he did it. At first I thought it was because my mother taught in the same school. One day, Bobby, while laughing at me, called me "Dirty Jew!" Then I understood. I did nothing and never told my parents. My father would have castigated me for not fighting back and my mother would have gone to speak to the principal. I didn't want any of that. So I kept my mouth shut.

Decades later when I was a forensic psychiatrist, in May 2014, I received a call from a forensic social worker at Legal Aid in the Bronx. They were representing NE, a 14-year-old boy who took matters into his own hands. It seems that throughout the school year, up through the spring, one boy in his class constantly bulled him. The bully, TR, called NE's mother all kinds of names, such as "crack addict," or "whore," or "lazy." NE would run home to the projects and quickly slam his door. TR banged on the door and then urinated on it. One day NE almost hanged self with a belt until his grandfather saved him. Taken to Bronx-Lebanon Hospital, he did well for two weeks and was discharged on Zoloft and Risperdal. Two days after he was back at school, TR, the bully, approached NE and began pushing him against a wall. This time, NE took out a kitchen knife he had brought from home. He stabbed the bully three times in the abdomen. He lacerated the liver, hit a major artery and pierced his heart.

School authorities had known everything about the bullying but did nothing. Even NE's mother had once come to the school to complain. So did the grandfather. When NE had been released from the hospital, and through tears, asked the school officials and Board of Education to transfer to another school, the school said no, as the academic year was coming to the end. That is what prompted NE, who had never been in trouble before, to carry the knife.

First, charged with homicide by the DA of the Supreme Court in the Bronx, NE's case was transferred to Juvenile Court, where he would not be charged as an adult and would instead be charged with manslaughter. Legal Aid was, at the time of this writing, looking for a therapeutic foster family, a special school and intensive psychotherapy. They were also looking for a family to provide – in the future – a safe, healthy permanent home.

> *"One form is to use our clinical skills and knowledge of the law in various localities to knock the bully off his or her pulpit."*

Bullying has now been recognized by everyone as a menace to a child's growth and development. It is now noticed as child abuse was in the late '60s. It consists of aggressive behavior and threatening and hurtful talk which sets up a power differential. The child being bullied is often different from other children. He may wear different clothing, eat different foods, or have families that are known by other children as being different or filled with problems. Bullied children are seen as weak and easily pushed around. They may have some physical disability, or come from a troubled family. The bullied children may have a different life style, such as being gay, lesbian, bisexual or transgender. They may be loners or perceived as having low self-esteem.

A powerful form of bullying today is cyber bullying, using the Internet to make fun of kids who may be physically or emotionally different. This may appear in Messages or Facebook, and may include photos of the bullied child. They can occur all day or night, through emails and comments that spread across the Internet in minutes.

Stopbullying.gov indicates children who are bullied via the Internet are likely to use drugs as an escape from their pain, fail to attend school (NE had been absent from school for 53 days), get poor grades, and have some disability. As we all know from the media, some children commit suicide. A Missouri girl killed herself several years ago because an ex-boyfriend posted provocative photos of her on Facebook. A New Jersey college student who was gay was subjected to a dorm member taking pictures of him engaged in sex with his lover. The boy from New Jersey jumped off the George Washington Bridge to his death.

DH, for example, suffered from Tourette Syndrome and absent medication, was always having tics and grunting. He was bullied incessantly.

The incidence of bullying seems to increase with school grades. Some schools today are more aware of bullying and take it very seriously. Their actions involve dealing with it within the institution to involving the community and police. In 2011, President Obama called for a White House conference on bullying. The President pointed out that about one million children report being bullied every year.

A comprehensive website which addresses bullying in all its forms is www.thestopbullingproject.com. This is a good starting off point for those looking to get involved. It has been pointed out that a surprisingly high percentage of adults who work in offices may also face a similar situation.

Forensic psychiatrists may become involved first in evaluating a child who has been bullied to make recom-

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Nicole Johnson, MD

Philip Candilis MD

Nicole Johnson recalls digging through the rubble of Ground Zero on 9/11, coming home covered in soot. A clear day with brilliant sunshine had turned into the city's worst nightmare. As a resident at St. Vincent's Hospital in Manhattan, Dr. Johnson had fully intended to make her dentist's appointment that morning, dropping by the office to check in with her program. She didn't know what to make of the smoke billowing from One World Trade Center, but saw the South Tower collapse.

As the news unfolded, Dr. Johnson and her colleagues were quarantined at the hospital and then taken by van to Ground Zero. On hands and knees, they searched for survivors that day, moving debris, calling out in hopes of a response, and uncovering unspeakable vestiges of the attack. It was an indelible introduction to forensic practice.

Dr. Johnson was already primed to enter law and psychiatry. One college summer, the undergraduate psychology major had followed her attorney sister to Louisiana where she clerked for a sitting judge. When the same judge was accused of conspiracy and bribery, Nicole attended the trial and the judge's conviction. It was a powerful impression of the legal system at work.

Working with first-responders after 9/11, Dr. Johnson reinforced the connection between her education and her experiences. As she sat in New York firehouses, it was clear how much even the most battle-hardened veterans needed someone to talk to. "Once they realized you were there to talk and be a part of it, they opened up," she says. "They knew you weren't going to be there just once and leaving."

Yet the path to forensics was not pre-ordained. Nicole was an NCAA athlete, running track at Duke and entering the Match in Orthopedics before finding her calling. Her prowess as a heptathlete led her to the PENN Relays and an appreciation for knee injuries, but it was an experience in her early training that gave her the nudge she needed to enter the right specialty.

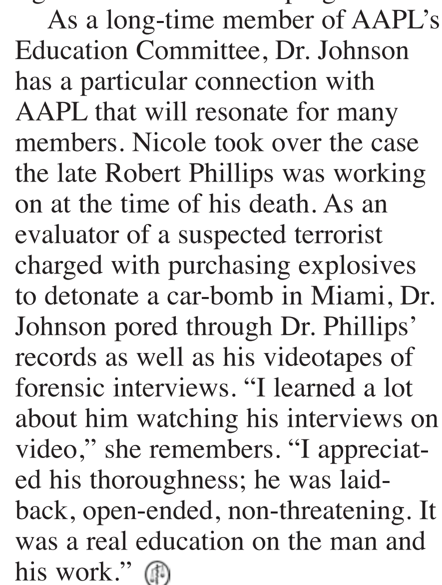
"In a med school elective I was at the hospital with my Ortho chief resident, when her daughter came in to see her," she recalls. "They didn't see each other often, and when she called her mother by her first name, I was just shocked." A schedule and lifestyle that interfered with family life so dramatically could not be the right path for her. Now married with two daughters, Dr. Johnson is sure of the wisdom of her choice.

Nicole met her fellowship director Merrill Rotter at AAPL. "He was great," she remembers. "He put the fellows' education and potential first. You knew he would help with your career. He just sold his program by caring about education." The Albert Einstein fellowship also offered a child concentration that strongly matched Nicole's interests. Working with court evaluators and even watching outside school to determine which parent came by to pick up their child was both an educational experience and a professional adventure.

Rotating through Sing-Sing Prison during fellowship training was also an inspiration for later professional efforts. Dr. Johnson's work re-connecting inmates with community services and observing the difficulties of re-integration were direct influences on her current work easing federal prisoners into local systems.

Now, as Dr. Johnson leads outpatient forensic services for Washington DC's Department of Behavioral Health, she works to develop a specific program for juvenile competence restoration. Her model outpatient competence restoration program for adults already offers multiple educational modalities and strong restoration rates for the city, but a trained cadre of practitioners for children had been absent. As she develops a programmatic structure with city leaders and brings in evaluators to conduct juvenile assessments and training, Dr. Johnson works to expand access to much-needed forensic services. Increasing classes and decreasing class size to assist those with cognitive limitations, as well as considering how to expand the service into the correctional system are part of her hopes for an increasingly rigorous and accessible program.

As a long-time member of AAPL's Education Committee, Dr. Johnson has a particular connection with AAPL that will resonate for many members. Nicole took over the case the late Robert Phillips was working on at the time of his death. As an evaluator of a suspected terrorist charged with purchasing explosives to detonate a car-bomb in Miami, Dr. Johnson pored through Dr. Phillips' records as well as his videotapes of forensic interviews. "I learned a lot about him watching his interviews on video," she remembers. "I appreciated his thoroughness; he was laid-back, open-ended, non-threatening. It was a real education on the man and his work."



Greg Barak/ Donald Shelton

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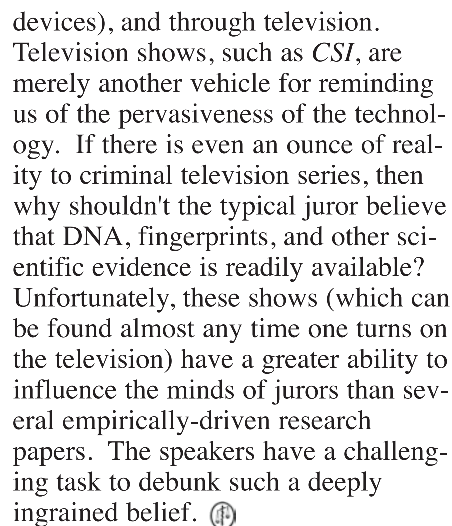
devices), and through television. Television shows, such as *CSI*, are merely another vehicle for reminding us of the pervasiveness of the technology. If there is even an ounce of reality to criminal television series, then why shouldn't the typical juror believe that DNA, fingerprints, and other scientific evidence is readily available? Unfortunately, these shows (which can be found almost any time one turns on the television) have a greater ability to influence the minds of jurors than several empirically-driven research papers. The speakers have a challenging task to debunk such a deeply ingrained belief.



Dialectical Behavior Therapy in Forensic Settings

Syed Khalid Abubaker MD

As I rapidly approach the halfway point of my forensic psychiatry fellowship, I have come across a multitude of forensic settings that could benefit from implementation of Dialectical Behavioral Therapy (DBT). Whether dealing with patients in the emergency room, outpatient clinic, or correctional setting, forensic clinicians can offer a common framework for understanding high-risk patients that goes beyond alternative models.

