



## Trauma and Transformation: The History and Future of Child Soldiers

Joseph Simpson, MD, PhD

After a moving introduction by one of her first mentors, Dr. Sally Johnson, AAPL President Dr. Emily Keram opened the 47th Annual Meeting with a wide-ranging discussion about children impacted by war, conflict and terrorism. Her address examined international human rights laws and staked out bold and emphatic positions with regard to juveniles who are recruited into violent extremist organizations.

Dr. Keram began by pointing out that in her professional life she has seen the potential of trauma to transform people in both negative and positive ways. Trauma pushes people to extremes, and we need to avoid both overidealizing positive responses on the one hand and becoming defeatist about trauma's negative effects on those who experience it on the other.

She told the story of Omar Khadar, born in Canada to a *jihadi* family in 1986. His parents were close to Osama bin Laden. As a young teen he fought with the Taliban. At age 15 he was severely wounded in a battle against American troops. He ended up at the military prison at Guantanamo Bay, Cuba. Dr. Keram was an informal trial consultant to his defense team, and recommended bringing in a child psychologist and psychiatrist.

In 2010 Omar entered a guilty plea to murder and four other war crimes. It was stipulated that he would receive a maximum of eight years in prison. There was a sentencing hearing, because the commission could have sentenced him to less than eight years. They recommended 40 years. About two years later, he was transferred to Canada and at age 28 he

was released on bail. Dr. Keram pointed out that during his more than ten years of incarceration, he had received no rehabilitation program or education. Since his release, he has entered college, been certified as a paramedic, and is hoping to become a nurse. If he had received the 40-year sentence, he would have been released at age 66.

Dr. Keram next told the audience about a young man who was charged one week after his 18th birthday with conspiracy to use a weapon of mass destruction. When he was 16 he was in a chat room, and the FBI began a sting operation which culminated in them giving him a bomb just after he turned 18. Dr. Keram was disturbed by the plea negotiations, in which the authorities were talking about very long sentences for someone who became interested in *jihad* as a juvenile.

Dr. Keram reminded the audience that as social media have become more widely used, recruitment by extremist groups has increased, and children are prime targets. These cases tear apart families and communities. The families of those who have been recruited become radioactive. Others are afraid to interact with them because they fear that they may in turn be scrutinized by the government.

Dr. Keram now made a bold proposal: Children recruited in the US for terrorism should be protected by the same laws that pertain to child soldiers. To develop her thesis, she next provided a primer on international law in this area.

International Humanitarian Law refers to a set of rules which seek, for humanitarian reasons, to limit the

effects of armed conflict, to protect persons who are not or are no longer participating in the hostilities, and to restrict the methods of warfare.

Another category of international law, International Human Rights Law, includes the United Nations Convention on the Rights of the Child, set forth in 1989. This Convention defines a child as every human being below 18, unless under the law applicable to the child majority is attained earlier.

Article 38 of the Convention pertains to war and armed conflict. It holds that governments must do everything they can to protect and care for children affected by war. Children under 15 should not be forced or recruited to take part in war or join the armed forces. An optional protocol raises the age for direct participation in armed conflict to 18, and establishes a ban on compulsory recruitment for children under 18.

The Rome Statute of the International Criminal Court was promulgated in 2002. It established the International Criminal Court (ICC) to prosecute international crimes including genocide, crimes against humanity, war crimes, and the crime of aggression. The ICC has jurisdiction only when states are unable or unwilling to do so themselves. Recruitment and use of children in armed conflict is defined as a war crime.

The Paris Principles were developed in 2007. There are six important sections: Defining protected populations; preventing unlawful recruitment or use of children; addressing the specific situation of girls; release and reintegration; justice (including for those who recruit children); and monitoring, follow-up, and evaluation, both of the former child soldiers and of the rehabilitation programs themselves.

Why recruit children? They are economically efficient, since they

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Manuscripts are invited for publication in the Newsletter. They should be submitted to the editor via email to [aaplnewsletter@gmail.com](mailto:aaplnewsletter@gmail.com)

The Newsletter is published in January (deadline for submission is November 15), April (deadline February 1), and September (deadline July 1).

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## COVER STORY

### Trauma and Transformation

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don't demand high pay; they are easily indoctrinated; and they make efficient fighters because they have a different perception of death.

What are the factors leading children to join armed groups? There are both "push" and "pull" factors: The "push" factors include outright abduction as well as a desire to escape from poverty. "Pull" factors include the desire to obtain skills and status, to combat discrimination or defend one's family or country, and the desire for martyrdom. Yet it is important to remember that when talking about children, there is no voluntary enlistment.

Girls are uniquely at risk for sexual violence and exploitation, which can have physical and mental health consequences. They may be subject to early marriage and pregnancy. Wives may not be included in a negotiated release. Family ties, dependency and rejection by their home communities may lead them to stay. Girls are often bypassed by rehabilitation and reintegration programs.

The goal of release and reintegration programs is to enable former child soldiers to play an active role as civilian members of society, integrated into their community and where possible reconciled with their families. Reintegration should be community-based, involve preparing the community, and be directed by the best interest of the child.

Obtaining justice for the children means treating them as victims and/or witnesses. Protective measures such as disguising the face or testifying in a different room may be necessary. Reparations should be child-specific and address their physical, mental health, educational and vocational needs.

What about children who committed war crimes while juveniles? Under the Paris Principles, they are considered primarily victims, and preference should be given to non-judicial dispositions. The death penalty and life without parole are

prohibited for crimes committed before the age of 18.

Dr. Keram asked the audience: Where do you think the US stands on these international laws? The US signed the Convention on the Rights of the Child, but did not ratify it. It is the only UN member which is not a party. The convention has never been sent by a President to the Senate. The reason seems to be related to concerns about protection of home schooling and parents' rights. The US also has not ratified the Rome Statutes and notified the UN that we will not participate in the ICC. The US has not signed or endorsed the Paris Principles.

Currently the US does not have a definition of a protected population. Dr. Keram proposed that the US adopt the Paris Principles' definition of a child soldier, and potentially offer those protections to juvenile recruits. She pointed out that this should not be done universally, because, as all of us as forensic psychiatrists realize, maturity varies widely.

The US currently has no centralized programming assistance for preventing unlawful recruitment or use of children. As the federal response to the epidemic of opioid overprescription indicates, we do have the capacity to develop such programs. Right now however it is very piecemeal, such as the FBI's Teen website.

Dr. Keram proposed that the US develop a centralized library of programming which communities can adapt to their needs. Surveillance of at-risk children must continue, but sting operations involving children should be abandoned. Such efforts are not supported by what we know about adolescent brain development. Dr. Keram reminded the audience that as a society, we must find a way to balance human rights and national security. She asked if we could do a better job of managing extremist recruitment websites in some way, while acknowledging that there is a

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## “A New Hope” For the New Year

Susan Hatters Friedman MD



Happy New Year! As we make our New Year’s Resolutions, the timing seems right to consider work-life balance and burnout prevention.

A recent survey of American Surgeons considered burnout, and found that those surgeons who highly rated the importance of a work-life balance philosophy, finding meaning in work, finding importance in life, and a positive outlook were less likely to experience burnout. (Shanafelt, 2012a) A 2011 American survey of physicians found the highest rates of burnout in the front-line (e.g. ER doctors and PCPs). (Shanafelt, 2012b) When compared to other working Americans, physicians were significantly more likely to experience burnout and significantly less likely to be satisfied with their work-life balance. (Shanafelt, 2012b)

And it appears to be getting worse, not better. The 2011 survey was repeated in 2014, and significantly higher rates of burnout were found among American physicians, as were decreasing rates of satisfaction with work-life balance. (Shanafelt, 2015)

So, is it better for psychiatrists, with our vast mental health knowledge? Not much. A Japanese study of academic psychiatrists reported that 46% of respondents had difficulty with their own work-life balance. (Umene-Nakano, 2013) One-fifth (21%) experienced high levels of emotional exhaustion or burnout—which correlated with perceiving less support and difficulties in work-life balance. Close to half of psychiatrists reported burnout on the 2014 American survey. (Shanafelt, 2015) And just under half were satisfied that work left enough time for their personal life.

Forensic studies are limited. One study found that forensic mental

health nurses had less burnout than general mental health nurses. (Happell, 2003) An earlier inquiry into burnout among multidisciplinary forensic mental health workers found that females had higher rates of burnout than men. Nurses had the highest rates of burnout, and forensic psychiatrists, the least. Two other factors were correlated with burnout: those with apathy toward this population and having been threatened by offenders. (Cacciacarne, 1983) “Physician, heal thyself”?

How can we fight burnout in ourselves, in our departments and our colleagues? Vacation, the focus of my last editor column, is not the only way. Peer support (as well as the support of mentors and outside friends) ranks highly in combatting burnout. Managing workplace stress most effectively involves eliminating the stressors—problems of workload, resources, issues with management. (Edwards, 2002) Family time, of course, is critical. But, prioritizing not only one’s family but also oneself is important.

Taking care of ourselves (the things we tell our patients), getting enough sleep, eating right, and exercise are important, as is mindfulness (with a quick plug for yoga nidra). But I would argue that so are our outside avocational interests—which I’ve heard a lot of psychiatrists say that they don’t have time for. But to think that one does not have time for other activities might be because of a skewed view of the work-life balance. I also figure that learning Italian (albeit very slowly) or stained glass window making or Bollywood dancing is using different parts of my brain and eventually staving off dementia.

We work with the most unwell troubled patients and often hear horrific stories. We must remember to take a step back and think about ourselves. How do I have time not to try my hand at writing a play? (and—no surprise—a play with forensic psychi-

atric themes). As a teacher of residents and students, I convinced myself that it was a meta-communication about the importance of work-life balance to perform clarinet or saxophone solos at the medical school and community programs. But it was great fun as well, and rehearsing with musicians again, creating something was rejuvenating. The world might’ve done without my tap dance performance though...

We hope you enjoy this issue of the Newsletter. Within these pages you’ll find summaries of various talks (including the distinguished lunch speakers) from our recent annual meeting in Portland. You’ll find many committee articles highlighting the latest in various areas of forensics. You’ll read of AAPL’s representation at the AMA, as well as AAPL members making international connections. And, you might learn something about Edgar Allen Poe. *Leggete! Godete!* ☺

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## Truth and Corrections

Michael A. Norko MD, MAR



It is a great privilege to be writing this column, as I am honored and humbled by the opportunity to serve AAPL for this year as presi-

dent. In AAPL, through the interplay of fate and design over decades of endeavor, we have gathered to our unique missions some of the most accomplished, thoughtful and hard-working psychiatrists in this country and beyond. The range and depth of scholarship, practice and teaching among this body of forensic psychiatrists is truly extraordinary, and I will not hesitate to remind us of that happy circumstance, which we may be prone to take for granted. It can all seem so natural, so ordinary, when we gather together to share experience, knowledge and aspirations.

The annual meeting is a remarkable event, one that has been a rich source of professional fulfillment for me over 30 years. It is thus a great pleasure to be planning for our next gathering in Denver. The agenda that I am imagining is, by way of abundant enthusiasm, somewhat involved and worthy of a bit of explanation.

Over the last 2-3 years I have had numerous conversations with AAPL colleagues about our relationship to correctional psychiatrists, and the underdeveloped state of that relationship given the tremendous overlap of our multifarious concerns in delivery of care, jurisprudence and policy-making. I see the Denver meeting as a chance for us to attempt new levels of outreach and welcome to our colleagues practicing in correctional settings. We will be highlighting the interconnectedness of the community, hospital and corrections domains of public sector forensic practice. A group of AAPL committee chairs and correctional liaisons are actively composing a significant initiative to welcome our correctional colleagues in a

special way in Denver. (You can read more about this corrections initiative in the Medical Director's column by Jeff Janofsky in this issue of the *Newsletter*.)

Several of our committees have been asked to consider presentations on their own or in collaboration with other committees that relate to the confluence of forensic themes across correctional, hospital, and community psychiatry. All our colleagues are invited to do the same, and we are especially hoping for submissions from psychiatrists working in correctional settings highlighting innovative programs, research, policy or practice.

But I also want to try to describe how I see this initiative coming together with the conceptual theme that I wish to explore (The Search for Truth) through various planned activities and invitations for your abstract submissions. The AAPL Ethics Guidelines remind us that we "should adhere to the principle of honesty and should strive for objectivity" in our forensic work. This is the beginning of the search for truth, but it is not the end of the discussion. Honesty is not fully contained in the box marked "Just the facts, ma'am." The subjectivity of perspective, narrative and voice complicate and widen the terrain of what honesty and authenticity must cover. The clinical/forensic dualism seems no longer a rich enough construct to adequately address the range of inquiry or the complexity of professional tasks and challenges. Truth is hard work.

And then there is the confounding variable of the medium through which our work is processed. Although it is an obvious first lesson of forensic psychiatry, clinical and legal systems operate within very different functional paradigms. This leads to unavoidable levels of misunderstanding or incomplete understanding – the very substrate of forensic training. But our best efforts

as forensic practitioners, even combined with the best collaborations with our legal colleagues, may not deliver the wholeness of truth we aspire to within our system of justice.

So while we are encouraging abstract submissions for presentations of particular interest to correctional psychiatry and its interconnections, we are also seeking proposals that examine how the adversarial system uses expert knowledge to make decisions, and the effectiveness of that process at discovering *the* truth (and not just merely deciding it as our best approximation of that goal). In other words, how well does our grasp serve our reach?

The other side of the equation is seldom discussed at AAPL and I very much hope that we might explore it further – that is, what possible alternative mechanisms might be available to channel the presentation of forensic expertise in various legal settings? What data are available from other legal systems to enrich our thinking about our role in court? What theoretical models might stir our imagination? Are there potent avenues of dialogue to be had with our legal colleagues which have not been tried or at least not yet exhausted?

Reena Kapoor, Program Chair for the 2017 meeting, and I have planned some focal points for these explorations by way of luncheon speakers. Carrie Menkel-Meadow, Professor at the University of California, Irvine School of Law, will discuss her experiences as a mediator interested in the deeper psychological needs of the parties in a legal contest. The Honorable John L. Kane of the U.S. District Court of Colorado will illustrate his efforts to apply sentencing guidelines fairly to individuals living with mental illness. Anthony Graves will describe his experiences in our criminal justice system as a death row exoneree. We are working on constructing a mock trial to illustrate one possible alternate mechanism for the presentation of psychiatric testimony by way of an expert consensus panel.

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## AAPL Outreach to Front Line Correctional Psychiatrists

Jeffrey S. Janofsky MD



AAPL's incoming President Mike Norko has announced a special initiative during his presidential year to reach out to psychiatrists

delivering direct care to psychiatric patients in correctional settings. Our next Annual Meeting in Denver in 2017 will have an extra correctional track added to Saturday sessions (four extra sessions total). Those Saturday sessions will focus on helping correctional psychiatrists improve practice in correctional settings. Mike is especially interested in collaborative submissions emphasizing continuity of care and the collegiality of public sector psychiatrists working in different settings for the largely overlapping public sector and correctional populations. Workshop presentations designed to encourage discussion about practical tips to improve forensic practice are also encouraged. Mike hopes that local correctional psychiatrists will be able to attend the Saturday session, even if they are unable to attend the whole meeting.

Those of you who were certified by the old AAPL Board of Forensic Psychiatry probably remember that the treatment of patients in correctional settings was not originally a focus of our speciality. It was only after forensic psychiatry became an American Board of Medical Specialties subspecialty that correctional psychiatry became a core competency for board certified forensic psychiatrists. Mike, through his correctional initiative, hopes to continue the expansion of correctional psychiatry at AAPL, and to make AAPL the professional home of correctional psychiatrists.

As we all know, jails and prisons treat many persons with serious mental illnesses. According to the Treatment Advocacy Center (TAC) the

number of persons with severe mental illness in jails and prisons exceeds the number treated in state psychiatric hospitals by a factor of ten. The TAC also found that in 44 of the 50 states and the District of Columbia, correctional facilities hold more persons with serious mental illness than the largest remaining state psychiatric hospital.<sup>1</sup> Thus there is a significant need for psychiatrists to provide direct treatment care to incarcerated persons.