As the primary treatment model for Borderline Personality Disorder (BPD), DBT has the largest number of published evidence-based articles on its effectiveness (13 Randomized Control Trials versus 2 for the treatment model of the next highest rank). Internationally, DBT has been shown to be effective at reducing suicidal behavior, psychiatric hospitalizations, ER visits, and other key outcomes of interest to public sector and forensic psychiatry at the same time.

Patients from the public psychiatric emergency room exemplify how BPD is one of the most crippling and frequently lethal of all psychiatric illnesses. Overall the condition has a prevalence of about 2% of the general population, 10% of psychiatric outpatients, and 20% of psychiatric inpatients. In the public sector population in particular, the most common behavioral pattern associated with BPD is chronic non-suicidal self-injury and suicidal behaviors, including frequent suicide attempts. Rates of non-suicidal self-injury among individuals diagnosed with BPD range from 69 to 80%. The suicide rate is 5-10%, and doubles when one considers only those with a previous history of suicide attempts and/or self-injury.

Specifically, my experiences at the District of Columbia Department of Corrections and Superior Court Urgent Care Clinic have taught me that forensic patients struggle with a myriad of issues involving violence, substance abuse, psychotic and mood disorders, as well as personality disorders. DBT can serve as a useful means of treatment for all of these conditions because it addresses characteristic behaviors, encourages personal responsibility, and strengthens the therapeutic relationship.

The high demand for treatment among forensic patients with BPD is often coupled with a poor response to standard outpatient interventions, leading to high rates of healthcare utilization and an increased financial burden to health systems in general. Many patients with BPD are among the highest utilizers of services within public sector settings. Studies even suggest that they consume up to 40% of mental health services provided even on an outpatient basis.

Of the five mainstream approaches used to manage BPD, DBT has been studied the most extensively. It uses principles of cognitive behavioral therapy (CBT) combined with mindfulness, acceptance, and dialectics. DBT, however, differs from CBT in that it places less emphasis on using cognitive methods and focuses instead on the learning and practice of new skills. Normally delivered over one year, outpatient DBT changes behavior and manages emotions through what one group calls "a balance and synthesis of both acceptance and change."

A multi-pronged approach comprising skills-based training, individual psychotherapy, telephone calls and consultation team meetings, DBT can have a positive effect on therapists as well, shifting pessimism towards therapeutic optimism.

In the outpatient setting in particular, a skills-based training group lasting up to two hours per week is designed to augment patients' problem-solving skills by encouraging role play. Weekly individual psychotherapy occurs concurrently for 60-90 minutes. Therapy then relates the skills from the group to the client's personal circumstances. It also allows time for addressing commitment to the therapy and reducing problem behaviors. Brief telephone consultations are designed to assist participants with appropriate coping skills, to maintain the therapeutic relationship, and provide another way for the individual to ask for help. Weekly consultation meetings among therapy team members facilitate case discussion, enhance therapists' skills by focusing on the treatment plan, and prevent therapist burnout.

Recent studies indicate that DBT can be cost-saving or at least revenue-neutral, especially in the outpatient setting. But most notably for clinicians themselves, a number of studies have found increased clinician satisfaction with the approach compared to usual care. This is a critical component of DBT that holds promise for reducing the exhaustion and fatigue associated with clinician burnout.

For patients with PTSD as well as BPD – often found in forensic settings – studies suggest that patients do not require significantly lengthier PTSD treatment when they use DBT concurrently. Overall, DBT appears to be an effective, evidence-based approach to treating the chronic, self-injurious behaviors that are prevalent in the public sector.

As fellows train in public sector forensic settings it may be clear that implementation of DBT-related interventions may effectively help reduce violence and self-injury by making feelings of anger and hostility more manageable for patients, increasing their accountability, and decreasing clinician burn-out all at the same time.

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References used for this column are available from the author at syed.abubaker@dc.gov

Ohio Fellowships Collaborate on Mock Trials

Stephen Noffsinger MD and Douglas Mossman MD

Testifying effectively is a key skill for forensic psychiatrists because the content and perceived credibility of expert mental health testimony can significantly influence jurors' decisions.[1] The Forensic Psychiatry Milestones developed by the Accreditation Council for Graduate Medical Education[2] state that by the end of training, forensic psychiatry fellows should "independently and appropriately communicate well-supported forensic psychiatric opinions in oral and written formats" and "provide testimony in a clear and professional manner."

Typically, forensic psychiatrists learn about testifying through real-world, trial-by-fire experiences, often after making numerous missteps on the witness stand. Although a few authors have provided written introductions to testifying that are suitable for forensic psychiatry fellows,[3,4] reading how-to books does not provide the kind of exposure and practice needed to become capable, credible experts who testify persuasively on direct and cross-examination.

For more than ten years, the fellowship programs at University Hospitals of Cleveland and the University of Cincinnati have collaborated via videoconference to provide mock trial experiences for their forensic psychiatry fellows. Mock trials let the fellows practice testifying in the controlled environment of a simulated trial so that they can make errors without affecting the outcome of a real trial and receive feedback from fellowship faculty on their strengths and weaknesses as an expert witness. Mock trials occur twice a month, and each fellow testifies at least four times during the fellowship year.

Fellows take the role of expert witness at each session. During the first half of the academic year, fellowship faculty assumes the roles of direct examiner, cross examiner, and judge. Fellows prepare for the mock trial by submitting a sanitized report to the faculty and having a pre-trial conference with the direct examiner to plan the content of their direct testimony. Mock trials simulate actual trials by having segments for *voir dire*, direct and cross-examination, but we reserve ample time at the end of videoconferences to critique our fellows' performances and to discuss the clinical and scientific issues that testimony often raises. During the second half of the academic year, the fellows also assume the roles of direct examiner, cross-examiner, and judge. Serving as *faux* attorneys helps the fellows deliver effective direct testimony and anticipate cross-examination of their own opinions in later cases.

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Science of Adolescent Brain Development

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are usually committed by adolescents when they are emotionally aroused and with their friends – two conditions that increase the likelihood of impulsivity and sensation-seeking and exacerbate adolescent immaturity. From a neuroscientific standpoint, it therefore makes perfect sense to have a lower age for autonomous medical decision-making than for eligibility for capital punishment.

Dr. Steinberg delineated the increased importance of neuroscience research in Supreme Court decisions, from *Roper*, in which adolescent brain development was mentioned during oral arguments but it was never explicitly referenced in the Court's opinions, to *Miller*, in which neuroscience warranted an entire paragraph in the majority opinion. Writing for the majority, Justice Kagan went into greater detail about brain science, specifically mentioning adolescent immaturity in higher-order executive functions such as impulse control, planning ahead, and risk avoidance.

Dr. Steinberg concluded by saying that although neuroscience appears to have been an influence on the Supreme Court's deliberations, it is important to recognize that the essential logic of these decisions is based primarily in a description of the ways in which adolescents' behavior and thinking differs from that of adults, and only secondarily in differences in their brain structure and function. The neuroscience complements and corroborates the behavioral science, but it doesn't make the behavioral findings any more real. When all is said and done, the most convincing evidence that adolescents are different from adults is in fact "what every parent knows." The neuroscientific evidence likely was persuasive to the Court not because it told us something new, but precisely because it aligned with behavioral science and common sense.

Ask The Experts

Robert Sadoff MD
Neil S. Kaye MD

Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send question to nskaye@aol.com.

This information is advisory only for educational purposes. The authors claim no legal expertise and should not be held responsible for any action taken in response to this educational advice. Readers should always consult their attorneys for legal advice.

Q. The plaintiff in a civil suit, pro se against his parents (alleging sexual abuse) is serving two life sentences. The records are clear that he has an antisocial personality and no other diagnosis. Why should I even try to interview this "jailhouse lawyer"?

A. Kaye:
The AAPL Ethics Guidelines, Section IV state: For certain evaluations (such as record reviews for malpractice cases), a personal examination is not required. In all other forensic evaluations, if, after appropriate effort, it is not feasible to conduct a personal examination, an opinion may nonetheless be rendered on the basis of other information. Under these circumstances, it is the responsibility of psychiatrists to make earnest efforts to ensure that their statements, opinions and any reports or testimony based on those opinions, clearly state that there was no personal examination and note any resulting limitations to their opinions.
It has long been held that making a diagnosis without interviewing the individual creates a bad impression of psychiatry and leaves our field open to harsh criticism. However, there are situations when a person cannot be interviewed and an opinion can be rendered. This is common in contested will cases (testamentary capacity) but also is common when one party refuses to be interviewed, often for fear of self-incrimination. It is also common in threat assessment cases where interviewing a person may increase the risk to the public or retaining party.
While making a diagnosis without an interview should generally be avoided, there are times where sufficient other information is available to make a diagnosis. In all cases, it is an affirmative duty of the evaluator to make it clear that the basis of the opinion has not included an interview.

A. Sadoff:
First of all, do not take a pro se case. I teach my fellows and students never to take a pro se case, especially if the defendant (or in this case the plaintiff) is in jail or prison. The likelihood of your getting paid is slim to none. Non-lawyers do not know about retainer fees and are reluctant to pay in advance and would be especially challenging in this case where your diagnosis is antisocial personality disorder.
Having said that, why should you examine the plaintiff? For several reasons:

> *"Certain jurisdictions (California) actually allow an expert to be sued by the plaintiff for failure to conduct the interview."*

1) Assuming you receive your retainer fee and are comfortable examining the plaintiff with no bias toward him because he is serving two life sentences, presumably for murder, you may find that he has other diagnoses that other examiners may have missed (e.g., PTSD).
2) You may be able to connect the murders with his claim of sexual abuse by his parents and demonstrate serious emotional or mental impairment that stimulated the violence or that he could not keep from committing the acts that led to his conviction: e.g., the victims for which he was charged with and convicted of murder may have been sexually abusing him at the time.
3) He is entitled to a comprehensive examination by a competent forensic psychiatrist for both his civil claim against his parents and for the criminal charges that may be related to his claim of sexual abuse. However, he may also be malingering or lying about the abuse, so evidence must be obtained to confirm or deny his accusation.