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*“He is trying to get people interested in thinking about the spiritual dimensions of patient care...”*

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I had an opportunity to interview Mike. He talked about his hope to see more correctional psychiatrists join AAPL. By collaborating with front line correctional psychiatrists Mike hopes that we can learn more about what they experience on the front lines, and that together we can think about more ideas for how to combine our efforts. Mike notes that AAPL presently has many great correctional academicians doing policy work, but he hopes the Denver session will focus in part on issues front line correctional psychiatrists don't get to hear about in other settings. Mike is particularly focused on boundary issues, ethics concerns, and the conflicted relationships that correctional psychiatrists have to deal with every day. Mike believes that many front line clinicians may be left to their own devices and may not have an organized practiced way of thinking about these issues. He hopes to begin to solve that problem at our next meeting.

Mike's interest in correctional psychiatry began when he started work

as a clinician in Connecticut's maximum security mental hospital in 1988. Although run by the public health authority, the Whiting Forensic Institute had a Memorandum of Agreement with the Department of Corrections that Corrections would give Connecticut funds to create a unit and, in return, Connecticut offered hospital services for correctional patients who were the most severely mentally ill. When Mike came on board he opened two new units to provide clinical treatment services to the correctional population. At Whiting, Mike treated people who might otherwise have been in a prison infirmary bed. Mike's group at Whiting provided treatment. After stabilization the patients were sent back to Corrections for outpatient prison treatment.

Mike worked as a front line clinician at Whiting for four years. After that Mike became the Assistant Director of a hospital and then CEO. After taking time off from the public sector Mike returned and then eventually became the Director of Forensic Services for the State of Connecticut.

Mike's other main academic interest that informs his care of patients is his interest in religion. He obtained his Master's Degree in religion from Yale. Mike sees his clinical and religious work as connected. Since he finished his degree Mike has taught a twelve week course at Yale on religion, spirituality and world view in psychiatry. He is trying to get people interested in thinking about the spiritual dimensions of patient care, and is also getting divinity students involved in the course. Mike is hoping the interaction between divinity students and clinicians will help spur interest in prison chaplaincy as a vocation. Mike hopes to have a session on prison chaplaincy at our annual meeting. ☪

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## Emmanuel Jal: Story of a Warchild

*Renée Sorrentino, MD*

Amongst his many distinctions, Emmanuel Jal has the additional distinction as the sole AAPL luncheon speaker who emancipated a conventionally reclined audience into Twerking. Emily Keram got it right “There was the Denver Blizzard and now there is the Portland Twerk.” Awakening his audience is part of Emmanuel’s message. Emmanuel was born in the early 1980s in the war-ridden Southern Sudan. Born into the life of a child soldier, he escaped into the life of a peacemaker and teacher. Emmanuel described his mission as “sharing my experience for social and emotional learning. To put the spotlight in darker places to cause conscious global awakening.” He implored the audience to ponder, “Who owns your mind?”

Emmanuel answered the question with one word, “trauma”. He described, “At one time trauma owned my mind.” He defined trauma as “an internal genocide. It is a virus that invades the mind. Self-worth and confidence are gone. The internal infrastructure is taken away from you.” Emmanuel understands trauma having grown up in the war-torn regions of the Southern Sudan. He categorized his life experience into three journeys: happy memories, the lowest point in my life, and the things I’m doing now with my life.”

In his youth, Emmanuel’s childhood and adolescent experiences were the antedents to his trauma. He learned to “get used to seeing people die. As a kid it was part of the environment.” In this environment he trained as a child soldier. His reasons to become a child soldier reflect his innocent turmoil. As a child he chose to train for war because he wanted a bicycle and he wanted revenge. He understood both would be delivered in his role as a child soldier. This decision resonates in his lyrics, “My dreams are like torment...Sin to make

a living...War child.”

“The lowest points in life inspire me,” said Emmanuel. He continued, “What doesn’t kill you makes you stronger. We (child soldiers) planned to escape. It took us three months. We would eat anything we could find. We would use the dew as water. We drank our own urine. Some just blew



their heads off.” Emmanuel described one night in which he attempted to take his life with a gun. He stated, “The bullet failed. I didn’t die. I continued moving. I wanted to die naturally. There were mine fields everywhere. We hadn’t eaten. I told one (child soldier), ‘I am going to eat you tomorrow.’ We just looked at each other’s eyes. I didn’t want anyone to know I was going to eat him. It was a battle of the mind—eat or not. I waited, remembering my mother who used to pray. I prayed, ‘Mom, God if you are there give me something to eat.’ I waited. A crow fell to the ground. That moment prevented me from eating my friend.”

Emmanuel moved from the darkest and lowest stories of his history to his triumph and success. Moments after silencing the audience with his canni-

bal thoughts he sings out “The story is long but when I think about it, it gives me energy.”

Emmanuel was “rescued” by a British woman who brought him into civilization. He was placed in school and promised an education. But Emmanuel’s challenges did not disappear. He described ongoing conflicts with peers and teachers. He wished that some one acknowledged his suffering. He recalled, “I wished someone asked what has happened? I was taught to cry inside. I was programmed to function in a specific way. Trauma takes space in your mind.” He decided then, as a young child, to make a difference by ending suffering. Emmanuel found solace in music. He was good at music and soon learned what it meant to have self worth.

Emmanuel’s message is about peace and forgiveness. He shares his story of trauma to illustrate the wide reaching effects of trauma. More importantly he shares his story of healing to help others heal and to teach us to heal those who suffer. In describing his transformation, Emmanuel stated, “If I never forgive it would have not happened. A person has to forgive the person who traumatized them and then themselves. Peace is the message I push. Also piece of mind.” He asked the audience to consider how one defines “peace.”

Emmanuel’s current journey in life is devoted to sharing his message of trauma and resurrection through music and activism. His charity Gua Africa was founded to work with individuals, families and communities faced with the adversities of war and poverty. His triumph resonates in his music of peace and forgiveness. Today Emmanuel lives in Toronto where he delivers his message personally. A self-described, “accidental entrepreneur,” Emmanuel developed “Jal Gua” a powder mixture made from organic ingredients he imports from his home country of South Sudan. This supplement, much like Emmanuel’s life message, nourishes the mind and the soul. ☯

## Zak Ebrahim: The Terrorist's Son: My Path to Peace

Joel Watts, MD, FRCPC



At this year's Annual Conference, we were fortunate to welcome Mr. Zak Ebrahim to give a luncheon distinguished lecture.

As the son of former El-Qaeda terrorist El-Sayyid Nosair, Mr. Ebrahim spoke eloquently about growing up with a notorious father and his attempts to distinguish himself by speaking out against fanaticism and promoting peace. Mr. Ebrahim spoke to a rapt audience about how a boy raised by a Muslim zealot wished to now dispel myths too often advanced by politicians and media pundits about the Muslim faith. He reminded us that religiously motivated violence exists in the extreme reaches of all faiths.

Mr. Ebrahim began his story by explaining how his father's radicalization had already begun to take hold when he was a child. He later explained how his father had perhaps become so radicalized after a series of personal setbacks. Perhaps some of it was influenced by long-simmering humiliation and hostility after having personally been accused of a sexual assault for which he was never charged or convicted, resulting in a loss of his reputation and a need to move cities. He suffered an injury at work, spent a long time on sick leave and became depressed. He began spending long periods immersed in the Koran and eventually met radicalized Muslims.

Mr. Ebrahim explained how his father took him to a particularly radical sheik at a mosque when he was 6 years old. This occurred at the height of the Afghanistan war involving the Soviet Union. They knew neighbors who had taken their children with them to go and fight in Afghanistan. In 1990, his father murdered the leader of the Jewish Defense League.

The summer after Mr. Ebrahim turned 7 years old, his grandfather came to visit, and tried to convince his father to revisit his extremist views, but the latter was unwilling to find non-violent outlets for his frustrations. His plans for some terrorist attacks in New York were foiled by an FBI informant. While in prison, he helped plan the 1993 bombing of the World Trade Centre. Mr. Ebrahim recalled how, prior to his father's arrest and conviction, his proudest moment was when his father had taken him shooting automatic rifles with his "uncles," other men who were also convicted of the 1993 bombing.

Mr. Ebrahim explained how he spent many years afterwards visiting his father in prison on weekends along with his mother and siblings. This became routine. After his mother remarried, they stopped visiting him and his mother changed their last name to hide their identity. They were afraid of being associated with his father, living in shame of his misdeeds. Mr. Ebrahim has suffered attacks by others over the years due to his family's history, including at the hands of a "friend" who lunged at him with a knife. By 19 years of age, Mr. Ebrahim had moved 20 times, had frequently been the target of bullies due to always being the new kid and now recognizes that as a consequence, he lacked social skills. He had learned up to that point to judge others by their race. He remembers clearly that this way of thinking was first challenged during the 2002 US presidential election when he met a Jewish kid and befriended him. Having a Jewish friend gave him a sense of pride. A visit to Busch Gardens shortly afterwards opened him more to appreciating diversity when he met gay dancers doing a show and realized that they were kind and gentle people. He realized that his own experience of being bullied had

taught him empathy towards others – he did not want to treat people and make them feel the way he had himself. He shared these thoughts with his mother around the same time and she answered, "I'm tired of hating."

Mr. Ebrahim told the group that his father had reached out to him since he began his public speaking. He eventually decided to respond because he still had many questions he wanted to ask him. His father initially expressed that he was happy Mr. Ebrahim was speaking about peace and spoke of wanting Israel and Palestine to resolve their conflicts. He explained the hardships that he had experienced in prison. However, his emails slowly changed in tone as he began to talk of things being "all in God's plans" and encouraged Mr. Ebrahim to return to his faith. Ultimately Mr. Ebrahim decided to end their contacts as he had found the experience disheartening. He had put a lot of importance on getting answers for his questions and they ultimately went unanswered. Eventually, he felt some relief, realizing that he had learned what he wanted to know and didn't need his father's answers. This realization set him free.

Mr. Ebrahim spoke about the shame he has experienced over the years for his father's actions, but he realized after a while that he could use his story to show others that he had not become radicalized despite his father's influence and teachings. He thoughtfully reminded AAPL members that for some individuals like himself, exposure to a great deal of violent ideas does not always lead them to become violent themselves later in life. In his words, "It does not have to define your character." He urged us to not give into fear caused by groups like ISIS and warned that "we cannot bomb people into democracy."

Mr. Ebrahim told us that the most moving speech for him was one he gave to victims of terrorist attacks and 9/11. He was extremely nervous prior to giving it, but afterwards realized that he had needed to learn a lesson. Namely, the victims present

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## Christy E. Lopez: Transforming the Police: The DOJ Civil Rights Division and Police Accountability

Brian Cooke, MD

AAPL attendees were privileged to hear Attorney Christy E. Lopez speak about current strategies for bringing about change to decrease police misconduct and the potential opportunity for psychiatrists to positively influence police conduct. As detailed by the annual meeting program, Ms. Lopez is a Deputy Chief in the Civil Rights Division of the US Department of Justice (DOJ). She heads the Special Litigation Sections' police practice group, which has primary responsibility for conducting "pattern-or-practice" investigations of law enforcement agencies. She led the team that investigated the Ferguson Police Department, the New Orleans Police Department, the Los Angeles Sheriff's Department, the Newark (New Jersey) Police Department, and the Missoula, Montana investigation. She is currently leading the team investigating the Chicago Police Department. Ms. Lopez was also the Deputy Chief overseeing the Division's recent successful litigation against the towns of Colorado City (Arizona) and Hildale (Utah), in which a jury found that the towns' law enforcement agencies enforced the edicts of a religious sect rather than the rule of law. She helped formulate and draft the DOJ statement of interest in the Floyd litigation challenging the New York Police Department's stop-and-frisk practices.

Ms. Lopez's primary argument was that there is an obvious need to transform policing in the US and that psychiatrists have a unique role in this. She admitted she has spent the last 20 years thinking about this. These ideas originated from growing up in Southern California and having a father who was a police officer. Her current role in the US DOJ is to investigate entire police departments and try to prevent further misconduct. Statutes give her department this authority.

The provisions of court-ordered consent decrees enact reform, and officers are held accountable when appropriate.



Photo Credit: Andrew Kaufman, MD

From her experiences, she argues that the police in the US are at a crossroads. There have been tragic shootings of persons with mental illness. Civil unrest has increased awareness of police activity and is readily captured by the media. To understand the current reaction of the public, she argues, it is important to understand the broader context. First to appreciate is the New York City stop-and-frisk policies. Her investigations revealed that this was overwhelmingly biased toward black and Latino people. In 2011, only 1.9% of the stops actually turned up a weapon. Unfortunately, these policies are used in many states.

The second important contextual factor is Ferguson, Missouri. Her team revealed a revenue-driven approach to policing, where the department was over-policing the small stuff. For example, one incident in 2007 of African American woman who parked too far from the curb resulted in a multitude of fines, citations, additional criminal charges, and arrests. The

shooting of 18-year-old Michael Brown by a police officer was viewed by people against a broader backdrop of policing, which included awareness of many examples just like this. Ms. Lopez voiced confidence that deadly force will be held accountable.

A prescription of compassion and deliberate change will be necessary to influence the current culture of policing. Ms. Lopez asserted, "It's going to take more than a piecemeal approach," and it is paramount we "change the entire mindset of policing." Central to this idea is her opinion that the police must change from warriors to guardians, an idea espoused by Chief of Police Adam McGill (Truckee, CA). Can different training make police officers more respectful and fair, which in turn might increase the public's trust and confidence of them?

Speaking directly to her audience, Ms. Lopez encouraged the input of mental health professionals to help affect positive change. She identified several areas in which we can assist including the following: recruitment of police officers, training of officers (especially in "complex psychological dynamics"), responding to officers on the wrong trajectory and making an intervention, and providing better mental health treatment to officers and their family members (especially cognizant of the effects of vicarious trauma).

Although the investigations led by Ms. Lopez's teams provided many reasons to be critical of the state of policing in the U.S., her comments were hopeful. First, she provided an important cultural context to understand the crisis faced by our country. Second, she remained optimistic and enthusiastic, proposing specific ways the profession of psychiatry can make a meaningful impact to improve this national crisis. Our profession has been challenged to continue our efforts liasoning with law enforcement and to further our efforts in the community. ☯



## Beers, Cheers, Tears and Ears

Jacquelyn T. Coleman, CAE, Executive Director



Who knew that some of my experiences in the fall would turn into a rhyme?

So we can start with beers. Unfortunately I did not get to sample many of the local beers in Portland during our Annual Meeting, but I would note that many people did. They also seemed to enjoy many other parts of the Portland experience. Food trucks were mentioned often. We also had pretty good weather for Portland. But just to be clear, we had a very successful educational meeting. Some of the presentations had overflow crowds. The variety of lunch speakers also caused all three to be sold out.

As for the cheers, you may have noticed that there was a pumpkin contest going on at the Hilton, with different departments vying with each other to create the best pumpkin. The sales and catering staff carved three pumpkins, all with an AAPL theme. We conducted a "get-out-the vote" drive to reward their efforts.

We were informed last week that "our" team won, resulting in each person getting an hour off with pay. They thanked us profusely for our assistance in getting them over the top.

Tears, both happy and sad, for Kristin Loney's departure. We are sad to see her go. However, on November 29, Kristin and Dan welcomed Olivia Rose Salvatoriello into the world. We wish her, Olivia, and Dan well on their new journey as a family.

I also want to note that the Awards Committee of AAPL presented the Amicus Award to Marie Westlake and Kristin. I find AAPL to be unique in its support of the staff. Kristin's successor, Molly Reynolds, immediately noted the friendliness and respect accorded to staff.

And on to the ears. The Interim Meeting of the American Medical Association was held at the Disney World Swan and Dolphin, a sprawling

complex on Disney's Orlando property. I was amazed at the growth of the area since my last visit perhaps 5 years ago. Also stunning is the amount of construction going on everywhere that is not already owned by a Disney property. When I lived near Orlando many years ago, Disney World was the only attraction. Epcot was only on the drawing board.