Having said all that, I still would not get involved with this particular plaintiff for a number of reasons besides the economic one. He feels like trouble and is late in accusing his parents of sexual abuse, most likely to gain an advantage legally and to get back at his parents. What would keep him from accusing you of malpractice if you do not find in his favor? We do not have to accept every case that is offered to us. Using good discretion is an important part of any forensic practice. There are perils and pitfalls we need to avoid in order to practice comfortably.

Take Home Point:
Even when there is sufficient other information available, it is usually preferable to conduct an interview. Doing so, makes it harder to allege bias and shows the evaluator is striving to reach an objective opinion. Absent the interview, one could be accused of potentially missing information or of doing sloppy work. Certain jurisdictions (California) actually allow an expert to be sued by the plaintiff for failure to conduct the interview. However, there are times when it is appropriate to not conduct the interview. It is important to be clear of the basis of your opinion. Pro se cases have significant problems and in general we both advise against getting involved.

The Psychological Autopsy in Forensic Psychiatry

Mace Beckson MD, Suicidology Committee, and Alan L. Berman, PhD

The Centers for Disease Control and Prevention (CDC) define "suicide" as "death caused by self-directed injurious behavior with any intent to die as a result of the behavior" (CDC, 2014). The term "psychological autopsy" was coined by Dr. Edwin S. Shneidman, who stated, "the psychological autopsy is no less than a reconstruction of the motivations, philosophy, psychodynamics, and existential crisis of the decedent" (Shneidman, 1973; p. 132). Psychological autopsy is a specific example of forensic retrospective assessment of mental states, such as that used in assessing mental state at the time of a criminal offense; the altering of a last will and testament; or entering into a contract. In its original use, the psychological autopsy "was conceptualized as a thorough retrospective analysis of the decedent's state of mind and intention at the time of death, and initially used by the medical examiner in 'equivocal' deaths where the manner of death could be either suicide or accident" (Botello et al., 2013). In addition to "cause of death" (e.g., gunshot wound of the head), the medical examiner determines "manner" (or "mode") of death, which is usually certified as "natural," "accidental," "suicide," "homicide," or "undetermined." Over the years, the most common reason for referral by the L.A. County Chief Medical Examiner-Coroner's office for psychological autopsy was in cases of deaths due to alcohol and/or other drugs. Psychological autopsy also was used when family members contested a determination of suicide as the manner of death.

In addition to equivocal death cases, the principle of psychological autopsy, with its systematic method to understand the psychological and contextual circumstances preceding suicide, has been utilized, in clinical contexts (e.g., to help survivors of suicide better understand the "why?" in order to assist the grieving process); in medical/institutional contexts (e.g., quality improvement investigations/root cause analyses); in governmental inquiries into major public suicides (e.g., death of White House deputy counsel Vincent Foster, Jr.); and in legal contexts (e.g., litigation). Furthermore, it has informed efforts in suicide prevention, crisis intervention, and research efforts to identify individuals "at risk" of committing suicide. The psychological autopsy is a practical and widely-used approach to studying the proximal risk factors for suicide, i.e., psychological circumstances and contextual factors close in time to the suicide. Because suicide is a relatively rare condition (e.g., approximately 25 per 100,000 per year in men 25-64 years old in 2009), longitudinal studies requiring large sample sizes are impractical, while case-control psychological autopsy studies can reveal proximal factors that lead to suicide.

> *"Through discovery, however, the forensic psychiatrist may have a large database, containing much information previously unavailable to the medical examiner who did the original certification of cause and manner of death"*

Various methods are used to conduct psychological autopsies and there is no single standardized protocol. Common to all methods is the systematic collection of psychological, psychiatric, medical, and social data, including first-person accounts of the decedent's last days of life, such that "conclusions can be drawn as to the intention of the decedent, therefore the decedent's role in effecting his/her own death" (Berman, 2005; p. 365). Relevant information is obtained from review of available collateral records (e.g., police investigation; suicide note(s); autopsy report; postmortem toxicology; psychiatric, medical, pharmacy, criminal, employment, financial, military, and school records; personal journals; computer hard drive contents; insurance policies; wills) and interviews of survivors (e.g., significant others, family members, friends, coworkers) and other observers of the decedent in the last days of life. It must be kept in mind that family members and close friends may have feelings of guilt, anger, or shame, which may result in biased reporting. However, these survivors typically know the most about the decedent's history and can provide specific observations and temporal milestones pertaining to events and circumstances occurring shortly before his/her demise. Snider et al. (2006) proposed a template of areas of inquiry: site of death; demographics; recent symptoms/behaviors; precipitants to death; psychiatric history; physical health; substance abuse; family history; firearm history; attachments/social supports; emotional reactivity; lifestyle/character; and access to care. Knoll (2009) similarly outlines a protocol for conducting the psychological autopsy.

In civil litigation, plaintiff's attorney will make decedent's family available for face-to-face or telephone interviews by plaintiff's expert. However, these informant are typically not available to the defense expert, who instead must rely upon depositions and other sources of information. Both cause and manner of death may be contested as part of the litigation. Medical examiners variably have access to information from coroner's investigator reports, police investigation reports, medical records, and pharmacy records. Through discovery, however, the forensic psychiatrist may have a large database, containing

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Sally Johnson receives the Seymour Pollack Award from Jeffrey Metzer.

Magnificent horse facing the entrance of meeting venue.

Another magnificent horse facing the entrance of meeting venue.

Richard Frierson is honored with the Red AAPL Award.

Michael Deegan is presented with the Amicus Award.

Behold, the next batch of Rappeport Fellows!

Renée Binder is honored with the Golden AAPL Award.

Attendees pose with award winner Sally Johnson.

Grand lobby of the meeting hotel.

Peter Ash accepts the 2013 Poster Award on behalf of his co-presenters.

Research Committee Chair Andrew Kaufman presents the Young Investigator Award to Jennifer Piel.

Program Co-Chairs Christopher Thompson and Gregory Sokolov give an update during the Annual Business Meeting.

Photo Credits: Eugene Lee MD; Alan Newman MD; Roni Seltzberg MD; James Wolfson MD

American Medical Association 2014 Interim Meeting Highlights

Barry Wall MD, Delegate, Ryan Hall MD, Alternate Delegate, and Jennifer Piel MD, JD Young Physician Delegate

The American Medical Association's (AMA) November 2014 Interim Meeting was held in Dallas, Texas and focused on advocacy, education, and public health concerns.

Resolutions specifically pertinent to psychiatry and forensic psychiatry included prohibition on the use of solitary confinement in correctional settings for juveniles; enforcement of advance directives during pregnancy; legal protection for sexually exploited youth; and ensuring mental health care for unaccompanied minors detained by immigration services. There were also resolutions addressing broader access to psychiatric services and models to improve psychiatric reimbursement.

Regarding correctional juvenile solitary confinement; the AMA adopted the new policy of "oppos[ing] the use of solitary confinement in juvenile corrections facilities except for extraordinary circumstances regarding acute risk of harm to self or others." The question on use of solitary confinement for adults with mental illness was removed from the original resolution due to the complexity of the issue which was not adequately addressed in the initial combined adult/juvenile resolution. A new resolution regarding solitary confinement in mentally ill adults is expected to be submitted at the next AMA meeting in June 2015.

The AMA adopted the following new policy pertaining to sexually exploited youth: "[W]here appropriate, advocate for legal protection and alternatives to incarceration for commercially sexually exploited youth as an alternative to prosecution for crimes related to their sexual or criminal exploitation and encourage the development of appropriate and comprehensive services ..."

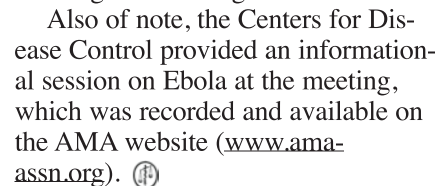
The American Medical Association also adopted the position that ". . . new immigrant children receive timely and age-appropriate services that support their health and well-being..." in response to the influx of unaccompanied minors across the borders, largely coming from Central America via Mexico.

The AAPL delegation was active in addressing ethical issues coming before the AMA. The House of Delegates voted on whether or not to approve the Modernized Code of Medical Ethics which was developed by the Council on Ethical and Judicial Affairs (CEJA). While this has been a transparent, six-year long process thus far, this was the first time the Code Modernization Project was put before the House of Delegates for a vote of approval. Dr. Ryan Hall served on the reference committee that heard initial testimony on this and other CEJA reports. Ultimately, the House of Delegates voted that the Modernization Project be sent back to CEJA for additional work. It is not uncommon for CEJA items to be referred back after initial presentation to help ensure language is as clear as possible.

> *"The American Medical Association also adopted the position that . . . new immigrant children receive timely and age-appropriate services that support their health and well-being..."*

CEJA always hosts an open forum at American Medical Association meetings. At the forum, CEJA indicated they may be addressing the issue of dual agency in physicians who work in correctional facilities after the issue was brought to their attention by an individual delegate from California. The AAPL delegation encouraged CEJA to look at AAPL's prior work on this topic in its Ethics Guidelines for the Practice of Forensic Psychiatry. The AAPL delegation also offered to work with CEJA if it decides to go forward with a report on this topic.

Other general issues discussed at the meeting included positions on Ebola, mandatory CPR training in high schools, regulations on electronic cigarettes, pharmaceutical concerns regarding generics (e.g. bioavailability, costs), position on "medical marijuana," maintenance of certification, and implementation of ICD 10. For more information on the resolutions and the actions of the AMA House of Delegates at the 2014 Interim Meeting, please go to http://www.ama-assn.org/sub/meeting/index.html.



Also of note, the Centers for Disease Control provided an informational session on Ebola at the meeting, which was recorded and available on the AMA website (www.ama-assn.org).

The Bully Pulpit

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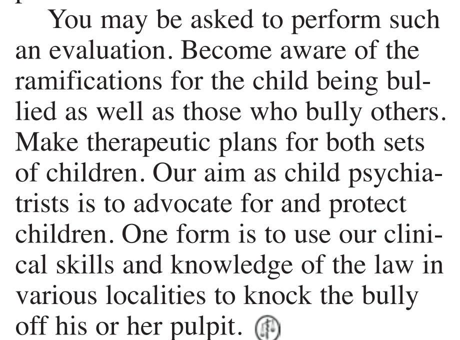
mendations about fighting back. It is important for parents of bullies to recognize their sons and daughters have serious behavioral problems. Law suits could arise for emotional damage allegedly caused by the families of those who bully. Schools and Boards of Education could likewise be sued. Certainly if there are suicides related to being bullied, lawsuits can arise with the parents as plaintiffs.



You may be asked to perform such an evaluation. Become aware of the ramifications for the child being bullied as well as those who bully others. Make therapeutic plans for both sets of children. Our aim as child psychiatrists is to advocate for and protect children. One form is to use our clinical skills and knowledge of the law in various localities to knock the bully off his or her pulpit.

APA Assembly Highlights

Debra Pinals MD, APA Assembly Representative, and
Cheryl Wills MD, Alternate Representative

The fall meeting of the APA Assembly was held in the J.W. Marriott Hotel in Washington D.C. from November 7-9, 2014. The APA continues to experience a growth in membership and an increase in strategic partnerships. The organization has 35,918 members which, relative to last year, represents a 5% increase in members and a 3.8% increase in dues membership.

The Revenue of the American Psychiatric Foundation, as of September 2014, is above budget. There tends to be positive revenue from the Annual Meeting when it is held in larger cities, such as NY and San Francisco. Advertising revenues have stabilized. The profits from the DSM-5 are better than expected, however sales are expected to decline in the next two years.

There are a number of changes in the APA administrative team. Jason Young, the APA's new Chief Communications Officer, is tasked with the challenge of reorganizing how APA administrators communicate with the members. Efforts will be made to streamline communications, by reducing the duplication of information that is distributed to members, and by making the APA's website more user-friendly. Ranna Parekh, M.D., M.P.H. will be leaving the Massachusetts General Hospital, where she worked on numerous diversity projects, to become the new Director of the office of Diversity and Health Equity. Annelle Primm, M.D., M.P.H. will serve as the APA's Deputy Medical Director. The departure of Deborah Hales, M.D. from the APA has resulted in a search for a new Director of Education. Rodger Currie, who has extensive experience as a healthcare lobbyist, has assumed the role of Chief of Government Affairs. Also, recruitment is underway for a Director of Research.

The APA continues to promote policy development that is conducive to effective psychiatric practice. The new policy finder tool, which may be found at http://library.psych.org/dbtw-w is designed to facilitate access to relevant information regarding APA policy and practices. Also, there is a two-part guide, titled Building a Career in Psychiatry, which is accessible on the residents' page on the Website. The document contains a wealth of information that may be useful to residents and early career psychiatrists.

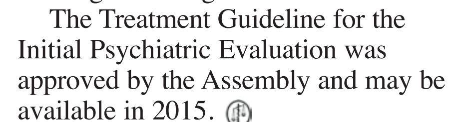
The APA's efforts to promulgate parity have not ended with passage of the Mental Health Parity and Equity Act. The organization had filed an amicus brief related to a New York State Psychiatric Association lawsuit against United Behavioral Health on behalf of psychiatrist members and their patients for violations of the federal parity law, as part of the Employee Retirement Income and Security Act of 1974 (ERISA). The case was dismissed by a lower federal court, which held that an organization does not have the authority to file suit on behalf of its members' patients. In addition, the APA filed suit against Anthem in a Connecticut case, although the federal court dismissed the case. Nevertheless, the APA continues to track these kinds of cases and look for opportunities to advocate for parity. Also, the APA has been advocating for mental health "bump" payments similar to the compensation enhancements that Medicaid has earmarked for primary care specialties.

There are several projects underway to increase the APA's collaboration with other organizations. For example, the APA has worked with the National Association of Social Workers to create a "Social Workers Track" at the Institute on Psychiatric Services. Also, the APA is collaborating with several mental health groups to market and provide outreach of a consumer-friendly book titled **Understanding Mental Illness.**

Marsden McGuire, M.D., the Deputy Chief Consultant for Mental Health Standards of Care, at the Department of Veterans Affairs, addressed the Assembly. He reviewed the Veterans Access, Choice, and Accountability Act of 2014, which appropriated $17 billion for contracted healthcare, $5 billion of which will be used for staff and space. The money will be good for three years or whenever the funds expire. The VA, which employs three thousand psychiatrists, serves six million veterans and 25% of them utilize mental health services. The demands for mental health services is increasing in the VA system.

Dr. McGuire stated that the goal is to make the VA a veteran-driven organization that focuses on prevention, rather than disease management, and that results in a stepped measurement-based system of care that is supported by "robust internet technology" and informed by outcomes. The principles of recovery and resilience need to be conducive to producing the highest level of functioning and the lowest level of disability. Outreach will include veterans crisis lines (that now have higher volumes of calls with gradually declining acuity); annual community mental health summits for each of 150 mental health centers; community mental health pilots (which are part of President Obama's executive order); web-based tools for veterans and their families; families; partner organizations that facilitate access to care for willing and resistant veterans; mobile applications; and partnerships with professional mental health organizations such as the APA and NAMI. Information management is a huge challenge in the VA.

The Treatment Guideline for the Initial Psychiatric Evaluation was approved by the Assembly and may be available in 2015.



AAPL Semi-Annual Business Meeting Saturday, May 16, 2015

(Guttmacher Lecture will not be given.)

An Underexamined Topic: The Issue of Criminal Responsibility and the Crime of Rape

Ryan S. Shugarman MD, Criminal Behavior Committee

In 2012, 84,376 forcible and attempted rapes were reported in the United States, with 52.9 out of 100,000 women having experienced a forcible rape.[1] As forensic experts, we encounter those accused and convicted of rape in a variety of settings, including during the assessment of criminal responsibility. While instruction on the mechanics of assessing criminal responsibility constitutes a core competency within forensic psychiatry fellowship training programs, it is unclear the extent to which training programs teach charge-specific material that merits consideration in these cases. Review of the available literature on the topic of criminal responsibility and rape via a PubMed search utilizing the keywords "rape," "sex," "sexual offense," "criminal responsibility," and "insanity" revealed the existence of fewer than twenty publications to date, most of which only peripherally address this issue. Further exploration of this topic is warranted. The present article is intended to provide an overview of the medicolegal topic of criminal responsibility for defendants charged with rape. A more extensive review is presently in progress in anticipation of a submission to JAAPL and presentation at a future AAPL meeting.

Prior to discussing the issue of criminal responsibility for persons charged with rape, a brief review of the legal definition of this offense is warranted. Though jurisdictional definitions vary, *rape* involves the commission of sexual intercourse (vaginal, anal, or oral penetration) with a non-consenting individual by means of threat or force, or by substantially impairing the victim's power to appraise or to control his/her conduct (e.g. by administering intoxicants), or by engaging in intercourse with an individual who lacks the capacity to consent (e.g. due to intoxication, medical infirmity, limited intellect, or age, in the case of statutory rape). Rape is classified as a *general intent* offense, meaning that an individual can be charged with the crime if he/she engages in nonconsensual intercourse secondary to recklessness or negligence, but did not purposely or knowingly commit the act. This includes defendants who did not intend to engage in nonconsensual intercourse, but did so in the context of an impaired mental state (e.g. intoxication, limited intellect, or psychiatric symptomatology), or who failed to sufficiently consider the victim's capacity to consent.

Within the United States, the relevance of an individual's capacity to refrain from committing a crime due to mental disease or defect varies considerably depending on the jurisdiction. In states that utilize a M'Naghten derivative, volitional capacity is irrelevant in insanity defense pleadings, whereas this issue factors prominently in jurisdictions that utilize a Model Penal Code (MPC)/American Law Institute (ALI) derivative or incorporate an irresistible impulse clause into their statute. In states that employ M'Naghten Rule (which involves knowledge of the nature and quality of the act, as well as its wrongfulness), barring voluntary intoxication (which is non-exculpatory), few scenarios present in which mental health factors could substantially compromise an individual's ability to know the nature and quality of the act of rape. Psychotic conditions may do so if, as a result of delusions, hallucinations, or grossly disorganized thought process, the defendant believes that he/she is not engaging in intercourse or is having intercourse with a non-human entity. Delirium, conditions involving insane automatisms (e.g. complex partial seizures and parasomnias), and in some cases, involuntary or pathological intoxication, could also predispose an individual to engage in sexual activity without knowledge of the nature and quality of his/her behavior. With respect to the second prong of M'Naghten (knowledge of wrongfulness), conditions such as pervasive developmental disorders, intellectual developmental disorders, or dementia can impair an individual's ability to recognize the victim's lack of capacity to consent or to accurately interpret social cues, resulting in the misbelief that intercourse is permissible or even desired. In psychotic conditions, grossly disorganized thought process may impair an individual's ability to recognize signs that intercourse is unwanted, or the presence of delusions and/or hallucinations may cause one to believe that intercourse is actually welcomed. In other instances, persons with psychosis may understand that the intercourse is non-consensual, but the presence of hallucinations and/or delusions may nevertheless lead them to believe that their conduct is justifiable, or even necessary. Examples include the conviction that the victim is only protesting because the devil is compelling him/her to do so, that the perpetrator is performing an act mandated by God in order to remove an evil spirit from the victim, or that the perpetrator's own life is in danger at the hands of the victim if the sexual act is not performed.