Mickey Mouse ears are now rendered not only in the simple black some of us grew up with. Sparkles are *de rigueur*. There are apparently no longer any rules. The ears can have pastel sequins for princesses, even some with veils attached. (Princesses are a very big deal at Disney). There were special Christmas ears, in green and red sequins. Ears are now available as holograms that change. Some exhibit changing rainbows of colors. Despite the number of grown women I saw sporting Mickey ears, I was not tempted.

Despite how you feel about the whole Disney enterprise, you have to admire their logistical skills. Buses from each of the hotel complexes pick up passengers bound for different corners of the empire. I chose to visit Disney Springs, a massive shopping and entertainment complex, on a Saturday evening. There were 29 bus lanes dedicated to busses picking up and dropping off passengers. Disney's ability to organize large crowds is legendary. But it doesn't stop there. They have formed a Disney Institute that teaches leadership skills to a broad variety of people. I attended a



talk by one of their faculty a few years ago and was very impressed.

There were lots of serious things debated and decided, and not decided, (see physician-assisted death) but I leave that account to our able AMA Delegates. They were not playing, in fact I sometimes wonder why AMA goes to various places, because, at least in my observation, the delegates (and staff) don't get many breaks!

I have just one regret – I really wanted a magic wand from the Harry Potter attraction, but it was too far away. ☹

## MUSE & VIEWS

### Novel Explanation

A Florida man crashed his car into a large window at the State Attorney's office. After failing multiple sobriety tests, he surprised officers by telling them that he had not been drinking. He conveyed to the officers that he was not drunk, he was high.

Source:  
<http://weirdnews.about.com/od/weirdphotos/ig/Weird-Crime-Mug-Shots-.5Hz/-I-m-Not-Drunk--I-m-High--.5Iv.htm#step-heading>

Submitted by William Newman MD

## Zak Ebrahim

*continued from page 7*

refused to let their negative experiences define their lives, rather, they used them as motivation to improve the world. Mr. Ebrahim ended by stating that he hoped to teach others that hate leads to hate, and after a pause affirmed, "I am not my father."

Unsurprisingly, there was an enthusiastic lineup of questions for Mr. Ebrahim after a standing ovation by those in attendance. One of the last questions asked where he finds the strength and courage to do what he does? Mr. Ebrahim answered simply, "People tell me I'm brave and courageous, but I just do what I do." He mentioned that Nelson Mandela was once asked a similar question and responded that he did what he felt compelled to do and did not consider what he did to be remarkable at all. ☹

## Dr. Robert I. Simon: In Memoriam

Liza Gold, MD



With sadness I report the death of Robert I. Simon, MD. Dr. Simon, an American Academy of Psychiatry and the Law member for 40 years, considered AAPL his professional home. In addition to serving on a variety of committees, Dr. Simon served as Counselor, Vice President, and as AAPL President in 2006-2007. His service and efforts were instrumental in establishing forensic psychiatry as a recognized psychiatric subspecialty with its own board certification.

I first met Dr. Simon in the mid-1990s, when I was retained in the first case in which I served as an expert psychiatrist. I was retained by the plaintiff's counsel; Dr. Simon was retained by the defense. The case ultimately settled, but in reading Dr. Simon's report and C.V., I became intrigued by the forensic process and the possibility of adding a small forensic practice to my clinical practice.

Unfortunately, with two very young children and no local forensic fellowship available, I was not in a position to pursue formal forensic training. So I made a list of all the forensic psychiatrists I could identify in the DC area to see if any of them could give me advice on starting a forensic psychiatric practice. The list was not long but I put Dr. Simon's name last. I was convinced that because we had been on opposing sides in that one case, he would ignore my call or dismiss me immediately (that's how little I understood about forensic psychiatry at that time). I called everyone else on the list and got some advice, but nothing I could use to explore or launch a forensic side-practice.

Finally, feeling I had nothing to lose, I called Dr. Simon. Much to my surprise, he answered his own phone – even in 1997, we expected calls to

be answered by a machine rather than a person. I stammered out my name, and said, "You probably don't remember me" (hoping that was true). But Dr. Simon said, "Oh yes, of course I remember you." I took that as a bad sign and I got even more anxious. Nevertheless, feeling like *Oliver Twist* asking for more porridge, I said something to the effect of "Please sir, I would like to learn about becoming a forensic psychiatrist, sir."

To my surprise, my fears were completely unfounded. Dr. Simon could not have been warmer or more welcoming. At that time Dr. Simon held an informal monthly meeting at his home for local forensic psychiatrists to discuss writing and publishing in forensic psychiatry. He invited me to join the group, directed me toward AAPL, and the rest is history.

Dr. Simon and I went on to form a close mentor/mentee relationship and over the past twenty years we collaborated on numerous projects, presentations, and books. I came to discover Dr. Simon's generosity of spirit, warmth, and humor. He had an endless willingness to teach, not only through writing and editing, but also by sharing his experiences and explaining how to navigate the "shark-filled" waters in which we forensic psychiatrists swim.

As many people know, Dr. Simon's passion was writing. Quoting Benjamin Disraeli, Dr. Simon often said, "The best way to become acquainted with a subject is to write a book about it." I last saw Dr. Simon on the day before he died. Although ailing, he asked about writing a paragraph for a chapter in the forthcoming 3rd Edition of the *Textbook of Forensic Psychiatry*, for which he was to be Editor Emeritus.

Dr. Simon was fond of quoting William Osler's three categories of writers: Creators, Transmuters, and Transmitters. Creators, people like Shakespeare, Darwin, or Freud, are rare. Transmuters, authors who put a

new spin on ideas, and transmitters, authors who distribute ideas and information, are essential to education and research. Clearly, Dr. Simon meets the categories of transmuter and transmitter.

However, in his AAPL Presidential Address of 2006,<sup>1</sup> Dr. Simon expressed his belief that Osler's distinctions were "too categorical" because opportunities for creative authorship are not limited to literary geniuses. Dr. Simon himself was one of the most creative writers in the field of forensic psychiatry. No other author has contributed to the depth and breadth of the literature of forensic psychiatry as has Robert Simon.

By the way, Dr. Simon also agreed with George Orwell, who said, "Writing a book is a horrible, exhausting struggle, like a long bout with some painful illness. One would never undertake such a thing if one were not driven on by some demon whom one can neither resist nor understand." Every time Dr. Simon finished a book he swore he would never do another. No one ever believed him, because as he also said in his AAPL Presidential Address, "The joys of life-long learning and creativity through writing can be sublime. The experience of creativity is one of life's most fulfilling, exhilarating experiences ... all the agonies of writing seem trivial in contrast."

Dr. Simon authored more than 100 peer-reviewed articles, more than 60 book chapters, and authored or edited approximately 20 books, many into second and third editions. His book *Clinical Psychiatry and the Law*, published in 1987, was cited in the Supreme Court's 1990 decision in the landmark case of *Washington v Harper*. Dr. Simon's publication "Bad Men do what Good Men Dream: A Forensic Psychiatrist Illuminates the Darker Side of Human Behavior" first published in 1996, has been translated into Japanese, Chinese, and Italian. Dr. Simon won the prestigious Manfred S. Guttmacher Award honoring an outstanding contribution to the literature on forensic psychiatry three times:

(continued on page 37)

## Eindra Khin Khin, MD

*Philip J. Candilis, MD*



Washington DC's Eindra Khin Khin recalls a Grand Rounds during her third year at UVA medical school that introduced her to the nefari-

ous exploits of physician-turned-serial killer, Michael Swango. Killing off one's patients was a far cry from the idealism of medical school, yet it held a certain morbid fascination. Similarly, an elective course in criminology, like Robert Simon's contemporary book *Bad Men Do What Good Men Dream*, impressed her with how similar good and bad people could be. Dr. Khin Khin consequently developed a project on healthcare providers who were serial killers – cementing her move into forensic psychiatry.

Eindra's fascination with forensic psychiatry extended into an internship year collaboration with Arturo Silva and Barbara Haskins. Studying serial poisoners and presenting at AAPL in 2006.

Dr. Khin Khin extended her exploration of the field. Although she tried to remain open to other specialties, especially psychosomatic medicine and its tight mind-body connections, forensics ultimately offered a broader platform for professional practice.

The intersection of law, medicine, and public responsibility allowed community education on a grander scale and an application of psychiatry beyond the profession itself. It was a clear inspiration for her current responsibilities as Residency Training Director at the George Washington University School of Medicine (GWU).

As Eindra developed expertise in public policy and advocacy – she now runs the department's Human Rights Clinic – it is not difficult to see her roots in a powerful immigrant narrative. Dr. Khin Khin arrived in the US as part of a formal asylum

request. Her mother was a general practitioner and epidemiologist in Myanmar until she was forced to flee because of her membership in the anti-junta National League for Democracy party. The family sold everything to fund the escape and Eindra stayed with relatives until her mother could arrange her emigration. Eindra consequently completed high school in Myanmar and moved to Los Angeles on what immigration officials call “derivative political asylum” (i.e., asylum derived from her mother's political status).

Accompanying her mother on school health inspections and homeworker trainings Eindra learned the importance of social and cultural issues at a young age. The impact of education on nurse's aides and healthcare workers made a strong case for the effect of education on the families and workers who made up the local community.

Dr. Khin Khin describes a period of initial culture shock in the US, during which she even resisted speaking English, a language with imperialist connotations back home. But as she worked two jobs to get through community college she increasingly connected to her new home and earned an undergraduate scholarship to GWU.

In taking time to learn research and save money before medical school, Eindra took a two-year lab appointment at NIH. Recognizing that she could save enough to enter medical school a year later, she accelerated her schedule to complete the research in a single year, matriculating to UVA's medical school after a year of 12-hour days, six days a week. In a program that valued collaboration and education, Eindra rotated through old psychiatric hospitals, took call in ancient sleeping quarters, and made night-time raids on the pantries of a bygone era. “I never wanted to leave the hospital,” she says.

Now as a training director and

head of a psychiatry department's forensic services, Dr. Khin Khin advocates a strong education in forensic psychiatry. Medical-legal issues pervade psychiatry, so robust preparation in forensics is a necessary part of the residents' training. Working with the local forensic fellowship at Saint Elizabeths Hospital, GW residents work with public sector faculty, rotate through state forensic units, and work in her Human Rights Clinic.

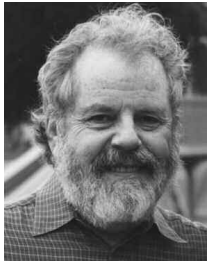
The clinic's work with refugees and asylum seekers is a unique contribution to the community and its vast array of immigrants, offering residents and fellows the opportunity to follow current international movements that most only read about in the papers.

“We need to start students and residents early in mental health,” she says, underscoring her interest in bringing newcomers into the field. An example of this is her involvement with the well-known Camp Neuro at GWU Medical School, a nationwide program run by local medical students. The group works with gifted high school students to explore medicine in general and neuro and behavioral sciences in particular. “I developed my interest early on,” she says, “now I just want to pay it forward.” ☯

*Associate Editor's note: In the controversy over Myanmar's name, Dr. Khin Khin explains that the previous name “Burma” is an anglicized (i.e., colonial) version of the name of the majority ethnic group. Although the military government controversially re-named the country “Myanmar,” it is often considered more inclusive of the nation's hundred or more ethnic groups. Some activists argue that the name was changed without a referendum, and is still derived from a written root of the old name. We defer here to Dr. Khin Khin's preference.*

## The “Bully” Pulpit

Stephen P. Herman, MD, DFAPA, DFAACAP



Craig was 18 years old when he became a frequent visitor on an Internet chat line, only reached by going into the “dark web” via a secret portal.

There he met two young teenage girls in another state. After friendly chats which became increasingly sexual, Craig asked both girls to strip to their waists so he could watch. They did, briefly, while the boy took photos. Soon, he asked them to discard all their clothes. The girls refused. Craig threatened to put their faces and chests on Facebook, while creating Photoshop images of their nudity. Finally, terrified, the girls told their parents. Through authorities finding Craig’s IP address, he was arrested by local police and charged with felony harassment and threatening.

Craig was a loner. No friends, never dating, he just surfed the web day in, day out. He worried his parents, but they could do nothing. Their marriage was not happy. In fact, Craig witnessed domestic violence by both parents. His father couldn’t hold a job; his mother drank too much. He was doing well in school, never used drugs, and was looking forward to attending a college. When Craig was caught, though, he showed no remorse.

A forensic psychiatrist hired by his lawyer could not help. Craig did not suffer from a diagnosable disorder. During the forensic evaluation, he admitted that given the opportunity, he would get on the Internet and repeat his behavior. The criminal defense attorney told the psychiatrist not to write a report because the findings would surely hurt his client.

Samantha and her friends constantly taunted Alyssa, whose mother was thought to be a crack-using prostitute. Samantha would secretly follow Alyssa home and once threw dog feces against her front door. Alyssa

never complained – never told anyone. But one day, as school let out, and Samantha made her usual approach to bully her daily victim, Alyssa suddenly took a knife out of her pocket and stabbed Samantha through the liver.

What makes a child become a bully? Are there common factors, unique predispositions, or a combination of the two? To use an outdated expression, is the origin nature or nurture?

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*“Based upon what they hear at home, on the media, or from other children, bullying kids often single out special groups...”*

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Kids bully for many reasons. They may not get the attention they crave at home. There are a variety of reasons for this: divorce, child custody disputes, parental drug addiction and imprisonment, or absence in the life of the child. Some child bullies witness and model their parents’ negative behavior: emotional, physical or sexual domestic violence, bullying another of their children, using drugs and so on. Others have low self-esteem – a core of fear – and camouflage it with verbal and/or physical aggression against others.

Based upon what they hear at home, on the media, or from other children, bullying kids often single out special groups, such as LGBTQ students, Muslims, Jews, Hispanics, African-Americans and immigrants.

Other children grow up thinking they are entitled. Their parents are wealthy, do not set limits, and the kids get everything they want. They lack perspective and a value system that considers the needs of others.

Then there are kids who grow up

“congenitally” lacking in empathy.

Charlie was like that. He had all his basic needs met. Although he was a below-average student, he got by, charming his teachers. But at age 11, he was taking pleasure putting garbage bag ties around the neck of cats, strangling them. During the Christmas season, while delivering the local morning newspaper on his bike, he’d stop and set fire to crêches along his route. When caught by the police, he displayed no remorse for the pain he had caused his neighbors. A local judge send him to “therapy,” without a clue about Charlie’s needs. Finally, two weeks later, in a local park, Charlie came upon 4-year-old Toby. He circled around her on his bike, getting closer and closer. She started to cry. He got off his bike, pushed her down, and dragged her into nearby woods. There, he sodomized, tortured and eventually murdered her. The defense forensic psychiatrist diagnosed Charlie with Intermittent Explosive Disorder. The prosecutor’s expert psychiatrist vehemently disagreed, testifying that Charlie knew what he was doing, never showed remorse and was an inchoate psychopath. Throughout the trial, Charlie sat expressionless and showed no remorse. The jury took note of that and convicted him of second-degree homicide. Tried as an adult, he was sentenced to 9 years to life.

There is much current research using PET and fMRI scans to view the brains of criminals – especially convicted psychopaths. The results so far are disputable. Any specific findings would eventually have to fulfill *Daubert*, *Kumho Tire*, and *Frye* tests. That day is far off.

But what if brain abnormalities *are* demonstrated in bullies who committed Internet and other crimes, possibly causing a child victim to commit suicide? Would criminal charges lead to convictions and civil suits prevail? Or would biology win out? What role – if any – might forensic child and adult psychiatrists play then?