In states that allow for a defendant to be found not guilty by reason of insanity based upon an inability to conform his/her conduct to the requirements of the law (ALI Rule) or because his/her actions were committed due to an irresistible impulse, volitional aspects of the offense necessitate careful consideration. Cognitive disorders may compromise an individual's ability to refrain from acting upon sexual impulses due to impairments in executive functioning and/or increased disinhibition. In conditions involving the presence of psychosis, gross disorganization of thought and/or behavior could impair an individual's ability to refrain from

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Munchausen Syndrome by Proxy: DSM-5 changes and the impact of social media

Archana Kathpal MD, Tarun Kumar MD, Susan Chlebowski MD, Child and Adolescent Committee

Munchausen syndrome by proxy (MSBP) was first highlighted in 1977 by British pediatrician Roy Meadow, who described it as “a condition, in which a parent or other caretaker persistently fabricates symptoms on behalf of another, causing that person to be regarded as ill”. He was also the first physician known to have conceptualized MSBP as a form of abuse[1].

Even though the term "Munchausen syndrome by proxy" is widely used, other terms also are employed to describe this condition. In the United States, the disorder is known as “Factitious disorder by proxy” (FDP or FDbP). In the United Kingdom, the disorder is called “Fabricated or induced illness by carers” (FII). In the DSM-IV-TR, this condition was listed under the diagnostic category of “Factitious Disorder NOS.” However, the DSM-5, which was released in 2013, has categorized it separately, as “Factitious Disorder Imposed on Another.” Regardless of the term used, the key component is that physical or psychological symptoms are falsified in another individual (generally by a caregiver) for the caregiver’s psychological (i.e., primary) gain. For several reasons, interest in MSBP as a clinically- and forensically-related entity has been renewed with the advent of DSM-5.

It is difficult to determine the true incidence and prevalence of MSBP because, to date, no population-based studies of this disorder have been conducted. Additionally, many cases of MSBP go undetected because most clinicians have limited prior experience in dealing with individuals with MSBP. Even if clinicians suspect MSBP, many hesitate to report or investigate such cases in the absence of irrefutable evidence because of fear of litigation or potential damage from an erroneous allegation. Finally, most cases of MSBP are not diagnosed for six to fifteen months[2], which is problematic when most individuals engaging in MSBP move frequently, for obvious reasons.

Generally, individuals who engage in MSBP are female, have histories of childhood abuse, are employed in the healthcare field, and frequently have a diagnosis of “Factitious Disorder Imposed on Self”[3]. Although most perpetrators of MSBP are mothers, occasionally fathers, babysitters, nannies, or grandmothers may engage in this practice. Siblings are additional victims 25%-35% of the time. Significant victim morbidity and mortality is not uncommon - 7% of victims experience long-term sequelae and 6% die[4].

Treatment of MSBP perpetrators is extraordinarily difficult and no successfully-treated individuals have been identified (though short- and long-term psychiatric treatment of perpetrators is recommended). However, some effective strategies for protecting the victims of MSBP have been developed. These include: utilizing a multi-disciplinary treatment approach, observing caregiver-child interactions, separating the suspected perpetrator from the victim (to ascertain whether symptoms resolve in the absence of the perpetrator), obtaining collateral information (e.g., hospital records) from previous providers (in order to avoid exposing the child to unnecessary and repetitive medical procedures), reporting the case to the relevant authorities when there is a “reasonable suspicion” of MSBP, placing the child in protective custody to ensure their safety, evaluating the other children/individuals in the household (in order to screen for other instances of MSBP; medical records can also be reviewed if available), and verifying that long-term monitoring will be provided by the court. Ideally, the multi-disciplinary team assembled should have experience evaluating allegations of MSBP.

The DSM-5 appears to recognize better the potentially very harmful nature of this psychiatric disorder, using terminology such as “perpetrator” and “victim” in the disorder’s diagnostic criteria. Because criminal charges can be, and sometimes are, filed in cases involving MSBP, interesting questions arise: Can defense attorneys cite the presence of this disorder as a mitigating factor, attempting to minimize the perpetrator’s culpability for their actions?; Can the perpetrator even attempt to claim that he/she suffers from a “legitimate” mental disorder (which is listed in DSM 5) and therefore contend that he/she should not be prosecuted at all? Even if the case “only” involves potential termination of parental rights as opposed to criminal charges (e.g., battery, child endangerment), the standard of proof employed is still “clear and convincing evidence” – which also can be a difficult one to meet. Because of these relatively high standards of proof and the potential damage of falsely accusing a caregiver of intentionally harming his/her child (or other individual), the most commonly employed technique to confirm the presence of MSBP is video surveillance recording, a technique which potentially raises additional issues (e.g., privacy violations).

A more recent concern raised is the possibility that the proliferation of social media outlets and users has increased the prevalence of MSBP by providing another avenue for these caretakers to seek attention and subsequent psychological gratification. Recently, three mothers from Seattle falsely “blogged” that their children were terminally ill, and in return, received significant support and prayers from on-line followers. In another case in Westchester County, New York, a mother (Ms. Lacey Spears) was charged with second-degree murder of her five-year old son, who died after his sodium levels rose to a lethal level without an obvi-

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Changes in ABPN Maintenance of Certification (MOC) Requirements: Report of the Education Committee

Richard Frierson MD, Chair, Education Committee

The American Board of Psychiatry and Neurology has recently announced changes to its Maintenance of Certification (MOC) Program that relaxes some requirements for those participating in the 10 year MOC. The AAPL Education Committee presented a session at the AAPL annual meeting in Chicago where Larry Faulkner, MD from the ABPN announced these changes. Based on recent feedback from the field and limited availability of ABPN-approved MOC products, the ABPN reduced the number of self-assessment CME credits and Performance in Practice (PIP) units required in order to assist diplomates in meeting examination requirements for the MOC examinations in 2015-2021. For those sitting for the 2015 MOC examination, the SA CME credits were reduced from 40 to 24. For those sitting 2016-2021 for the MOC examination, the number of SA CME credits was reduced from 80 to 24. Additionally, eight self-assessment CMEs can be earned through completion of specific non-CME activities such as publishing a peer-reviewed paper or an approved grant application.

Please see the ABPN website for more details (www.abpn.com). In addition, the PIP unit requirement was reduced from three to one. The requirement of 300 category 1 CME credits remains the same.

A PIP Unit requires a **clinical module** and a **feedback module**. For the **clinical module**, clinicians audit patient charts and compare them to published practice guidelines via the use of an assessment form approved by ABPN. AAPL has two such ABPN - approved assessment forms: one to assess performance in Capacity to Stand Trial evaluations and the other to assess performance in Disability Evaluations. These forms are available on the AAPL website under the member section (i.e. you must log in to get to them).

Each **feedback module** requires the clinician receive feedback from one of the following groups: five patients, five peers, five supervisors, five residents, or a 360 evaluation. The clinician can choose which group to survey. Therefore it is no longer required that the clinician receive feedback from patients unless he or she chooses to do so.

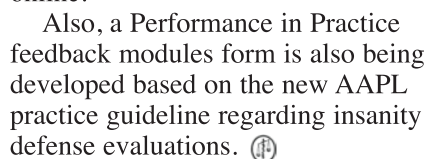
AAPL has developed a generic feedback form designed to be given to forensic evaluees. This form is available for free on the AAPL website.

For those individuals certifying or recertifying in 2012 or later, after successfully passing the exam the diplomate will be enrolled in the Continuous Maintenance of Certification (C-MOC) program. Such individuals must maintain an unrestricted license, earn 90 CME credit hours every 3 years (24 of which must be from Self Assessment CME) and complete a PIP Unit every three years.

Also, rather than paying a lump sum fee for recertification examination, the diplomat will pay a yearly fee of $175.00 and will not have to pay an additional fee for the examination.

Finally, under the leadership of a subcommittee chaired by Debra Pinals, the AAPL Education Committee is continuing to produce products that will be useful to AAPL members in the MOC process. A Self Assessment Examination worth up to 24 Self Assessment CME credits is online.

Also, a Performance in Practice feedback modules form is also being developed based on the new AAPL practice guideline regarding insanity defense evaluations.



An Underexamined Topic

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engaging in the unwanted sexual act, as could the delusional belief that one's life would be endangered were he/she not to commit the act. For individuals with paraphilias, an inability to refrain may be argued, but courts may fail to confer a finding of insanity on this basis alone (e.g. the court's ruling in the case of Jeffrey Dahmer).

Evaluating the relative contributory roles of a defendant's psychiatric symptomatology to the criminal act of rape, as well as ascertaining whether or not a particular prong of a jurisdiction's insanity statute is met, are challenging tasks. Offense-specific considerations should include the utilization of coercion, threat, or violence; the degrees of restraint employed by the defendant; the presence of weapons; protestation by the victim; and the defendant's actions immediately preceding and following the offense. Additional factors that merit consideration include the nature of any prior relationship between the defendant and victim, the identification of potential sources of anger and/or feelings of rejection held by the defendant toward the victim, and an inquiry about any past instances of sexual aggression by the defendant. The evaluator should also explore the defendant's sexual fantasies, attitudes, and beliefs, as well as his/her beliefs about persons of the same sex as the victim. Such inquiry can yield pivotal insight into the defendant's sexual proclivities and identify potential rape-supportive views, thus unmasking motivations for the commission of the crime. Utilization of psychological assessment tools (e.g. Rape Myth Acceptance Scale (RMAS), Burt, 1980; Attitudes Toward Rape Victims Scale (ARVS), Ward, 1988; and Rape Supportive Attitudes and Beliefs Scale (RABS), Burgess, 2007) can assist in this regard.

Given the high prevalence of rape in both American culture and interna-

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Ethical and Legal Issues in Treatment of Mental Illness in Pregnancy

Susan Hatters Friedman MD, Ryan C.W. Hall MD, Anna Glezer MD, Abhishek Jain MD, Katherine Wisner MD, Gender Issues Committee

Bright and early on Sunday, a dedicated AAPL audience learned about ethical and forensic issues in the treatment of mental health issues in pregnancy. Informed consent, risk-benefit decision making, forced treatment, and research in pregnancy are important considerations.

Since approximately half of pregnancies are unplanned, many women are taking psychotropic medications in early pregnancy and exposing their fetus without awareness. While the general risks of not treating mental illness are well known, the importance of treatment is often forgotten in pregnancy, where the focus is frequently on the risks of medication rather than the risks of untreated illness. Untreated illness can lead to suicide, infanticide, poor self-care, poor prenatal care, substance abuse, and higher risk of prematurity and low birth-weight infants. Furthermore, one needs to consider more than merely the FDA categories for medications (which are being eliminated and replaced). When prescribing medications in pregnancy, risks to consider include teratogenesis, behavioral teratogenesis, preterm birth, neonatal toxicity/withdrawal, and risks of miscarriage and other negative outcomes.

A false dichotomy exists – that medications are good for "mom" but bad for "baby." In reality, these outcomes are not mutually exclusive and the fetus is completely dependent on the mother's environment. Doctors tend to weight more heavily toward the risks than the benefits of medication treatment, being more concerned about acts of commission (treatment leading to a bad outcome) than acts of omission (failure to treat).

The consult for psychiatric management of pregnant patients includes discussion of the lack of the risk-free pregnancy, teaching about disease and medication exposure, and consideration of other exposures during pregnancy. Untreated depression frequently recurs during pregnancy, which should be discussed as well. A risk-benefit approach to care is needed, with evidence-based treatment appropriate for the individual woman's disorder and discussions of any modification due to pregnancy. Careful documentation should be completed and the psychiatrist should confer with the obstetrician.

Despite millions of pregnancies in the USA annually, pregnant women are currently the #1 underrepresented patient population in medical research. Exclusion from clinical trials is generally under the premise of protection for the fetus. Much of the data we have on medication safety in pregnancy, therefore, comes from registry data rather than rigorous clinical trials. Yet, two-thirds of pregnant women take at least one prescription medication, and one-third take psychotropic medication. There are multiple physiologic reasons for the need for research specific to pregnant patients. These patients have increased cardiac output, increased plasma volume, changes in gastric emptying, and increased renal blood flow. These changes impact the pharmacodynamics and pharmacokinetics of drugs.

Currently, a number of national organizations provide guidelines regarding research with pregnant patients. The Code of Federal Regulations produced by the Department of Health, Education, and Welfare requires specific protections for special populations, including pregnant women. In general, research follows several ethical principles: *beneficence*, the moral obligation to act for the patient's benefit; *autonomy*, which refers to a patient's right to make decisions; and *justice*, which is an ethical mandate for access to research. There is also the issue of informed consent, which in cases of pregnant women includes information regarding the safety of the fetus. There are also some guidelines, such as from ACOG (American College of Obstetrics and Gynecology), that suggest the option of including the father in the informed consent process. There are also a number of ethical considerations with the fetus itself. From an ethical perspective, a pre-viable fetus becomes a patient when the mother confers that status to it. Additionally, a fetus can be exposed to more than minimal risk, as long as that risk is minimized. Finally, a research participant cannot be excluded based on their preferences regarding termination of a pre-viable fetus.

Additional research regarding medications in pregnant patients would likely be reassuring. In fact, of the 500 drugs approved by the FDA in the past 20 years, only 3 were found to have high teratogenicity. In moving towards an appropriate ethical framework for research, thinking critically instead of summarily excluding pregnant populations is important. It would be appropriate to borrow part of the framework used with other underrepresented populations in research, and to shift from the current standard of requiring justification for inclusion to one that requires justification for exclusion.

In addition, two evolving legal trends regarding individuals in state custodies are emerging. The first is the use of restraints or "shackles" in pregnant inmates. The second is state and federal laws addressing "personhood" of a fetus. In part these issues are garnering more attention due to national civil liberties organizations such as the ACLU and National Advocates for Pregnant Women (NAPW). The NAPW has been publishing legal studies, participating in national interviews (e.g. NPR), representing pregnant women who feel their rights have been abused, and filing amicus briefs with greater frequency recently. Many of the NAPW's positions reference medical knowledge and studies (e.g. harms of drug use during pregnancy).

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To Teach or Not to Teach

Carla Rodgers MD, Brian Crowley MD, James Reynolds MD, Henry Levine MD, Private Practice Committee

For many of the members of the Private Practice committee, being on the teaching faculty of a medical school is an extremely rewarding experience. The advantages are that teaching decreases private practice isolation, especially if one is in solo practice; encourages the forensic psychiatrist to keep up with all aspects of psychiatry, including psychopharmacology, and new forms of psychotherapy, and evaluation, and allows the forensic psychiatrist to share his/her unique perspective on doing clinically based, not just forensic, evaluations. The final advantage is that teaching is a way to "pay it forward," to assist those younger members of the profession as we were helped as students and residents.

The primary disadvantage is that it is generally not remunerated time, and for every hour lecturing, two or more hours of preparation may be necessary. Also, rigorous requirements on application to the medical school faculty, renewal of the appointment, and use of one's academic title often exist. One cannot just knock on the faculty door, and announce, "I'm here."

The following members of the Private Practice Committee have decided the pros outweigh the cons, and would like to share our experiences with other AAPL members.

Dr. Brian Crowley:

I am on the voluntary faculty at Uniformed Services University of the Health Sciences, and I taught medical students for years. These medical students differ from most, in that they are junior officers, all in uniform, in the Army, Navy, or Air Force. They are a sharp bunch, and all say "Yes, Sir" or "Roger that, Sir." The women are in the minority, but my global impression (for which I'm sure I'll be accused of sexism) is that as a group they may be somewhat ahead of the boys, who are also excellent.

We don't want either psychodynamic psychiatry or its emphasis on the importance of early life development to be forgotten. Recurrently I had to tell my students that a "Social History" on a patient does not begin at age 18 when he/she enlisted in the Army.

They [the students] gave me the joy and surprise of soaking it all up appreciatively, and of sometimes asking me questions to which I did not know the answer. Sometimes I'd look into it and get back to them; other times I'd appoint one of them to research it and get back to the group.

It was really a wonderful, enriching experience all way around.

Dr. James Reynolds:

I am on staff at five medical schools right now, and also host clerkship students occasionally from three schools in England. In a nutshell, I perform a service with at least one residency program where they have no forensic faculty other than me, so not only do I do some teaching for them, but I host their residents to do a forensic report which is an ABPN requirement for graduation.

My advantages other than satisfaction of teaching and mentoring, is the very tangible aspect of recruiting. Psychiatrists are VERY short in my area, and being exposed to a number of graduating residents each year opens opportunities to recruit. Students are a little further off from being recruits to psychiatry, but 4-6 years down the road, they may have fond memories of working for you and your facility.

Another benefit is a whole faculty of new colleagues you can bounce ideas off of, especially if you are kind of isolated in a rural area otherwise. And finally, I got at least one presentation at an international meeting in Europe based on a case one of my English students worked up over here with me, and we presented it as a poster to the Royal College of Psychiatrists.

Dr. Henry Levine:

I annually teach University of Washington residents on 4 different forensic topics. I don't necessarily consult with attorneys regularly on all these topics, so teaching forces me to update myself annually in all these areas.

Also, I live nearly 100 miles from the nearest forensic psychiatrist and from the university. For that reason, I often feel isolated from others with a common interest in forensics. The residents are almost uniformly eager to learn and question, and this certainly decreases that sense of isolation. So does the contact involved with other forensic teachers in planning the coming year's teaching.

The connection with the university has also been peripherally helpful in other ways, e.g., recruiting new practitioners to our underserved area via the training director. I also think the faculty membership increases the "gravitas" of my CV, which is useful to referral sources and in testifying before judges and juries.

There are other things I appreciate, such as the university library card and access to reference help there. I also like the ratings I get on residents' feedback sheets, but that speaks more to my narcissism than to utility.

Dr. Stephen Berger:

I teach medical students in classroom lectures and in a Community Mental Health Center setting. I teach medical students and psychiatry residents at my jail job. I get paid by those 2 employers at my usual hourly wage. The teaching is a volunteer add-on that is done during my paid hours. I was honored to receive the Volunteer Faculty of the Year Award last year from the Psychiatry Department of Indiana University School of Medicine.

The students get exposure, both observing and doing the examining and medication decision making. Most of them are very pleased with the experience, even if not interested in psychiatry.

I get tremendous satisfaction from having the venue for imparting the

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Spiritual or Psychotic? Culture and Forensic Psychiatry

Karen B. Rosenbaum MD, Maya Prabhu MD, Felix Torres MD, Alexander Simpson MD, Susan Hatters Friedman MD, Cross Cultural Issues Committee

This presentation from a panel consisting of members of the Cross-Cultural Issues Committee illustrated the importance of understanding the cultural beliefs of evaluees in order to make psychiatric diagnoses, assess the ability of the individual to understand specific concepts, and to generate formulations and opinions. For example, in some cultures, it is more accepted to turn to religious leaders instead of mental health providers when psychiatric symptoms emerge.

Cultural norms can influence the expression of symptoms. A good example is the expression of somatic complaints to describe stress or depression in cultures where mental illness is not accepted. Also, when assessing malingering, it is important to keep cultural context in mind. Psychological testing, often used to assess malingering, may be biased toward the dominant culture's knowledge and beliefs. Therefore, it is important to understand how the testing was standardized and scored.

Karen Rosenbaum MD presented some of the salient literature teasing out unusual culturally bound spiritual beliefs from psychotic symptoms. She described how to differentiate cultural beliefs in Possession States (believed in some cultures) from psychotic delusions of possession.