Stand by . . . ☎

## Animal Maltreatment Evaluation: A Growing Forensic Subfield

Brian Holoyda, MD, MPH, University of California, Davis



Since the 1960's the psychiatric community has identified a link between animal abuse and interpersonal violence. John Macdonald first intro-

duced this link when he described the triad of childhood animal cruelty, enuresis after age 5, and firesetting as predictive of violent behavior in adulthood. His trio of risk factors, later dubbed "Macdonald's triad," received substantial research attention at the time, but was later abandoned due to the paucity of evidence to support a relationship between the triad and later violence. Of the three elements, however, animal cruelty has remained a subject of study as a potentially useful marker of future interpersonal violence. Though current research supports this association, it remains unclear to what degree and via what mediating factors animal cruelty predicts violence. An emerging subfield of forensic mental health, the forensic animal maltreatment evaluations (FAME), takes as its goal to understand animal abusers and the risks that they pose to potential animal and human victims.

FAME pursues the understanding and appropriate evaluation and management of individuals who engage in animal cruelty. A book entitled *Animal Maltreatment* (edited by Levitt, Patronek, and Grisso, 2016) was the first to offer a name to this area of evaluation, despite our community's long-standing interest in and research of animal cruelty. Forensic psychiatric specialists can provide a host of skills necessary for the forensic evaluation of animal abusers, including psychiatric diagnosis and violence risk assessment, to assist the courts in the management of convicted offenders and their animal victims. Forensic psychiatric opinion can aid in deter-

minations regarding whether or not an animal is safe to return to its owner, whether an offender requires mental health treatment and, if so, what type of treatment, whether or not an individual's history of animal cruelty suggests an increased risk of offending against humans, and how such a risk may be mitigated. Courts may ask evaluators to answer questions regarding the causality of animal abuse, recidivism risk, general public safety, and remediation.

FAME is a uniquely multidisciplinary

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*"Though some have argued that bestiality is not a priori a violent or cruel behavior, the veterinarians in the audience clearly felt otherwise."*

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nary field that requires the expertise and coordination of forensic mental health experts and forensic veterinarians. Veterinarians trained in forensic science are able to conduct physical exams, obtain imaging, body fluid samples, and toxicologic screening, and perform necropsy on deceased animals suspected to have suffered from abuse, neglect, or other forms of mistreatment like dogfighting. These assessments determine whether or not there is evidence of cruelty, to propose means by which an animal may have died, and to postulate whether or not the animal suffered due to its treatment. In addition, such evaluations are necessary to aid the forensic psychiatric examiner. Forensic veterinary reports are necessary to fully understand and outline perpetrators' behaviors and motivations, which can clarify for the forensic psychiatrist

the types and severity of animal maltreatment. This information is instrumental for performing a thorough, evidence-based assessment of an animal abuser.

One organization that supports the collaboration of forensic mental health evaluators and forensic veterinarians is the International Veterinary Forensic Science Association. The organization held its 9th annual conference in St. Petersburg, Florida in 2016. Though the organization is relatively small, there were over one-hundred veterinarians and forensic scientists in attendance at the meeting. The audience was easily engaged in learning about relevant psychiatric diagnoses, classification schemes, legal sanctions, and other aspects pertaining to bestiality in the United States. I presented a recently published motivational framework for understanding why offenders engage in bestiality, with motivations including a desire for love and affection, cruel or violent intent, situationally and culturally dictated motivations, and secondary gain, among others (Holoyda & Newman, 2016).

Perhaps most striking at this meeting was the manner in which the audience responded to the discussion of individuals who engage in bestiality. Though some have argued that bestiality is not *a priori* a violent or cruel behavior, the veterinarians in the audience clearly felt otherwise. Perhaps it is their first-hand experience with victims of bestiality – or *animal sexual abuse* as it is known in the veterinary world (Stern & Smith-Blackmore, 2016) – that makes veterinarians so disturbed by this behavior. Indeed, the slides of anatomic pathology resulting from animal cruelty, specifically animal sexual abuse, at the conference were troubling and difficult to imagine having resulted from an individual expressing love for a pet. During the question-and-answer session of my talk, many audience members emphasized the need for more research on this topic to guide legislative efforts.

The IVFSA meeting raised important questions regarding how different

(continued on page 33)

## Predicting Restorability: Present and Future Challenges

Cristina Secarea, MD, St. Elizabeth's Hospital



The forensic literature is unclear on the most consistent influences on the length of time needed to restore inpatients' competence to stand trial (LOR). Some studies – including those conducted by AAPL members – find that a younger age at admission<sup>2-5</sup> and a more severe charge<sup>1,2,4</sup> are associated with an increased likelihood of restorability, while others emphasize the relationship between LOR and IQ<sup>1,2</sup> or diagnosis<sup>1,3,4,5</sup>. Generally speaking, intellectual developmental disorders and psychotic disorders have a strong influence<sup>3-5</sup>, although differences in sample size and population affect the generalizability of data. For example, two of the largest restorability studies in the literature<sup>3,5</sup> agree on some factors that positively influence adjudicative competence, like younger age, female sex, diagnosis of mood disorder, but disagree on what influence psychosis has. Other studies<sup>4,5</sup> do not comment on LOR and only one study<sup>1</sup> focuses on “treatment-specific variables” like medication adherence and “behavioral management problems” like episodes of seclusion and restraint. None of the current studies explore the influence of specific classes of medication or emergency episodes requiring involuntary medication.

In testimony, forensic evaluators can identify some of these factors in an attempt to determine whether defendants are restorable, but the inevitable follow-up question is invariably how much time is needed. For us in the District of Columbia, no more than 180 days is permitted, although this limit differs from state to state.

Consider attempting to predict the restorability for two fictitious patients. One is a younger woman


with a diagnosis of substance use and personality disorder, charged with a felony; no medications are prescribed during her hospitalization and she has received emergency medications during a number of violent episodes. The second patient is an older man with a diagnosis of schizophrenia and cognitive disorder, charged with a misdemeanor, who is prescribed three different classes of medications. He is adherent to his medication regimen and has no violent episodes that extend his hospitalization.

Predicting a shorter LOR for the first patient and a longer LOR for the second sounds like an acceptable assessment. But evaluators may be surprised that these two will restore – in the District of Columbia – in almost the same amount of time, around 50-60 days. How is this possible when factors like age and specific diagnosis predict LOR differently? And which factors should be addressed by their clinical teams during patient's hospitalization for competence restoration?

Younger age and a non-psychotic diagnosis, like substance use and personality disorder, are common factors that shorten LOR. However, if treatment is not vigorous, time to restorability may increase. On the other hand, a team may successfully treat the older psychotic and cognitively impaired patient with mainstream medication protocols and cognitive support. This may consequently place two different patients on the same time course.

In our experience, clinical teams focus on large diagnostic issues while placing less emphasis on those particular symptoms that interfere with competence. As courts call for greater clarity, our research team focuses on the less studied variables that affect competency restoration. Which are the most remediable variables that can decrease time in the hospital or in jail? In our public sector population,

we are studying whether treatment adherence, the presence of emergency interventions, and medication choice yield a triad of factors with a greater effect on restorability. Drawing attention to factors that focus the treatment effort on restoration may be a useful strategy for returning evaluatees to the judicial process.

Cristina M. Secarea, MD is a PGY-3 Psychiatry Resident at Saint Elizabeths Hospital/DBH. 

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### MUSE & VIEWS

#### No Monkeying Around

- Animal rights activists have filed a federal lawsuit against a British nature photographer claiming that the monkey, not the photographer, is the rightful owner of the selfies. According to the activists, 6-year-old Naruto, an Indonesian crested macaque, owns copyrights to the photos and should benefit from any proceeds related to the pictures.

Source: <http://www.facesoflawsuit-abuse.org/2015/10/peta-lawsuit-claims-monkey-not-photographer-owns-selfie-copyrights/>

Submitted by William Newman MD

## Rappeport Fellowship Retrospective: Michael A. Norko, MD, MAR

Britta Ostermeyer, MD, MBA



In this continuing series, we are talking with AAPL's former Rappeport fellows and exploring their career paths. It was a great honor for

me to speak with Michael A. Norko, MD, MAR, AAPL's current President. Dr. Norko received the Rappeport Fellowship in 1986, which was in the second year after its inauguration in 1985. This fellowship honors Jonas R. Rappeport, MD, AAPL's Founder (1969), first President (1969-71), and first Medical Director (1972-95).

Dr. Norko has been a highly influential leader and shaper of AAPL throughout his years as an AAPL member and Executive Council member. He received his undergraduate education at John Hopkins University, receiving a Seal of Excellence for leadership, service, and outstanding contribution to student activities. He attended medical school at SUNY-Upstate Medical Center. This was followed by a psychiatry residency at St. Vincent's Hospital and Medical Center in New York City, where he also obtained a Post-graduate Certificate in Mental Health Administration at the Graduate School of Management of the New School for Social Research. Dr. Norko did his forensic psychiatry fellowship at the Law and Psychiatry Division in the Department of Psychiatry at Yale University School of Medicine, where he has remained as faculty and built a very successful career.

Dr. Norko recalled fondly that Dr. Stephen B. Billick (AAPL President, 2009-10) introduced him to the field of forensic psychiatry, invited him to do research related to voluntary psychiatric admissions, and recommended him for the Rappeport Fellowship, along with the Department Chair, Dr.

Joseph English (APA President, 1992-1993). With some tender feelings, Dr. Norko considers Dr. Billick his "forensic father" and Dr. Robert Sadoff (AAPL Past President 1971-73), who trained Dr. Billick, his "forensic grandfather."

In recent years, Dr. Norko obtained an MAR (Master of Arts in Religion) from Yale Divinity School satisfying a longstanding interest of his and leading him to co-edit a textbook on sexual diversity in the Catholic Church.

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*"So when you get introduced to an organization that way you know, you just kind of sense, that it is a place of true collegiality and friendship... AAPL wants to encourage younger colleagues and help them move into positions of influence..."*

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With great enthusiasm, Dr. Norko recalled his Rappeport Fellowship year. He reported that the annual AAPL meeting that year was in Philadelphia where, back then, the Rappeport fellows were treated like "royal guests" by Dr. Richard Ciccone (past AAPL President, 1986-1987) and his Board Review Course team. "They stopped the meeting to introduce us repeatedly. And there was this man who was walking around with a camera, wearing a flannel shirt, taking pictures. He was just so nice, just so humble and helpful. He was a really nice guy. It was a tremendous experience!" With a tone

of sincere admiration, Dr. Norko shared that he only later discovered that this nice camera man was Dr. Jonas Rappeport himself. Dr. Norko added, "So when you get introduced to an organization that way, you know, you just kind of sense, that it is a place of true collegiality and friendship and it was just a very warm and inviting time for us. I think there is just a spirit that AAPL wants to encourage younger colleagues and help them move into positions of influence that make our systems better — our legal system, our mental health system — better policies, better research. It is just a group of people that has sort of the right spirit... You do not really have to go banging on doors to do this. It is there." During the 1986 AAPL cocktail reception, Dr. Norko described with a gentle smile, "The *Philadelphia Mummers* performed for the attendees ... Their whole performance right in the middle of this big ballroom with us in the middle of the reception!"

When I asked Dr. Norko how the Rappeport fellowship helped him, he stated, "It was much like an apprenticeship. I continued my interest (in forensic psychiatry) and it was sort of like after that, it was just set in stone. I wasn't going to go in any other direction." Dr. Norko explained that his fellowship introduced him to many well-accomplished AAPL forensic leaders who were "most helpful... We spent lots of time with them." Like every Rappeport Fellow, Dr. Norko also had an assigned fellowship mentor. Dr. Melvin Goldzband was his assigned mentor and Dr. Norko stated, "He was kind and warm, kept in touch, invited me out to his home. He was generous with his time helping a young forensic psychiatrist establish connections with older, more established people."

Rappeport Fellowship led to forensic fellowship and later faculty appointment at Yale, where he was trained and mentored by Dr. Howard Zonana (past AAPL President, 1992-93 and past AAPL Medical Director, 1995-2013), and later by Drs. Robert Phillips (past AAPL President, 2004-

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## Ask the Experts: Sitting at the Table

Neil S. Kaye, MD, DFAPA

Graham Glancy, MBChB, FRCPsych, FRCP(C)

Neil S. Kaye, MD, DFAPA and Graham Glancy, MB, ChB, FRC Psych, FRCP (C), will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send question to [nskaye@aol.com](mailto: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 lawyer in a criminal case has asked me to testify as an expert on the effects of alcohol and antipsychotics on the alleged victim, and also to sit with the lawyer during the trial to coach/assist her with questions of witnesses and the opposing expert. Can I do this?



**A. Kaye:**

While there is no prohibition against this, I highly discourage this practice. Specifically, I am against the mixing of roles. The

credibility of the expert would be inherently tainted by the apparent role of non-impartial advocacy when sitting at the defense counsel's table. Lawyers may not immediately see the conflict presented by such "dual agency" and so it is suggested that you discuss with the lawyer what she is hoping to achieve. Your guidance may be just the counsel the lawyer needs. Often, an expert will actually have more courtroom experience than the lawyer when the topic is a complex mental health issue and most lawyers are appreciative of our input.

I had a similar case recently and the lawyer wanted me to address issues related to the victim's use of illicit drugs and alcohol with her

antipsychotic medications, but without allowing me to examine the victim. I declined noting that unless the victim specifically refused to be interviewed, to opine on her condition and the effects of her mental illness based solely on a list of medications and a purported diagnosis would be below the accepted standard of care. The judge threatened me with contempt of court, but I held my ground and noted that while I could address things in the hypothetical, such an opinion was unlikely to be of real use and would easily be grounds for an appeal. After I sat in court for a few hours, the judge finally agreed to excuse me.



**A. Glancy:**

If the retaining counsel retains you to address the effects of drugs and alcohol in conjunction with antipsychotic medications, in

the hypothetical, there is no reason why he should not do this, if you feel qualified to do so. If you then do a report and possibly testify regarding your opinion, there is no reason why you should not sit with the lawyer in order to listen to and help prepare a cross examination of the opposing expert. If on the other hand you would be more comfortable interviewing the evaluatee, you should not be seen sitting at the table with the lawyer since this gives an appearance of advocacy. A cornerstone of the AAPL ethics guidelines is the striving for objectivity and honesty, and this should always guide our professional life.

The forensic psychiatrist acting as an evaluator and as a consultant might be considered a dual role. It does however appear to be contemplated in the landmark decision *Ake v Oklahoma* (470 US 68 (1985)). It may well be that lawyers have less difficulty with it than we forensic

psychiatrists have.

In Canada it seems to be less of an issue, and it is not uncommon practice for the forensic psychiatrist to sit at the table with the lawyer, often at the stage where a particularly important witness, such as the evaluatee, is testifying. Occasionally one has the opportunity to see the opposing expert testify and perhaps help prepare the cross examination. I have never known anyone to have a difficulty with this, and it never has been an issue to my knowledge. However even as I write this I can see the wisdom of Dr. Kaye's advice and I am in the process of revising my opinion.

**Take Home Points:**

Dual agency is often a delicate balance and an issue that demands an expert's vigilance. Expert witnesses and lawyers often appraise this issue differently and the pressure for an expert to stretch this boundary is a common occurrence in litigation. (P)

## Truth and Corrections

*continued from page 4*

We hope this experiment will form the nidus for discussion and interrogation of the potential pros and cons of such a prototype. I will, of course, also attempt some further considerations of the search for truth in my presidential address.

And we hope that your contributions will enlarge upon these inquiries and extend their reach. Submissions that manage to combine the search for truth with the corrections initiative will naturally get bonus points, which, if nothing else, may be redeemed for warm appreciation and a hardy handshake from your president (of AAPL... just to be clear).

The deadline is March 1 – submit early, submit often. And get excited. (P)



## American Medical Association 2016 Interim Meeting Highlights

Barry Wall MD, Delegate, Jennifer Piel MD, JD, Acting Alternate Delegate, Young Physician Delegate, and Tobias Wasser MD, Young Physician Delegate

The American Medical Association's (AMA) November 2016 Interim Meeting was held in Orlando, Florida, and focused on advocacy, public health, and education. Coming days after the 2016 political elections, AMA President Dr. Andrew W. Gurman, focused his presidential address on physicians' responsibilities to our patients and profession regardless of political climate. In his speech, he incorporated principles from the revised AMA Code of Medical Ethics, which was approved at the AMA Annual Meeting in June 2016, to lend support of his main point: advocacy is a professional responsibility. He gave examples of recent successful advocacy positions put forth by the AMA, including the AMA's leadership to end the opioid epidemic.