She also described how language and culture are important considerations in psychological testing even when the testing is performed in the same language as the evaluee, due to cultural biases in the translation of the tests. She concluded that cultural context is important to consider when evaluating an individual's competence to stand trial as well as criminal responsibility.

Maya Prabhu MD presented a case series involving recently resettled refugees who had involvement with the criminal justice system in the US. In each case, there was ambiguity as to whether the patient's manifestations of distress and illness were related to their histories of trauma, quasi psychotic in nature, or "misunderstood in translation." She noted that cultural differences can be both over and under interpreted by healthcare and social services providers and reminded attendees of the importance of the fundamentals of a comprehensive psychiatric examination. She also anticipated a future need for both language and cultural translators to assist refugees in navigating legal and court processes.

Felix Torres MD highlighted the importance of considering the socio-cultural aspects that may influence behavior and symptom expressions in clinical and forensic assessments. He presented on changes to the cultural formulation introduced in DSM-5, most notably the replacement of the construct of "bizarre and esoteric" Culture-Bound Syndromes in DSM-IV-TR with the more "culturally competent" Cultural Concepts of Distress: Cultural Syndromes, Cultural Idioms of Distress, and Cultural Explanations or Perceived Causes. Dr. Torres presented a case from his forensic practice where cultural issues played an important role.

Alexander Simpson MD presented on the conceptual limitations on our past approach to cultural syndromes, noting that it was always odd that culture based syndromes were disorders such as amok, but disorders like anorexia nervosa or dissociative identity disorder were not considered culture bound syndromes. DSM 5 has made considerable progress in overcoming this conceptual error.

He further observed that there appeared to be a link between psychosis and spirituality and noted that psychosis appeared to be a disorder that, at least in part, affected the brain systems that perceived social and personal meaning.
In his view, this can motivate violence. But religious ideation combined with other personal or cultural beliefs may motivate violence as well. He speculated that it is possible that the brain development necessary to be capable of self-transcendent beliefs may also be involved in the development of psychotic symptoms. He presented a case to illustrate these themes, and a need to pursue understanding, as well as truthfulness, in forensic psychiatric assessment

Susan Hatters Friedman MD presented the Cultural section of the AAPL Guidelines, which is pending publication. It had recently been available online for comment from AAPL members. She proposed that forensic evaluators should consider the evaluee's culture as well as the evaluator's cultural experience, beliefs, and worldview on every evaluation.

Often the evaluating psychiatrists are from the ethnic majority while the defendants being evaluated are from an ethnic minority. While striving for objectivity and understanding, caution must be used in making diagnosis. Even the non-confidentiality warning at the beginning of the evaluation merits special consideration when cultural issues are present due to potential misunderstanding.

Cultural identity should be queried rather than presumed. Open ended questions should be utilized. The mental status examination should be sensitive to culture and may change. For example, eye contact may mean something different in one culture compared to another.

To evaluate abstraction, proverbs from the evaluee's culture and language should be used; similarities may be used instead. Interpreters should be used whenever there is a language problem. Professional interpreters should be used rather than family members, and their role discussed with them prior to the evaluation to avoid misunderstanding. Further, it can be helpful to seek consultation about whether a belief is common in an evaluee's culture, subculture, or religion, or whether the belief might represent a psychotic experience.

The Psychological Autopsy

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much information previously unavailable to the medical examiner who did the original certification of cause and manner of death.

Particularly in cases of suspected alcohol- or drug-related deaths, in which the meaning and implications of the toxicological results are at issue, it is useful for the forensic psychiatrist to have some working knowledge of toxicological concepts and methods, in addition to awareness of relevant case-specific data, e.g., antemortem pharmacokinetics and pharmacodynamics; physiological tolerance; postmortem redistribution; byproducts of postmortem decomposition; underlying medical pathology; and concomitant medications. The forensic psychiatrist should understand the questionable validity of: so-called "lethal" levels of drugs; estimation of antemortem plasma concentrations or drug dosage based upon postmortem toxicology; and determination of cause of death based upon toxicology textbooks or tables without reviewing the extant scientific literature or considering case-specific details (Palmer, 2010). Discussion with a retained forensic toxicologist and/or forensic pathologist, review of corresponding expert reports, and/or review of the relevant scientific literature also assist the forensic psychiatrist in understanding the case.

In criminal and civil litigation contexts, forensic psychiatrists are called upon to perform a retrospective assessment of intent in cases involving death. Such contexts include: criminal cases in which there is contention that an apparent homicide was actually a suicide; allegations of criminal child abuse; wrongful death litigation involving possible "suicide-by-cop"; malpractice claims alleging suicide; institutional care (jail/prison suicides); product liability claims; insurance policies that cover accidental death or disability, but exclude suicide; motor vehicle insurance claims (e.g., single vehicle fatalities); workers compensation; and military benefits awards to surviving families. The court determines whether expert opinion testimony based upon a psychological autopsy is admitted into evidence. In federal court, the Daubert standard applies, i.e., scientific knowledge assists the trier of fact in understanding the evidence; and the expert witness is qualified by knowledge, skill, experience, training, or education. Sixteen states, including California, utilize the *Frye* standard, i.e., general acceptance within the field (Kim, 2014).

Systematic suicide risk assessment has been utilized in clinical settings for many years and is within the expertise of clinical psychiatrists. Retained forensic psychiatrists and psychologists can assist the trier of fact with expert opinions based upon careful postmortem assessment of suicide risk, based upon a systematic review of relevant sources of information that inform requisite areas of inquiry. In addition, the expert can analyze the data for "factors descriptive of high intentionality, which include "conscious awareness of consequences; goal of cessation; expectation of fatal outcome; implementation of a method of high lethality; minimal rescuability or precautions; premeditation [i.e., planning]; and communications [of intent]" (Berman, 2005; p. 369). A probabilistic assessment of suicide risk (e.g., low, medium, high) can be offered as expert opinion, without opining on the ultimate issue to be decided by the trier of fact. As noted by Berman (2005), while "the psychological autopsy is a powerful tool for the skilled suicidologist," nevertheless it "cannot definitively define cause-and-effect relationships, thus it cannot validly inform an expert that a suicide definitely occurred; rather it can better inform opinions as to whether a decedent likely completed suicide and provide a better understanding of pathways to the determined manner of death. As such, it informs coroners and medical examiners and the courts which are ultimately the decision-makers" (p. 369).

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An Underexamined Topic

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tionally, and the relative paucity of literature available on the topic of criminal responsibility and rape, further research and discussion on this important issue is warranted.

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Suicidal College Students: How Can We Help?

Darlinda Minor MD, Suicidology Committee

As an intern at George Washington University Hospital (GWUH), I became acutely aware of the complexities involved in providing care for the undergraduate and medical students from the university campus. On one busy call night, I was paged to see a freshman who voluntarily presented to the emergency room with worsening depressive symptoms and emerging suicidal thoughts. He was from another state and did not have any family member in the area. Although he had struggled with depression for many years, he was not on medications and had not found local providers. He had become extremely overwhelmed with school and felt isolated. Before presenting to the hospital, he had started thinking of jumping from a bridge. He had walked to the bridge that night but was turned away when he found the pedestrian entrance locked. He needed and wanted help but was afraid to be hospitalized. He had heard about other students facing consequences due to hospitalization. I assured him that I could not reach out to his institution without his permission, but he was convinced that somehow, the administrators would find out and lock him out of his dorm. I was confused. This young man with suicidal thoughts was trying to decide whether his mental wellbeing or college education was more important.

That was not my last case of that nature. I began searching for institutional policies to guide me. I also reviewed the HIPAA training material to refresh my memory on disclosures. I eventually came across an article by Dr. Paul Applebaum about school dismissals of students struggling with suicide[1]. The article included a case against George Washington University (*Nott v. GWU*), which enticed me to dig deeper into the issue. I found that these student dismissals were the result of institutions of higher education's (IHE) fears of liability if a student were to commit suicide on campus. This led to the development of blanket or zero tolerance policies.

In the case of *Schieszler v. Ferrum College* (2002), a college freshman committed suicide by hanging in his dorm room[2]. He had been assessed earlier in the night by the Dean of Students, a resident assistant, and a counselor, and it had been noted that he had self-inflicted bruises on his head and neck after trying to hang himself. Despite this knowledge, he was left alone in his room while those listed above spoke with his girlfriend in a nearby dorm room. His estate filed a wrongful death suit holding the institution liable for his death, and the courts ruled in favor of the plaintiff. They ruled that there was a special relationship between the university and student because his death was foreseeable. This case was shocking because it deviated from the precedent set by cases like *Bogust v. Iverson* (1996) and *Jain v. Iowa* (2000) in which IHEs had not been held liable for suicides committed on college campuses[3-4]. In those cases, suicide was considered an intentional intervening act, which broke the line of causality.

> *"A 2000 National College Health Assessment survey of approximately 16,000 college students revealed that 9.5% had seriously considered suicide the year prior, and another 1.5% had attempted suicide at least once[7]."*

After the *Schieszler* decision, IHEs struggled to deal with the crisis of campus suicides - a crisis confirmed by numbers. The suicide rate has been consistently reported at 6.5 to 7.5 per 100,000 students on college campuses[5-6]. A 2000 National College Health Assessment survey of approximately 16,000 college students revealed that 9.5% had seriously considered suicide the year prior, and another 1.5% had attempted suicide at least once[7]. IHEs have also been struggling to maintain adequate providers for students with mental illness, having an average of 1 counselor per 1,969 students and gaps even larger in state-funded schools[8]. Administrators at the IHEs were faced with the dilemma of balancing the best interest of students with attempts to minimize potential risks of their own liability.