Dr. Gurman honored Dr. Bennet I. Omalu with the Distinguished Service Award for his work discovering chronic traumatic encephalopathy (CTE) in American football players. A forensic pathologist, Dr. Omalu spoke to the House of Delegates on seeking the objective truth and advocating for one's position, even under adversity. AMA delegates passed a resolution to support research into the detection, causes, and prevention of injuries from conditions such as CTE.

Dr. Patrice Harris, a child and forensic psychiatrist and AAPL member from Georgia, continued in her role of Chair of the AMA Board of Trustees. She hosted a reception to thank her supporters from the Section Council on Psychiatry and the Georgia delegation. Among her recent accomplishments, she chairs the AMA Task Force to Reduce Opioid Abuse. At the Interim meeting, the AMA passed additional resolutions aimed to further this cause, including efforts to continue funding for state prescription drug monitoring programs (PDMPs) and that the AMA

work to improve interstate operability of PDMPs.

The meeting was held 15 miles from the site of the June 2016 Pulse Nightclub mass shooting, which left more than 50 people dead. Reference to this and the AMA's response was a recurrent theme at the Interim meeting. Drawing on AMA policy from June 2016, including efforts to declare gun violence as a public health crisis, delegates passed a resolution calling for the AMA to issue a report on the organizational actions taken on AMA policies regarding removing restrictions on federal funding for firearms research and suggestions for future actions. Also passed was a resolution in support of the recommendations in "Firearm-Related Injury and Death in the United States: A Call to Action from 8 Health Professional Organizations and the American Bar Association," published in the *Annual of Internal Medicine* (April 2015). The American Psychiatric Association assisted in this publication, which aims to reduce health and public health consequences of firearms.

Of particular interest to AAPL members, the AMA passed a resolution to oppose detention or incarceration of juveniles less than 18 years of age in adult criminal justice facilities. Of note, the AMA has had several existing policies aimed at legal and judicial reforms to prevent incarceration of children in adult prisons or pretrial confinement facilities, which can be found in the AMA Council on Science and Public Health's report on Juvenile Justice Reform, issued at the June 2016 meeting. The new policy fills a gap by addressing reform for children currently detained in adult facilities. The AMA also passed policy to advocate for improved access to care for juveniles and adults in the correctional system, as well as efforts to improve payment to health care

professionals providing services to justice-involved patients. The policy calls for action to improve Medicaid eligibility and coverage upon release from correctional facilities.

The AMA delegates passed several resolutions aimed at increasing access to mental health and substance use assessment and treatment: improving mental health at colleges and universities for students; support of mental health and community partnerships for culturally competent care; advocating for removal of "fail first" policies (e.g., requiring a patient to fail an outpatient program before eligibility for higher level of care) by some insurance companies and others for addiction treatment; promoting integrated primary care and mental health training in residency; and urging state medical boards to refrain from asking applicants about histories of mental health or substance use conditions, but rather focus on impairment. The AMA reaffirmed existing policies on raising awareness and treatment for persons at risk for suicide.

In the wake of the recent political election and concern for possible changes to U.S. immigration policies, AMA delegates directed the organization to issue a statement of support of U.S. health professionals, including those training as medical students, residents, or fellows, who are recipients of the Deferred Action for Childhood Arrivals (DACA) status. Many medical schools have welcomed applications and accepted for matriculation "DREAMers," which are undocumented immigrants who were brought to the U.S. prior to age 16 and have been raised and educated in the county for more than five years. The policy aims to preserve DACA student continued participation in their health-related program.

With the recent elections, six states (California, Colorado, Montana, Oregon, Vermont and Washington) and Canada now allow some form of physician-assisted death. The AMA is therefore reviewing its current policy prohibiting physician participation in assisted suicide. At this meeting, the AMA Council on Ethical and Judicial

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## Proposal: A Committee on Recovery in Forensic Mental Health Care

Sandy Simpson, MBChB

Recovery is now the predominant paradigm in mental health services, as noted internationally by organizations such as SAMHSA in 2006 and the Mental Health Commission of Canada in 2009. The core principles of recovery for people with mental illness are hope, mastery, respect and autonomy. Recovery is the journey a person with a mental illness is on; recovery with, rather than recovery from, the challenges imposed by mental illness. Services for people with SMI need to be developed to assist and support the person-in-recovery, and can be designed and evaluated to see how well they enhance recovery<sup>1</sup>.

There is a small but building literature about recovery in forensic psychiatry<sup>2-6</sup>. Whilst earlier literature suggested that there may be an antithetical relationship between recovery principles and the forensic needs for security and safety, more recent literature describes ways in which security and recovery need not be seen as in conflict, and that recovery tasks begin wherever the patient's journey happens to begin. There are theoretical reasons, and initial evidence, that suggest that attending to recovery principles in forensic mental health services will increase patient engagement, therapeutic alliance and trust. This suggests ways we can deliver rehabilitative services that enhance recovery and the quality of outcomes for forensic patients-in-recovery.

Recovery tasks for forensic patients may be more complex than recovery for patients in general mental health. Dorkins and Adshead<sup>7</sup> describe that in addition to the recovery tasks for people living with serious mental illness, recovery for forensic patients is also a moral journey: how do I live better so as not to harm others? The challenge for forensic psychiatry is to determine how best to help people with these tasks.

Legal scholars have begun to con-

sider the demands of the therapeutic aspects of law under the rubric of therapeutic jurisprudence<sup>8</sup> but much more cross discipline research is needed to address how legal frameworks and specialist tribunals can be responsive to the demands of recovery oriented services.

### Why have a Committee on Recovery?

There is currently no committee of AAPL dedicated to therapeutic processes and outcomes that considers recovery issues. Mullen argues that forensic psychiatry is at risk of being "impoverished" if not informed by and rooted in clinical practice of the care and rehabilitation of forensic patients<sup>9</sup>. Seen in this way, studying the outcomes of forensic rehabilitation is a vital area of work for AAPL. What is the range of treatment needs of forensic patients? How effective are our treatments? How are they experienced? What enhances or impedes recovery? How do recovery concepts and legal systems interact?

Implementing recovery involves new partnerships and approaches to care: advocacy, peer support workers, new methods of care planning such as collaborative care planning and advance directives, relationships with family and issues of victim accountability. New methods of measurement of the domains of recovery have been published and applied in forensic settings<sup>2-4</sup>. There is little literature on the application of peer workers in forensic mental health, although these models of care are slowly developing. Victim relationships and responses are relatively unexplored in literature or in practice<sup>10</sup>

Because there is no committee of AAPL that currently attends to these issues, it is proposed that a new committee be established with the following mission:


To address the definition of recovery in forensic settings and encourage discussion of models of recovery ori-

ented forensic practice;

To promote the study and measurement of recovery in forensic settings;

To promote the study of outcomes of recovery based forensic services;

To consider models of victim-perpetrator restitution in forensic psychiatry.

Recovery is promoted in different ways in different state and federal jurisdictions, and internationally. There is great opportunity for learning and supporting innovation in forensic services and developing clinical collaboration and learning and research opportunities amongst AAPL members. I would welcome greatly hearing from colleagues interested in joining a Committee on Recovery in Forensic Mental Health Care. Please email me with your interest at Sandy.Simpson@camh.ca. 

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# Reorienting Forensic Psychiatry

Reena Kapoor, MD, Community Forensics Committee

A few months ago, I was seated beside a young British forensic psychiatrist at a conference luncheon. We made polite conversation, inquiring about each other's professional lives. Dr. A (as we shall call him) enthusiastically told me about his recent good fortune; he had been invited for an interview at Broadmoor Hospital, one of England's high-security psychiatric treatment facilities. As an American forensic psychiatrist, I was puzzled. Why would this interview be such good news?

"It's a very prestigious post,"

Dr. A explained.

Again, I was confused. In my experience in the US, maximum-security hospital jobs are not particularly attractive to young forensic psychiatrists, and the word "prestigious" is rarely used to describe them. I asked Dr. A what drew so many forensic psychiatrists to Broadmoor.

"It's pretty simple, really. That's where the sickest patients are, so that's where we need the best doctors," he replied.

My mind was blown.

This young man had given me a window into a major cultural difference between U.S. and U.K. forensic psychiatry. He went on to explain that, in the U.K., forensic psychiatrists are sometimes called "the surgeons of psychiatry," and the ability to treat the most difficult patients is seen as a badge of honor. Court reports (their term for forensic evaluations) were a necessary part of the business of patient care, but mastering them was not seen as a goal in and of itself. Expert testimony was viewed similarly. As Dr. A explained, the patient's treatment was the main objective, as would be expected for any doctor.

Who knew?

This conversation with Dr. A has stayed with me for several months now, leading me to marvel at the different viewpoints about professional opportunities for forensic psychiatrists in the U.S. and U.K. In particu-

lar, I have wondered whether American forensic psychiatry fellows could ever see treatment of forensic patients as an important career goal. In my experience at Yale, the fellows have pursued forensic consultation most passionately, seeing treatment in maximum-security hospitals, correctional facilities, and community programs as (at best) a stepping stone on a career path ultimately leading to high-profile expert witness work. Treatment of forensic populations is still viewed, in large part, as the stepchild of "real" forensic psychiatry.

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*"It's pretty simple, really. That's where the sickest patients are, so that's where we need the best doctors..."*

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This attitude about forensic treatment has existed at least since I was a general psychiatry resident 10 years ago. When I was considering entering the field, graduates of forensic fellowships warned me that the training rarely led to enhanced career prospects. As they put it, "Fellowship is a great year.... You learn a lot, and at the end of it you're extra qualified for a state hospital job that you could have gotten the minute you graduated from residency." It was clear that treating forensic patients was not seen as a promising career move, certainly not for psychiatrists of a certain caliber.

In the years since then, I've enjoyed my work in a number of forensic treatment settings, and I've remained curious about why the jobs are relatively unpopular. I asked senior members of AAPL about forensic treatment's place in the organization, and they explained that treatment was not originally intended as part of AAPL's mission. Correc-

tional psychiatry was only added to the organization's main focus—expert psychiatric evaluations for legal purposes—in order to gain formal subspecialty recognition from the American Board of Psychiatry and Neurology in the 1990s. Today, AAPL considers itself a "professional home" for correctional psychiatrists, but its focus remains primarily on the courtroom. For example, in the 2015 AAPL Annual Meeting, less than 10% of the almost 200 presentations focused on treatment of forensic populations (AAPL 2015). This lack of attention to forensic treatment is not limited to AAPL, as Ken Appelbaum recently noted. In the journal *Psychiatric Services*, 9 of the 158 papers published in 2015 addressed correctional psychiatry or the criminal justice system, and just 3 of 155 in the *American Journal of Psychiatry* focused on these topics (Appelbaum 2015). The American Psychiatric Association (APA) has identified the advancement of correctional psychiatry as a priority for over 40 years (APA 1974), but forensic treatment systems still struggle to recruit competent mental health professionals. In short, forensic treatment is an underserved area, and forensic populations remain marginalized, stigmatized both by serious mental illness and by criminal justice involvement.

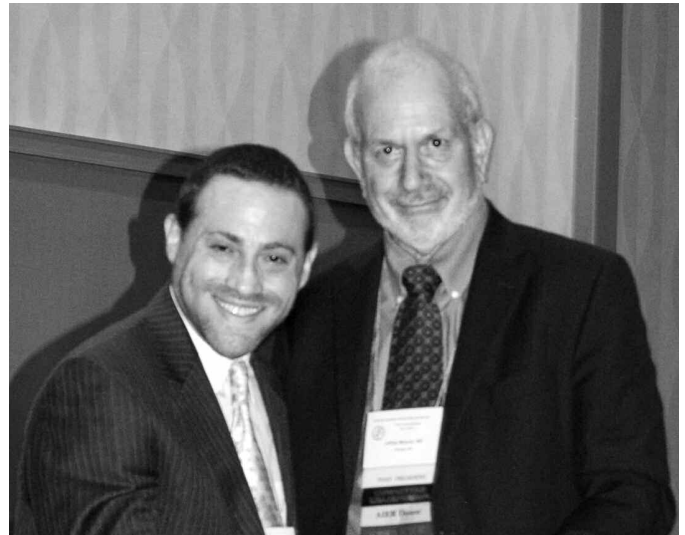
Despite this discouraging data, there are reasons to believe that attitudes are changing. Forensic psychiatry is beginning to embrace a focus on individuals with mental illness in the criminal justice system more broadly, not just in the courtroom. This past year, AAPL's Institutional and Correctional Psychiatry committee split into two committees, Correctional Forensic Psychiatry and Forensic Hospital Services, because of the high level of interest in both topics. In addition, the Community Forensics committee (co-chaired by Merrill Rotter and me) was born, largely in response to the challenge posed by 2014 AAPL President, Debra Pinals, for members to become more involved in public policy, program design, and treatment of forensic

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# PHOTO GALLERY



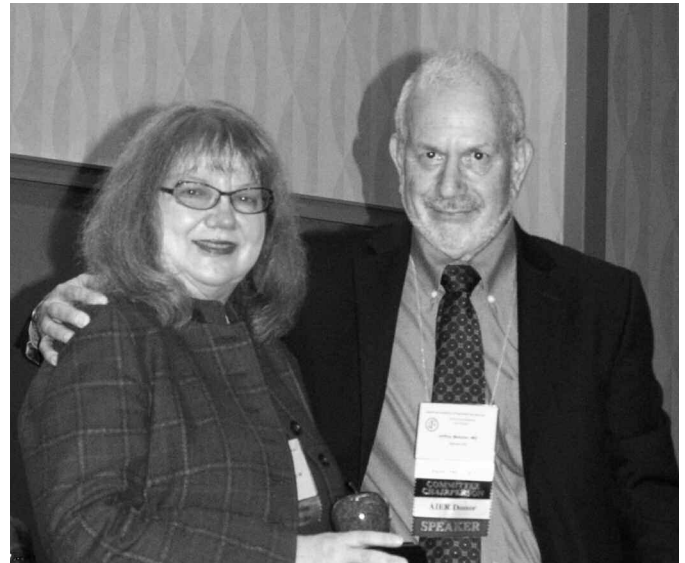
Jeff Janofsky and Emily Keram



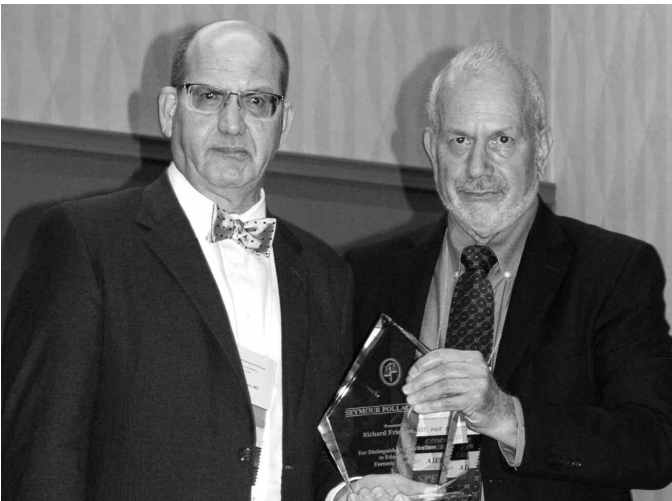
Jeff Metzner giving Ryan Shugarman the Award for Outstanding Teaching in Forensic Fellowship Program



Jackie Coleman accepting the Amicus Award on behalf of Kristin Loney, AAPL Executive Assistant



Marilyn Price receiving the Red Apple Award



Richard Frierson receiving the Seymour Pollack Award



John Bradford receiving the Golden Apple Award

# PHOTO GALLERY



Seth Judd receiving Young Investigator Award from Andrew Kaufman



Samuel House receiving the 2015 Poster Award



Sally Johnson with Emily Keram



2016 Class of Rappeport Fellows with Committee Chairs, Susan Hatters Friedman and Britta Ostermeyer



Incoming President Mike Noroko addresses the assembly



Incoming AAPL Officers

Photo Credit: Eugene Lee, MD

## The Tell-Tale Trial

Anthony Tamburello, MD

One evening not long ago, I learned that my daughter was working up a statement to present to her eighth grade advanced literature class to prosecute the narrator of Edgar Allen Poe's *The Tell-Tale Heart*. The apparent lesson plan was to conduct a mock trial during which each student would present a case, either that the protagonist was mentally ill and should be acquitted as not guilty by reason of insanity, or that he was a murderer who should receive his just desserts. Well, that certainly caught my attention. The dinner conversation became an excited sampling of the history of the insanity defense, as well as the methods of inquiry, analysis, and forming opinions on it that I have learned during fellowship, in the Forensic Review Course, and elsewhere over the years. When Virginia responded with interest and curiosity, I offered to contact her teacher about making a guest appearance to supplement the mock trial.

Ms. Schmus accepted, sending me a copy of the same materials provided to her students. It had been some time since I had read the story. To summarize,<sup>1</sup> the unnamed narrator (nicknamed Oswald Cobblepot by some of the students) shared a residence with a man with whom he had no quarrel, except that he disliked his housemate's eye. This distressed him to the point that he plotted over several days to kill the proprietor of the offending oculus, eventually doing so, then hiding the remains under the floorboards. When the police came to investigate a noise complaint related to the commotion, our narrator showed them all was in order and contrived a story about the victim's whereabouts. Just as the authorities were seemingly satisfied and about to leave, Cobblepot, worked into a state of agitation by what he perceived to be the sound of the old man's heart coming louder and more insistently through the floor, confessed to the crime:

...I knew that the sound was not in my ears, it was not just inside my head... It was a quick, low, soft sound, like the sound of a clock heard through a wall... Louder it became, and louder... No! They heard! I was certain of it. They knew! Now it was they who were playing a game with me... Suddenly, I could bear it no longer. [Ref. 1, p. 67]



So I took the morning off from work and attended the two classes participating in the mock trial in separate periods. While I would have enjoyed facilitating a court-style experience, I thought it best to not interfere, and the format was actually quite straightforward: a case was presented by a lead prosecutor, followed by a few minutes of supporting arguments each by half of the classmates, then the same was done by the defense. There were different juries for each period comprising teachers, administrators, and the school resource officer (who sat for both). Once every student there had the opportunity to speak, the jury deliberated outside the classroom and returned with a verdict.

During the presentations, I was just an observer. Though I did not expect the children to know much about either psychiatry or the law, I was impressed with the effort and energy they invested into the exercise. Some, while not quite right, had clearly done their research, such as

the defense argument that the narrator acted like a "wild beast" and was thus legally insane. Ms. Schmus provided them a Medscape article for supplemental reading, "Portrait of a Psychopath,"<sup>2</sup> which was about the BTK serial killer who perpetrated a string of ten murders between 1974 and 1991. It discussed the "mask of sanity" of psychopaths living among us. Many of the students took this to mean that these individuals' mental health is a façade, and that they actually have a deep-seated illness, and as such, argued in his defense that Cobblepot wore such a mask.

After the jury left, I had the remainder of the time available to share my perspective. In preparing for the day, I discovered a fascinating backstory. I concretely observed that *The Tell-Tale Heart* was originally published in 1843,<sup>3</sup> the same year of the M'Naghten decision.<sup>4</sup> As it happens, Poe's interest in the insanity defense is well known and often discussed in literary circles.<sup>3</sup> There were two highly publicized insanity defense cases: James Woods and Singleton Mercer, both of whom were acquitted on the basis of insanity around that time in Philadelphia. In fact, the Mercer case may have received more public attention in the United States than M'Naghten.<sup>3</sup> A comment on the James Wood trial in a local newspaper account on April 1, 1840 is attributed to Poe. He suggested there that (likely influenced by similar writings by his contemporary Isaac Ray), the outward signs of rationality exhibited by Wood as he procured the pistols used to kill his daughter (in contrast to his typically anxious nature) was the best evidence of Wood's insanity.<sup>3</sup> The parallels between this account of Wood and the narrator of *The Tell-Tale Heart* lead to a reasonable conclusion that Poe had a similar view of the latter.

Poe was a writer, not an alienist, and even if he had been, he had no access to our accumulated knowledge on mental illness, psychopathy, and related jurisprudence. Nevertheless, *The Tell-Tale Heart* illustrates the views of an intelligent and engaged

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## Workplace Violence Among Returning Vets with PTSD

Stuart B. Kleinman, MD, Trauma and Stress Committee

Many of the soldiers who were deployed to Afghanistan and Iraq have suffered severe trauma<sup>1</sup>. A 2008 RAND<sup>2</sup> study indicated that of approximately 1.7 million troops who had been deployed in Operation Enduring Freedom (Operation New Dawn, as of September 2010), and Operation Iraqi Freedom, approximately 50% had a friend who was seriously wounded or injured, 45% witnessed dead or seriously injured non-combatants, and 45% witnessed an accident resulting in serious injury or death. Moreover, approximately 23% reported being physically moved or knocked out by an explosion, approximately 18% reported having a blow to the head from any accident or injury, and approximately 10% reported engaging in hand to hand combat.

The prevalence of post-deployment PTSD amongst United States' soldiers who have served in Iraq and Afghanistan is significant, but uncertain. Rates vary largely with sample type and assessment methodology, ranging from 1.6%, amongst 41,561 marines active in Iraq and Afghanistan measured via the PCL (using ICD 9-CM definition)<sup>3</sup>, to 50%, of 338 Veterans Administration affiliated veterans<sup>4</sup>, assessed via the Primary Care-PTSD screen (II and III). The only study specifically designed to represent the deployed force revealed a prevalence estimate of 14%<sup>2</sup>. Potentially particularly relevant to development or expression of later workplace problems, up to 44% of soldiers who were deployed to Iraq and reported experiencing a loss of consciousness following head trauma may develop PTSD<sup>5</sup>.

Active duty members return to, or enter, the civilian workplace at the end of their enlistment. National Guard members, for example, do so either 14 days (with service of 31 to 180 days) or 90 days (with service of 181 or greater days) following return

to the United States. Unfortunately, little is currently known about *how* laws, i.e., the Uniformed Services Employment and Reemployment Rights Act, specifically, and the Americans with Disabilities Act (ADA), generally, designed to protect veterans against employment discrimination, are applied to their psychiatric difficulties, especially difficulties potentially associated with their acting violently in the workplace. With the changes to the PTSD diagnostic criteria contained in the DSM-5, there is now both: 1) more specific basis for evoking the 'direct threat' exception to the ADA, yet, perhaps, 2) also greater basis for regarding PTSD which generates potential workplace violence as a condition meriting, if not requiring, reasonable accommodation. Unlike the DSM IV, the DSM-5 directly links violent behavior with PTSD (Criterion E1 states: "Individuals with PTSD may be quick tempered and may even engage in aggressive verbal and/or physical behavior with little or no provocation (e.g., yelling at people, getting into fights, destroying objects"), (p275).

At one time, there was significant concern among some that the psychological injuries, particularly the newly recognized diagnostic construct of PTSD, suffered by those who had served in Vietnam would create a rash of serious criminal behavior. Demonstrating otherwise, Shaw *et al.*<sup>7</sup>, found there was no greater prevalence of PTSD amongst incarcerated than non-incarcerated felons, and a Bureau of Justice Survey<sup>8</sup> of state prisons found that violent crime did not occur more frequently amongst Vietnam veterans than non-veterans. Of course, as Shaw *et al.* note, in particular instances, traumatic stress, as in the seminal case of *State of Louisiana v. Charles Healds*<sup>9</sup>, may generate violent behavior, including, specifically, dissociation-based lack

of *mens rea*.

Creating psychological, and potentially legal, complications, certain personality or psychological constellations which may contribute to some seeking military service may also render individuals especially susceptible to developing PTSD. Whether, or how, to potentially accommodate workplace problems displayed by such individuals would to a significant extent depend upon the relative role of personality-based variables in producing impairing or threatening behavior. Determining the origin of such behavior may be very difficult, especially as personality-based variables and PTSD symptomatology may reciprocally and dynamically interact.

Further complicating assessment of the relationship between military-induced PTSD and violence, although increased criminal behavior did not occur in conjunction with service in Vietnam, veterans with PTSD were seemingly at some increased risk of acting violently. Beckham *et al.*<sup>10</sup> found that such veterans averaged committing 22 acts of violence annually, versus 0.2 acts by veterans without PTSD. Similarly, McFall *et al.*<sup>11</sup> found that veterans receiving inpatient treatment for PTSD were in the four months prior to initiating such treatment, approximately seven times more likely to have committed acts of aggression than veteran inpatients without PTSD. Additionally creating concern regarding interpersonal violence, Beckham *et al.*<sup>10</sup> found that 57%, of 118 help-seeking veterans studied reported engaging in six or more self-reported interpersonal violent acts in the prior year. A study of 265 male combat veterans<sup>12</sup> which employed structural equation modeling, more specifically found that "PTSD symptoms were directly associated with higher levels of aggression" (p141), and that dysphoric, but not anxiety, symptoms partly accounted for such. Combat exposure was not, however, directly associated with aggression, suggesting that the aggression supported or enhanced by military training, and potentially

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## Workplace Violence

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adaptive in combat situations, does not, per se, create persistent aggression.

As with many studies of veterans, the Taft *et. al.* study<sup>12</sup> did not attempt to discern the role of compensation-seeking in how the veterans presented their symptoms. All studied were applying for some form of disability status. Additionally confounding, memories of combat experiences, even when genuinely reported, may change over time, including as a function of PTSD<sup>13</sup>.

Taft *et. al.*<sup>14</sup> further attempted to determine the mechanism by which PTSD may contribute to aggression. Again using structural equation modeling, they studied 1168 individuals who had served in the Vietnam theater of operations from 1964 to 1975. All were involved in Veterans Administration programs in psychiatry, substance abuse, PTSD, and readjustment counseling, and psychophysiologicaly assessed, including with measures of response to visual and auditory stimuli. Specifically of concern to the workplace:

1. 65.4% endorsed having been “verbally abusive.”
2. 42.2% endorsed having “threatened someone with physical violence (without a weapon).”
3. 23.4% reported having destroyed property.
4. 24.3% reported having had a fight.
5. 11.5% endorsed having “threatened someone with a weapon.”
6. 4.4% endorsed having “used a weapon against someone.”

This study did not identify toward whom, and in what settings, the above violence occurred, although data do support a specific association between PTSD and domestic discord, including domestic violence<sup>15</sup>.

Important for both treatment, and risk assessment, hyperarousal cluster scores in the above study best explained the relationship between PTSD symptoms and aggression, with alcohol use accounting for this associ-

ation. Psychophysiological reactivity was not in and of itself determined to mediate the effects of hyperarousal symptoms on aggression. Moreover, a negative association was found between avoidance/numbing phenomena and aggression. The article’s authors, however, caution that the overlap of DSM IIIR symptom clusters may have produced a spurious negative association.

Jakupcak *et. al.*<sup>16</sup> specifically investigated anger and aggression among Iraq and Afghanistan veterans, retrospectively studying 117 veterans who presented “with a variety of concerns” (p947) to the Deployment Health Clinic of the VA Puget Sound Health Care System between 2004 and 2005. The veterans’ specific reasons for seeking treatment were not available. Acts of aggression identified included:

1. Destroying property.
2. Threatening violence—with or without a weapon.
3. Physically assaulting another person.

After accounting for alcohol use and combat aggression, veterans with symptoms of PTSD exhibited significantly increased levels of anger, hostility and aggression. Over one half of the veterans in the PTSD-group (53.2%) and the sub-threshold group (52.4%) endorsed at least one act of aggression during the preceding four months, compared to 20.4% in the non-PTSD group. The modal number of aggressive acts was one. Significant to risk assessment, the group with PTSD reported significantly greater trait anger and hostility, but not more aggression, than the sub-threshold PTSD group. For many reasons, no one reliably knows the prevalence of significant sub-threshold PTSD symptoms among those who have served in Iraq and Afghanistan.

Once more confounding study interpretation, symptoms were based on self-report; no effort was made to control for potential compensation-seeking. Similarly central to assessment of risk of violent behavior amongst combat veterans, Beckham *et. al.*<sup>10</sup> additionally reported that cur-

rent alcohol problems (weakly studied via use of CAGE) were not specifically associated with self-reported interpersonal violence amongst 118 Vietnam combat veterans.

The above studies reasonably generate attention to the potential for some returning veterans plagued by severe PTSD, and other difficulties, to act violently in the workplace. Ultimately, however:

1. The risk of a particular individual doing so remains case specific; and
2. The type of psychiatric disturbance, and associated level of risk of violence an employer is willing to tolerate, and, perhaps, required to accept, is a function of employer-defined policy and dynamically evolving legal interpretation. ☹

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## Internet Crimes Against Children: A Forensic Analysis

Karen B. Rosenbaum, MD, R. Gregg Dwyer, MD, EdD,

D.J. Barton, MCJ, J. Paul Fedoroff, MD

*Liaison with Forensic Sciences Committee and Sex Offender Committee*

The Liaison with Forensic Sciences and the Sex Offender Committees created a joint presentation for the 2016 AAPL Annual Meeting entitled Internet Crimes Against Children: A Forensic Analysis. The panel included a featured guest speaker, Lieutenant D. J. “Bo” Barton, who is board certified in Criminal Investigative Analysis, currently assigned to the Behavioral Science Unit of the South Carolina Law Enforcement Division (SLED) as a criminal profiler. The panel also included Karen B. Rosenbaum, MD, chair of the Liaison with Forensic Sciences Committee; R. Gregg Dwyer, MD, EdD, Associate Professor at the Medical University of South Carolina (MUSC) Department of Psychiatry and Behavioral Sciences, and Paul Fedoroff, MD, Professor of Psychiatry at the University of Ottawa.

One of the goals of the Liaison with Forensic Sciences Committee is to facilitate and enhance collaboration between forensic psychiatrists and forensic scientists from different disciplines. The Forensic Psychiatry and Behavioral Science Section of AAFS is one of only eleven recognized sections in the organization. Many topics of interest to these organizations and AAPL involve the contribution of psychiatry to the other disciplines.

The Internet has been a vehicle for the distribution of child pornography since its inception. The Internet provides anonymity, ease of access, and apparent safety. While in the past, offenders typically operated in a specific geographical area, they now have practically unlimited ability to contact potential victims. With relative ease, these offenders can use the Internet to anonymously contact and prepare numerous children for exploitation.

Nielsen et al (2011) suggested that, “The growth of the Internet and

access to it has allowed those with an interest in child pornography to view and disseminate this material without interpersonal contact [of children].” The authors also surmised that the “advent of the Internet” promoted the interest in people who may otherwise not have had it and would not have sought it out, but were “attracted by apparent anonymity of the Internet and the range of available material.”<sup>1</sup>

Although there are several theories about who engages in Internet based sexual offending against children, there is not a universally accepted profile. Similarities and differences have been discovered among and between those who engage only in the downloading and exchange of sexually explicit material depicting underage youth and those who either engage in online sexual activity or attempt to meet in person for sexual activity. There are also distinctions between those who engage in offending behaviors that involve only pre-pubescent children and those who include peri-pubescent youths. Studies to date, which have been limited in size and scope, have reported the following themes:

Most people arrested due to offenses involving all types of behaviors have been male. Of those who have engaged in use of sexual explicit material depicting prepubescent children, the majority have admitted or been found to be sexually aroused by prepubescent children and meeting the DSM-5 diagnostic criteria for pedophilic disorder. Those with only online offending behaviors tended to have no other criminal history, have a higher education level and be less aggressive than those who engaged in physical contact offenses. Based on peer-reviewed findings to date it is likely there are different categories or types and each offender that will require different approaches to pre-

vention, identification, investigation, and treatment.