On one end of the spectrum was IHEs developing more programs and almost reverting to the days of *in loco parentis*, which would invite more liability if a student were to commit suicide on campus. On the other end of the spectrum were dismissal policies that would mitigate IHE liability if a student were to act on their suicidal thoughts. These dismissal policies alienate students and leave them to find help on their own. They also violate the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 as seen in the cases of *Nott v. GWU* (2006) and *Doe v. Hunter College* (2006)[9-12]. IHEs dismissing students for mental illness, suicidal thoughts, or even after a suicide attempt violate these acts and are usually subject to hefty fines and settlements. Unfortunately, IHEs did not have much guidance to resolve their plight. The Restatement of Torts, which is intended to address whether someone can be held liable for another person's suicide, does not provide much guidance due to its ambiguity. With the ruling in *Schieszler v. Ferrum College* coupled with this lack of guidance, IHEs continued to falter in their attempts to make things better for students and protect themselves.

This brings me back to the story of my young patient in the emergency room. His predicament, as that of so many other college students, was real. It was conceived in the attempt being

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Suicidal College Students

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made by IHEs to balance this tough situation. Sadly, not much has changed. A Huffington Post article from October 2014 reported a story about students at Yale being forced to take leaves of absence after receiving treatment for mental illness[13].

There remain several issues consulting clinicians and administrators must consider. Should IHE administrators, who are typically non-clinicians, be held liable for suicides on campuses? Should IHEs be providing services for students with mental illness or referring them off campus? Must parents be notified to help with at-risk students or would this be a violation of student privacy? These are some questions that still need answers. What we do know is that more people on college campuses should be trained at recognizing signs and risk factors for deterioration, and that there should be some consensus for assigning duty to prevent suicide and liability.

The case of *Mahoney v Allegheny College* (2005) may provide a way to navigate these issues. The family of Charles Mahoney, a college junior, filed a wrongful death suit stating that the IHE was liable for their son's death, and lost. The court stated "Failure to create a duty [to prevent suicide] is not an invitation to avoid action. Institutions have a responsibility to adopt prevention programs and protocols regarding students' self-inflicted injury and suicide that address risk management from a humanistic and therapeutic as compared to just a liability or risk avoiding perspective[14]."

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Ethical and Legal Issues

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The 'shackling debate' revolves around whether it is ever appropriate or necessary to use restraints on a pregnant inmate.

In 2008, the federal government passed the Second Chance Act, after which federal agencies including the US Marshall service and Federal Bureau of Prisons have adopted more restrictive policies on when restraints can be used on a pregnant woman in custody. In addition 18 states passed similar laws which either limit or outright prohibit the use of shackles during pregnancy.

A relatively recent federal court case of Nelson v. Correctional Medical Services (583 F.3d 522, 8th Cir., 2009) found restraining a woman during labor created potential harm to the mother and fetus, which may serve as a basis for additional lawsuits in jurisdictions which have not addressed the practices.

Finally, the majority of states have some form of fetal "personhood" laws. Most states have "feticide" laws which define a fetus as a person in cases of homicide or manslaughter.

Many of these laws were originally passed to protect pregnant women and their fetuses from being the victims of crime or violence. However, these legal concepts were expanded in many states resulting in laws which potentially allow for civil commitment or charges of child abuse and/or neglect if pregnant women do not follow medical advice or engage in activities such as substance use.

In addition federal laws also encouraged states to pass "Personhood" laws for substance use such as the Federal CAPTA Reauthorization Act of 2010 which required States to have policies and procedures to address: *illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure; or a Fetal Alcohol Spectrum Disorder*.

This raises many ethical issues such as who has the right to determine appropriate medical treatment (e.g. woman, doctor, midwife) and when can the state force a woman to undergo treatment by the principle of *Parens Patriae*? When a woman is forced to undergo treatment and for whose benefit (the woman or fetus) is the treatment?

This broadly highlights some critical mental health issues in pregnancy at the interface of psychiatry and the law. For additional discussion of malpractice concerns regarding use of psychotropic medications in pregnancy, the interested reader is referred to our previous newsletter article (Friedman & Hall, 2012).

To Teach or Not to Teach

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knowledge I have gained over my 42 years of being a psychiatrist. I feel like a storehouse of experience (analogy: a freezer full of food). I want others to make use of that experience (students as well as patients) before the food spoils (before I grow senile) and storehouse of experience is no longer useful to anyone. I never thought I would enjoy teaching, but I love the clinical teaching.

My forensic experience is just one more body of experience to impart to the students.

I often learn from my students the text book materials that they are learning, the material that is so new that I haven't been exposed to it.

Dr. Carla Rodgers:

My own experience in academia echoes that of my colleagues quoted above, although I am in an area which has many psychiatrists, Greater Philadelphia and South Jersey. Most of my teaching, therefore, is restricted to the forensic topics. The institution at which I have a faculty appointment is Cooper Medical School in Camden, NJ. I have not only enjoyed teaching the residents about forensics, but fielding their questions on malpractice and other forensic topics such as competency, and hearing them discuss the latest treatments and controversies in the field of psychiatry.

One of my most satisfying experiences has been mentoring a 4th year resident, who will be doing a forensic fellowship next year. I enjoy my forensic and clinical work, and it has been very satisfying to share both of those enthusiasms with residents, and give some input about their plans for the future.

We hope we have stoked the interest of AAPL members who do not have an academic affiliation. We would encourage those members to pursue this activity.

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We sincerely invite your interest in this very unique and rewarding opportunity. If you would like more information, please contact Octavio Choi, MD, PhD. We look forward to hearing from you.

Octavio Choi, M.D., Ph.D., Assistant Professor of Psychiatry/OHSU
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Munchausen Syndrome

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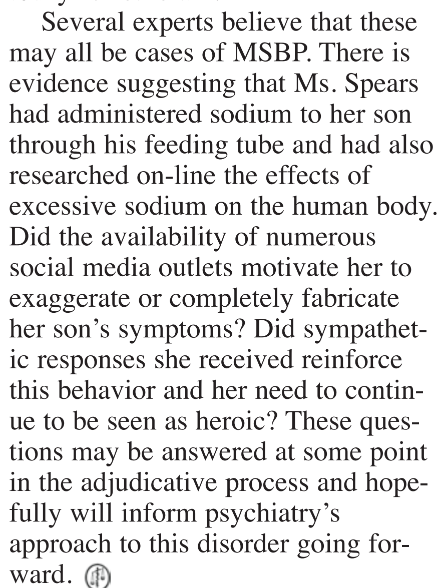
ous medical explanation. Prior to her son's death, Ms. Spears had moved around the country, having her son hospitalized more than twenty times. She kept her friends updated on her son's frequent hospitalizations with photos and musings on Facebook, Twitter, My Space, and her blog. During the last eleven days of his life, she had 28 posts, including this one, immediately after his death: "Garnett the great journeyed onward today at 10:20 am."

Several experts believe that these may all be cases of MSBP. There is evidence suggesting that Ms. Spears had administered sodium to her son through his feeding tube and had also researched on-line the effects of excessive sodium on the human body. Did the availability of numerous social media outlets motivate her to exaggerate or completely fabricate her son's symptoms? Did sympathetic responses she received reinforce this behavior and her need to continue to be seen as heroic? These questions may be answered at some point in the adjudicative process and hopefully will inform psychiatry's approach to this disorder going forward.



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Community Forensics Committee

Most justice-involved individuals with mental illness are not found in jail or prison settings. They have re-entered the community, often with criminal justice supervision. Nonetheless, much of the scholarship in forensic psychiatry to date has focused on evaluation and treatment of forensic populations in correctional institutions and high-security hospitals. In the Community Forensics committee, we seek to expand AAPL's mission of research and education to include forensic populations outside the walls of secure treatment settings. We focus on the needs of offenders with mental illness in the community and examine how best to meet those needs.

Our areas of interest include:

- Alternatives to incarceration (i.e. jail diversion) for individuals with mental illness
- Alternative courts, such as mental health and substance abuse courts
- Best practices for community treatment of justice-involved persons with mental illness
- Applying the recovery model to persons with mental illness under criminal justice supervision (probation, parole, and mandated treatment)
- Mental health, medical, and recidivism outcomes for offenders with mental illness in the community
- Public policy related to mental illness, criminality and violence in the community

We seek members who have knowledge and expertise in these areas, as well as newcomers who want to learn more. Interested AAPL members should contact Dr. Merrill Rotter (Merrill.rotter@omh.ny.gov) or Dr. Reena Kapoor (reena.kapoor@yale.edu) for more information.

Staff Psychiatrist

NMPRC has a current opening for a STAFF PSYCHIARTIST, Board certified preferred. Forensic certification or experience desirable but not necessary. 108 bed JCAHO-certified long-term adult forensic inpatient facility. Training site for Certified Forensic Examiners. Modern facility with electronic medical record. Medical school affiliation. Research opportunities and clinical assistance from academic pharmacy residency program on site. Salary competitive, with step increases for Specialty and Subspecialty certification. Income up to $235,000+.

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Contact:

James B. Reynolds, M.D., Medical Director
Northwest Missouri Psychiatric Rehabilitation Center
3505 Frederick Avenue,
St. Joseph, MO 64506
E-mail: james.reynolds@dmh.mo.gov
Call (816) 387-2505
or fax CV to (816) 387-2329

MUSE & VIEWS

The Honest Witness

- Plaintiff's Attorney: "What doctor treated you for the injuries you sustained while at work?"
- Plaintiff: "Dr. Johnson"
- Plaintiff's Attorney: "And what kind of physician is Dr. Johnson?"
- Plaintiff: "Well, I'm not sure, but I do remember that you said he was a good plaintiff's doctor."

Source: http://www.re-quest.net/g2g/humor/courtroom/

Submitted by William Newman MD

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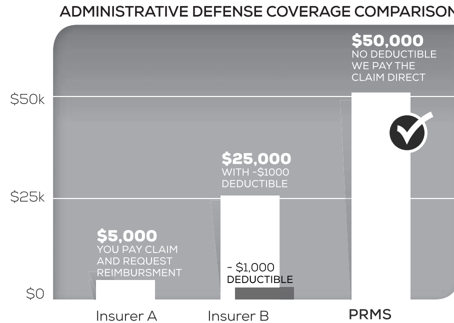

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