Henshaw et al (2015) reviewed the current literature on the topic of “Online Child Pornography Offenders.” The authors found that in general, online child pornography offenders (CPOs) were relatively high functioning and generally pro-social individuals with less extensive and diverse offending histories than contact offenders. CPOs also showed high levels of sexual pre-occupation, deviant sexual interests and deficits in “interpersonal and affective domains” compared with contact offenders.<sup>2</sup>

Lt. Barton described two distinct types of Internet child sexual offenders, and coined the terms “Dilettantes” and “Connoisseurs” to describe them. He said these categories have helped efforts to apprehend offenders. He defined the “Dilettante” as an adult who may be impulsive and curious, who has recently discovered the wide world of the web, or a curious adolescent simply searching for pornography online. These offenders may break the law while on the Internet, and consequently should be investigated and prosecuted. They typically have shorter online chats with their potential victim, and are usually quick to start chatting about sexual activity. They are usually explicit during discussions about sex, are less fantasy driven, and tend to use sex for immediate satisfaction. They usually have a reason or excuse for getting out of the chat once the cyber sexual act is finished.

In contrast, the “Connoisseur” is more likely to be found in the range of “preferential offenders.” They are primarily fantasy driven, and their behavior is continuous, repetitive and predictable. They are more likely to travel to meet their potential online victim. However, sometimes they may be simply satisfying their fantasies for children by masturbating, either during the chat or re-living the event at a later time. The Connoisseur may engage in long chats involving material unrelated to sex. This “grooming” approach involves asking

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## Royal College of Psychiatrists Forensic Faculty Annual Conference Glasgow 2016

Mary Whittle MD, Nicola Swinson BSc, MBChB, PhD, John Baird MD,  
Carolina Klein MD, International Relations Committee

The Forensic Faculty of the Royal College of Psychiatrists held its 2016 residential conference in Glasgow in early March, where about 470 delegates enjoyed a varied and lively program over three days.

The city of Glasgow is proud of its traditions and its reputation and, in certain respects, its history has similarities to that of Chicago. Its origins go back to the beginning of the industrial revolution, with trading, manufacturing and heavy industry. The tobacco trade came first in the 18th century and considerable wealth was accumulated in the city by a group who became known as "Tobacco Lords." American independence, however, saw the end of this period but heavy industry took over from early in the 19th century. Shipbuilding and other related industries, such as the manufacture of railroad engines, flourished during the period when the British Empire was the pre-eminent political grouping in the world. As a result, Glasgow was considered the second city of the Empire at the end of the 19th century.

During the first decade of the 20th century, approximately one third of all the ships afloat across the world had been built in Glasgow's numerous shipyards. This huge industry led to an increase in population and an influx of economic migrants, particularly from Ireland. A slow decline began around the time of the First World War, and by the 1970s the shipyards had all but gone, with little industry to take its place, even to this day. As can occur in a community which grows and prospers rapidly, with a large, predominantly male workforce, a "macho" culture developed with heavy drinking, violence and crime.

The background of the city gave a lead in to the first session of the con-

ference, which addressed the problem of violence. The audience benefited greatly from a talk in which violence was examined from a much broader perspective than merely that of forensic psychiatry. The evolution of social attitudes to violence was considered. For example, it is only in recent times that the offense of rape has been recognized within marriage and, until relatively recently, domestic violence was a term used mostly to describe civil disturbances. The speakers, from complementary perspectives, went on to look at strategies to reduce violence, including gender equality, fair and efficient law enforcement, a healthy community and technology, such as CCTV, all having a part to play. The benefits that can follow from mobile phone technology were highlighted and the audience was reminded that, of the seven billion people on the planet, 6 billion have access to a mobile phone, while only 4.5 billion have access to a functioning toilet. The implications of this technology to law enforcement are considerable.

Next came a discussion of individual aspects of antisocial behaviour and violence, with examination of the adverse effects of childhood trauma and neglect and the consequences in adult life, particularly for younger men, of long-term unemployment and a lack of purpose and hope. These factors can readily predispose to what was termed the "perfect storm" for violence, namely, loss of temper, drunkenness and access to a weapon. The social history of Glasgow and the consequences of unemployment for a generation of working men was presented as the reason why historically the homicide rate in Glasgow was twice the average for the United Kingdom. Among vulnerable and disadvantaged groups sui-

cide, addiction problems and early death were also much more common, although within the last decade there have been a number of interventions to reduce violence and the homicide rate has more than halved.

In the afternoon, the Investigating Law Enforcement Officer and a forensic psychiatrist gave powerful presentations that examined the case of a well-known UK show business "celebrity," Jimmy Saville, who during his life enjoyed the status of "national treasure" and who mingled with establishment figures at the very highest level. Following his death at the age of 84 in 2011, Mr Saville was found to have been a prolific and indiscriminate sexual abuser from his teenage years, leaving behind hundreds of victims. His sexual abuse was varied and included serious sexual assaults. He was intelligent, narcissistic, highly manipulative and possessed many psychopathic traits. One question that the audience considered was how such a serious and serial offender could flourish undetected for so many years. His many victims felt ignored and those who did report his conduct were discredited and were not believed. It is interesting to speculate if other similarly disordered, destructive, narcissistic individuals are in public life today. Clues to the identity of such people may be found in their unshakeable self-belief, their ruthless pursuit and abuse of power and their lack of insight and empathy, which together with their extreme narcissism leads them not only to behave outrageously, but to defy people who endeavor to stand up to them or expose them.

In the final session on the first day two doctors presented a play that they presented at the internationally renowned Edinburgh Fringe Festival in 2015. The play "Dial Medicine for Murder," tells the stories of two general practitioners, both of whom were prolific serial murderers in England. One, Dr. Bodkin Adams, who offended in the 1940s and 1950s, was charged but acquitted of homicide. More recently, Dr Harold

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## Royal College

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Shipman, a GP from the north of England, was convicted of the murder of fifteen of his patients. The subsequent investigation made clear that he had murdered well over 200. While such grave topics do not appear to lend themselves to a theatrical presentation, the performance was engaging, educational and entertaining.

The second day of the conference was divided between a series of clinical and research updates and parallel sessions. The subjects covered were varied and thought provoking. We had discussion of the increasing problem of the group of drugs known as novel psycho-active substances, (also known as “legal highs”). We learned that these drugs can be stimulants, sedatives, synthetic cannabinoids or synthetic hallucinogens, and that increasing volumes of drugs are being bought online and delivered by post, rather than through street corner deals. We were reminded again of the prevalence of stalking, with one in six women and one in twelve men likely to have been a victim of stalking at some point in their lives. Before a case of stalking is reported, it is likely that there have been, on average, one hundred unwanted contacts with the victim. Contacts are increasingly taking place online. The response of law enforcement is very important and, even nowadays, too many complaints by victims are dismissed by law enforcement officers. The links between pathological gambling and crime were highlighted, with the internet offering opportunities for gambling that never previously existed. The financial crime associated with pathological gambling also leads to considerable hardship for relatives, friends and employers. Another session explored the links between autism and violence and we learned that this is a particularly hot topic in the aftermath of a number of high profile cases. A very well attended and well received session was presented by Drs Reena

Kapoor and Maya Prabhu, both from Yale. They discussed gun crime and gun control, the movements to legalize marijuana and the role of psychiatry in death penalty cases. These were all emotive, sensitive and controversial topics but the two presenters struck a perfect balance, using a light touch to challenge the audience with the dilemmas and controversies in these important areas. Another parallel session discussed the experiences of those who have been involved in a homicide inquiry. These formal inquiries are held whenever a patient who is having treatment for mental disorder, or who has received treatment recently, commits a homicide. While the objective is to “learn lessons” to try to reduce the likelihood of similar events in the future, homicide inquiries are complex, prolonged and, for the clinicians concerned, extremely stressful. Whether the many homicide enquiries over the last fifteen years have had all the beneficial effects expected is unclear. The process, which does not include any element of litigation, probably contrasts markedly with what would happen in the US in similar circumstances.

On the second day, the President of the Royal College of Psychiatrists, Professor Sir Simon Wessely, talked about a number of his concerns. He emphasized the rather alarming fact that, in recent years, at the point when newly qualified doctors in the UK gain full registration, (which is two years after graduation from medical school), 50% either go to work abroad for a period or in some cases even give up the practice of medicine. In view of the size of the National Health Service in the UK, this represents a significant loss of resources and manpower and, in the long term it is probably not sustainable. Many see this ‘voting with their feet’ by junior doctors as a response to the financial constraints which Government has imposed on the NHS since the financial collapse of 2008.

As a diversion from all the academic topics and the worrisome trends

with the workforce, a “Fun Run” took place round the streets of Glasgow at the end of the day, followed by the Conference dinner. This was a great success, as was the special late night, post dinner attraction of a tutored beer tasting led by Dr Tim Webb, a retired psychiatrist who has carved out a new career for himself as an expert on all aspects of beer and who is an author of two books on the subject.

The last day of the conference included a visit to the State Hospital, Carstairs. The State Hospital is Scotland’s only high secure hospital and takes patients from Scotland and Northern Ireland. Four master class sessions were also offered, with an interactive tutorial style, and dealing with the topics of insanity, schizophrenia, sex offenders and career development.

The final session of the conference was a joint presentation of two cases, both high profile, and centered on a diagnosis of Asperger’s Syndrome. The cases were each presented chronologically, with pauses at crucial points in order to allow the audience to discuss what it thought should happen next.

Delegates agreed that the conference had been a great success, both academically and socially. The 2017 conference will be held in Madrid, Spain from 1-3 March 2017. As ever, colleagues from AAPL will be made most welcome. ☺

## MUSE & VIEWS

### Bear Essentials of the Law

If you happen to be driving through Missouri and see a bear on the side of the road with his claw in the air, resist the urge to stop and give it a lift. It remains illegal to drive with an uncaged bear in your vehicle. Many other states are behind in their bear transportation legislation.

Source:

<http://thoughtcatalog.com/rachel-hodin/2013/10/67-ridiculous-laws-from-around-the-world-that-still-actually-exist/>

## **NCCHC Honors Kenneth Appelbaum for Excellence in Communication**

*Joseph V. Penn, MD, CCHP*

At the most recent National Commission on Correctional Health Care (NCCHC) Fall Conference in Las Vegas, Nevada, October 2016, during the opening session, AAPL member, Kenneth Appelbaum, MD, was honored for his many accomplishments in correctional mental health. He was presented the B. Jaye Anno Award of Excellence in Communication. This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to individuals for bodies of work. The award is named after NCCHC's cofounder and first vice president.

With more than 60 books, book chapters and peer-reviewed journal articles to his name, Kenneth Appelbaum is one of the country's most well-respected researchers, authors and educators on the subject of mental health care in corrections.

He is coeditor of the recently published *Oxford Textbook of Correctional Psychiatry*. The 71-chapter textbook is widely regarded as a much-needed resource in a growing yet under-resourced field, representing an important step in the development of correctional psychiatry. It covers a wide range of topics, attesting to the unique challenges that face correctional psychiatrists and other mental health professionals.

Earlier this year, Dr. Appelbaum and his coeditors were awarded the Manfred S. Guttmacher Award from the APA and AAPL. The prestigious award recognizes outstanding contributions to the literature of forensic psychiatry.

Dr. Appelbaum said in accepting the award. "I hope that our book will enhance the care for countless individuals whose needs in the community and in jails and prisons have too often been neglected."

Currently a clinical professor of psychiatry at the University of Massachusetts Medical School, Dr. Appel-

baum has worked continuously with patients in criminal justice since joining the faculty in 1987. In addition to teaching, he is director of correctional mental health policy and research for Commonwealth Medicine, the public service consulting division of UMass Medical School.

From 1998 to 2007, Dr. Appelbaum served as director of mental health for UMass Correctional Health, and was responsible for mental health providers, programs and services at all Massachusetts Department of Correction facilities.

Prior to that he ran a state hospital forensic evaluation unit, established and directed the UMass Medical School forensic psychiatry fellowship program and helped establish a training program for forensic professionals. He currently provides consultation to state and federal correctional systems, including the U.S. Department of Homeland Security, on safety and delivery of mental health services.

Dr. Appelbaum is the recipient of the Red Apple Outstanding Service Award and the Golden Apple Award for significant contributions to the field of forensic psychiatry from AAPL, the University of Massachusetts President's Award for Public Service and the Outstanding Public Sector Psychiatrist Award from the Mass-

achusetts Psychiatric Society.

He has given more than 100 academic and national presentations, and has published extensively in the *Journal of the American Academy of Psychiatry and the Law* and the *Journal of Correctional Health Care*, among others.

The mission of the NCCHC is to improve the quality of health care in jails, prisons and juvenile confinement facilities. NCCHC's origins date to the early 1970s, when an AMA study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in 1983 became NCCHC, an independent, not-for-profit 501(c)(3) organization whose early mission was to evaluate and develop policy and programs for a field clearly in need of assistance.

Today, NCCHC's leadership in setting standards for health services in correctional facilities is widely recognized. Established by the health, legal and corrections professions, the NCCHC's *Standards* present recommendations for the management of a correctional health services system. Written in separate volumes for prisons, jails and juvenile confinement facilities, plus a manual for mental health services and another for opioid treatment programs, the *Standards* cover the areas of care and treatment, health records, administration, per-

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Pictured from left: Eileen Couture, DO, RN, CCHP-P (chair), Dr. Appelbaum, and Jayne Russell, MEd, CCHP-A .

# To Jail or Not to Jail: Trial Competency Restoration for Misdemeanants

Kristen C. Ochoa, MD, MPH and Joseph R. Simpson, MD, PhD

In California a 1992 law changed the treatment venue for defendants who had been charged with misdemeanor offenses and subsequently adjudicated incompetent to stand trial. Previously, like felony defendants, they were remanded to state hospitals. Since 1992 incompetent misdemeanants have been the responsibility of the county where they are charged, and may receive competency restoration treatment on an outpatient basis, in an inpatient hospital, or, most commonly, in jail. The Los Angeles County jail system has been administering the Misdemeanor Incompetent to Stand Trial (MIST) program since 2002.

The forensic mental health literature has established that defendants charged with misdemeanors are disproportionately more likely to be found incompetent, even though they face less complicated proceedings and shorter sentences.<sup>1,2</sup> Common charges in our MIST population involve “quality of life” offenses such as trespassing, loitering and petty theft. The amount of time a defendant can be incarcerated while incompetent is determined by the maximum sentence they could receive for their most serious charge, ranging from 90 days up to 12 months. Due to jail overcrowding, misdemeanants not found incompetent are most often released with time served as soon as their case is adjudicated, typically in a few weeks. Therefore, a declaration of doubt on a misdemeanor matter means that a defendant with a serious mental disorder might stay in custody for months longer than those who face similar charges but are not found incompetent. A national trend of increasing referrals for competency evaluations suggests that this due-process protection is perhaps being used as a device to gain much-needed, legally-compelled treatment for a

vulnerable population.

The jail provides a combination of medication management with training on competency materials. A split-treatment model is used; each MIST client is assigned both a psychiatrist to prescribe medications and a psychologist or social worker to provide competency restoration training. These team members work collaboratively, assessing client progress regularly with the goal of returning them to court as soon as they have been restored to competency.

Diagnoses for patients in the MIST program are primarily in the psychotic spectrum, with smaller numbers of patients with developmental disability or major neurocognitive disorders. The rate of restoration to competency, approximately 50%, reflects this predominance of severe mental illness. Roughly 10% of patients remain gravely disabled such that the jail treatment team places them on a conservatorship.

One aspect of MIST which has proven very helpful is the ability to administer long-acting antipsychotic medication involuntarily, without psychiatric hospitalization. The court order that commits a defendant to MIST also includes a provision for involuntary treatment. Working with Los Angeles Sheriff’s Department personnel, a protocol for safely providing involuntary injections has been developed. This has allowed MIST clients to be restored to competency more quickly, as acute hospital beds are a very scarce resource and were it not for the involuntary medication protocol, MIST patients who could not be convinced to take medications voluntarily would end up waiting for months without progressing towards competency.

The number of defendants enrolled in the MIST program began to expand in 2014. The average daily

census remained stable at roughly 70 male and female patients from 2008 until mid-2014. After the passage of Proposition 47 in November 2014, which reclassified several felony crimes to misdemeanors, the MIST population began climbing steadily. By 2016, the average daily census was over 200. The total number of inmates enrolled in MIST over the course of 2014 was 148, while for 2015 it was nearly double at 285.

In August 2015, Los Angeles County launched the Misdemeanor Incompetent to Stand Trial Community-Based Restoration Program (MIST-CBR). The program, led by the Office of Diversion and Reentry, brings together the legal, community mental health and jail systems in an effort to reduce the jail’s MIST population. It does so by identifying inmates who are eligible for diversion into several different levels of community care based upon individual need. Inmates who join the MIST-CBR program are released from jail to enter court-ordered community-based treatment programs; each person also continues to have an involuntary medication order and is required to appear in court for progress reports. Since its inception, MIST-CBR has diverted 215 patients out of the jail into treatment.

Despite these successes, MIST-CBR has not yet reduced the jail MIST population, because of the rate of growth. Over the past five years, Los Angeles County has seen a sharp increase in the number of competency referrals, by 350% between 2010 and 2015. In August 2016, the Office of Diversion and Reentry released a report on the causes of this increase,<sup>3</sup> one important factor being the improved training of the defense bar on the issues surrounding mental disorders, which has resulted in a better understanding of how treatment reduces recidivism and provides better long-term solutions for their clients. A paradigm shift in Los Angeles is seemingly occurring, where judges and attorneys are willing to risk longer periods of detention for misdemeanants in the hope of

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# Drug Policy May Cause More Violence Than Drug Abuse Does

Benjamin Goldberg, MA, MD

The controversial drug policy reforms sweeping across the United States, Canada, and Europe continue to raise important questions for the medical professions about possible effects on public health and public safety. These concerns often involve the risks of drug abuse and dependence, the rates of psychosis in youth, and “drugged driving.” While these questions may be less directly relevant for forensic mental health, there is one important concern particularly germane to our field: the potential impact that the legalization of cannabis, for example, might have on violence.<sup>1</sup> In my review of the relevant research from psychiatry, drug abuse, and other disciplines over the past several years, I have discovered a surprising hypothesis: ending drug prohibition, even if it leads to an increase in drug use, will likely decrease violence overall.

Few, if any, forensic psychiatrists would be surprised to hear that substance abuse and serious mental illness are important risk factors for violent behavior. Numerous landmark studies in violence risk assessment have supported this. According to the MacArthur Violence Risk Assessment Study, “The presence of a co-occurring substance use disorder [was] a key factor in violence...” The Epidemiologic Catchment Area Surveys, published in 1990, and the Swedish Cohort Study, provided similarly compelling evidence for the association of mental illness, substance abuse, and violent criminality.<sup>2-4</sup> It would be tempting to conclude, then, that the legalization of cannabis and other substances would necessarily increase rates of substance abuse and thus increase violence.

However, the presence of a strong association between substances and violence does not answer the fundamentally important question of causation. Substance use may directly

cause violent behavior in some cases, but violent tendencies may precede and/or predispose to substance abuse in others. Violence and substance abuse may also be tightly correlated due to other common biological, developmental, or situational risk factors. Not surprisingly, it also depends on the substance. In general, though, the forensic risk assessment literature does not specifically address the question of causality.

Is there data supporting a causal link between drugs and violence? To the extent that the research has supported a causal link between any specific substance and violent behavior, there is a vast literature indicating that alcohol is the most likely to be causally associated with violence. According to a 2016 review of the drug use and aggression literature, “The research supporting the relationship between all forms of aggression and alcohol use is enormous, unequivocal, and dates back to the 1930s.”<sup>5</sup>

Regarding possible positive relationships between cannabis, cocaine, heroin, amphetamines, benzodiazepines, or PCP and violence, however, the author of this review suggests that the research is far more ambiguous. For these drugs, she concludes that personality factors and environmental influences may be more important for predicting violence than pharmacology. Even for methamphetamines, no direct link with violence has been established. Among others, the US Office of National Drug Control Policy, in a 2013 review, failed to find a causal link between methamphetamine use and violence.<sup>6</sup>

The most compelling evidence for a causal relationship between non-alcohol substance use and violence comes from the literature on stimulant-induced psychosis, though there is no data suggesting this is a significant cause of violence in society

overall. While data documenting the effect of stimulant-induced psychosis on violence are predominantly empirical, with no reliable measures of the incidence of stimulant-induced psychotic violence, the risk of violence does appear heightened during psychotic periods.<sup>7</sup> It worth noting, though, that research on illicit substances may be less reliable compared to licit substances like alcohol, for a variety of reasons.

However, research from criminology, law, and economics has addressed this question more directly. There is compelling evidence from these disciplines that the vast majority of drug-related violence in the US is related to the operations of the illicit markets for cocaine, heroin, and methamphetamine, rather than the direct effects of drug intoxication or withdrawal.<sup>8</sup> A series of innovative studies of violent crime in New York City in the 1980s found that 39% of all homicides and 74% of drug-related homicides city-wide involved the operations of inner-city drug markets, particularly for crack cocaine, rather than the effects of the drugs themselves.<sup>9</sup> Similar studies have replicated these findings in other cities and at other times.

The economics research suggests that, as a direct result of anti-drug laws that criminalize all aspects of cultivation, manufacture, distribution, sale, and possession, these drug markets – worth tens of billions of dollars annually – are destined to be regulated informally by criminal enterprise through the threat and perpetration of violence.<sup>10</sup> Credible estimates suggest that 16%-18% of all gun homicides in the US are related to the operation of these drug markets.<sup>11-12</sup> The history of the prohibition of alcohol in the US in 1920 and its subsequent repeal in 1933 tells a similar story about prohibitionist policy and violence.

Of course, drug policy reform is controversial for a host of reasons, many of which are beyond the scope of the medical professions to address. Of the controversies that require a cautious note from medicine, and

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## Ethical Issues in Psychodynamic Practice

Karen B. Rosenbaum, MD

At the APA Presidential Symposium sponsored by The American Academy of Psychoanalysis and Dynamic Psychiatry, Elizabeth Auchincloss, MD spoke on “Helping the Patient to Change: The Problem of Undue Influence.” She presented the history of the problem, stating that Freud and others felt the problem did not exist. The therapist did not influence the patient directly, but rather used interpretation and insight to bring awareness and allow the patient to change. Suggestion was not a legitimate practice. Transference was considered a false connection and not real. Dr. Auchincloss stated the paradox of therapy’s goals of increasing freedom and autonomy, while the intensity of the relationship with the therapist may promote regression and dependency.

Extreme examples of undue influence include but are not limited to: Sex with a patient, exploitation, money raising and presents, collaborations, friendships between therapist and patient, and false memory syndrome. However, most forms of undue influence do not rise to these extreme levels.

Causes of undue influence include transference, the therapist’s subjectivity (the therapist’s self interest, or financial concerns). Countertransference and the inherent risks of setting up intimacy and dependency on the therapist can cause undue influence as well.

Dr. Auchincloss then presented arguments for the protection of the patient against undue influence of the therapist and for the protection of the therapist against undue influence of the patient. She said that in our field, we have words and concepts, which can give therapists a sense of false confidence. For example, words like, “neutrality,” “abstinence,” “anonymity,” and “blank slate” were all used to protect the patient. Some may feel that informed consent could protect

the patient from undue influence. She cited the landmark case, *Osheroff v. Chestnut Lodge*. In the 1980s, Osheroff was hospitalized at Chestnut Lodge and treated with a year-long analysis. Afterward he was treated with medication and got better in two days.

In the 1980s there were also many cases of false memory syndrome, where courts began to find therapists responsible for estrangement between patients and families where a therapist claimed to know the patient was abused and that the patient was repressing the memory.

The APA ethical guidelines state, “a psychiatrist should not withhold information that the patient could use to make informed treatment decisions.” The benefits of informed consent include less anxiety with more information. However, the danger is that most undue influence falls short and is not covered under informed consent. In addition, informed consent could be anti-therapeutic, and it could create a false sense of security on the part of therapist. More self-awareness on the part of the therapist may be protective.

Sharon Battista, MD, spoke on “Third Party Involvement in Psychotherapeutic & Psychiatric Treatment Relationships.” She presented two cases involving outside parties becoming involved in the treatment relationships. She said that it is important to consider who is the identified patient, any ethical concerns, boundaries, issues being enacted, financial influences, and the role of attachments.

Douglas Ingram, MD presented “An Experience as Plaintiff in a High-Profile Tarasoff Type Case.” In 1985, he had a patient who was a married 31 year-old resident and a candidate in the psychoanalytic training institute. In 1986, the patient disclosed strong erotic interest for young boys, which was ego syntonic. The patient

believed that he and others like him were wrongly regarded, and that they should have a right to pursue their interest. He felt his sexual orientation was pathologized. However, he said he would not act on his interest.

Within hours Dr. Ingram began seeking advice. He called multiple outstanding forensic psychiatrists, and other ethicists. New York state law for breaking confidentiality required a finding of “serious and imminent threat on an identifiable third party.” He found that his colleagues did not want to discuss the case. He finally spoke to an expert in paraphilias, who advised that the patient withdraw from the analytic institute, but that he should remain in treatment with Dr. Ingram in order to contain the pedophilia. Only if the patient specifically abandons therapy should Dr. Ingram take further action. He said that the patient should stay in residency and not lose his identity as a child psychiatrist. Three months after the disclosure the patient molested three boys, lost his medical license and served years in prison.

In 1993, Dr. Ingram received a formal complaint from a parent of one of the victims, citing that he failed to protect children from a predator. His insurance company agreed that what he had done was ethically correct.

In 1998, the New York law was interpreted by Connecticut law, where the child lived. Connecticut expanded the language from identifiable third party, to “identifiable class” which included “children.” A trial by jury found Dr. Ingram liable, but not the medical school. His insurance settled the matter but then denied him insurance. In 2001, New York State Department of Health found no misconduct. In 2013, his insurance was reinstated by his original company. Dr. Ingram brought up questions of how he could have done things differently. He said that thirty years later, he plays out different scenarios.

Sylvia Olarte, MD discussed psychotherapist personal disclosure. She said that personal disclosure can be used to facilitate the therapeutic process as long as it is not for person-

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## Of Hope and Perseverance: The Jacob Wetterling Story

Soniya Hirachan, MBBS and Chinmoy Gulrajani, MBBS, Sexual Offenders Committee

On October 22nd 1989, an eleven-year-old boy was kidnapped by an armed masked man as he was biking back home with his younger brother and his best friend after renting a movie.<sup>1,2</sup> The investigation drew national media and law enforcement from all backgrounds to the small town in St. Joseph, Minnesota. Sheriffs from Stearns County conducted the preliminary investigation but the FBI took over the case early on. We get to hear the boy, Jacob Wetterling's endearing voice in the first episode of a podcast "In the dark" that spent nine months investigating the case, long before the alleged abductor confessed to the crime.<sup>3</sup> This recording was made for a school project just a few days before his abduction where the listener is taken by his sweet voice as he talks about his favorite food being steak and how he loves football and the color blue.<sup>1,3</sup>

Needless to say, Jerry and Patty Wetterling, his parents, were distraught. However, they did not stop looking for Jacob and it seemed that the whole country was rooting for his return. For the next twenty-seven years, the parents of Jacob pushed for reform in child abduction cases relentlessly through their foundation, The Jacob Wetterling Foundation.<sup>4</sup> The Foundation was established a year following Jacob's disappearance and it advocated for reform in such cases of abduction. It also helped enforce the AMBER alert system in Minnesota. The Foundation strives to educate the public about "who takes children, how they do it and what each of us can do to stop it" along with a strong focus on working to end child maltreatment.<sup>4</sup> Another major outcome from this advocacy was the enactment of the Wetterling Act in 1994, five years after Jacob's abduction. This act established registration guidelines for states to manage sex

offenders requiring them to register for at least 10 years and life-long for those classified as sexually violent predators.<sup>4</sup> In cases where public safety would be a concern, the Act mandated that states release such information to the public.

For nearly three decades law enforcement chased numerous leads and kept the case open hoping for a break-through. But in the end it was the efforts of Baker, a blogger and Jared Scheierl, a sexual assault survivor that led to the re-examination of Heinrich as a suspect. Baker had been investigating a series of sexual assaults on young boys in a neighboring town of Paynesville in 2010.<sup>5,6</sup> In 2013 he met Jared Scheierl, a survivor of a sexual assault that took place in January 1989, a few months before Jacob's abduction. A piece of clothing that Scheierl had worn during the assault was tested for DNA that later matched that of 53-year-old James Heinrich. He was originally a suspect and had been interviewed about a month into the Jacob abduction but there was not enough evidence that tied him to the incident. This new lead led investigators to Heinrich's house where they uncovered child pornographic paraphernalia and he was then taken into custody.<sup>5,6</sup>

Finally, all speculation came to rest on September 6, 2016 in a Minneapolis court room when Heinrich confessed to abducting, sexually assaulting and killing Jacob. The confession was part of a plea agreement for pleading guilty to the charges related to possession of child-pornography.<sup>7</sup> He led investigators to the site where he had buried his victim and the remains were later identified as that of Jacob Wetterling. Speaking publicly for the first time after the confession, Patty Wetterling thanked investigators Baker and Scheierl for their continued efforts and said that "His (Jacob's) legacy will go on."<sup>8</sup>

Thus ended this sordid saga that had haunted the Wetterlings across three decades. ☯

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## NCCHC Honors

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sonnel and medical-legal issues. NCCHC also has several educational conferences for correctional physicians and health professionals. ☯



## Trauma

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slippery slope in this area.

Dr. Keram pointed out that girls in particular are targeted in a seductive way by groups like ISIS. They create recruitment materials specifically aimed at girls which encourage them to help with the civil government, medical care, and female law enforcement, as well as to “marry a *jihadi* and raise the next generation of *mujahideen*.”

Currently there is no programming for recruited juveniles in the US designed for reintegration and rehabilitation. Instead they are tried as adults. Dr. Keram proposed that at-risk children who have not committed an offense should be referred for rehabilitation services. Those who have committed illegal acts should be managed within the juvenile justice system. In both settings, when debriefing is necessary for national security, it should be performed by a professional with child expertise. Family participation is critical for eventual reintegration, as is community support.

Dr. Keram reminded us that children are children, regardless of what armed force recruits them. She ended with a quote from Nelson Mandela: “There can be no keener revelation of a society’s soul than the way in which it treats its children.” ☞

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## Animal Maltreatment

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groups view animals and their maltreatment, as well as how such differences might impact collaboration in the context of forensic animal maltreatment evaluations. Not surprisingly, the veterinarians at the meeting were in favor of animal rights and punishing offenders of animal cruelty, including those who engage in bestiality. How might such a natural stance conflict with that of the forensic psychiatrist who is dedicated to exploring and understanding the etiology, triggers, and potential treatments

for an animal abuser that he or she is evaluating? Though most forensic evaluators attempt to maintain neutrality within the forensic examination, might empathy for the evaluatee conflict with the veterinary expert’s opinion regarding the offense and appropriate sanctions? The parties might foreseeably disagree and therefore have to demonstrate sensitivity for each other’s opinions when developing a complete assessment of an animal abuser. In addition to issues surrounding collaboration, the meeting raised greater questions regarding animals and how they are viewed in society and the legal arena. To this day many states do not have legislation protecting animals from sexual abuse and various other forms of cruelty like hoarding and forced fighting. Even in many jurisdictions with such statutes, offenses commonly go unprosecuted or punished lightly because such cases are not viewed as significant. In modern society, the lack of protections that many states provide animals is astounding.

For anyone interested in the developing field of forensic animal maltreatment evaluation, I encourage attendance at collaborative conferences like the IVFSA meeting to be held in New York City in spring of 2017. In addition, the book *Animal Maltreatment* offers an excellent summary of the types of evaluations that one may perform and practical, legal, and ethical considerations pertaining to such evaluations. ☞

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## Rappeport Fellowship

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05) and Ezra Griffith (past AAPL President, 1996-1997).

I asked Dr. Norko about the theme for his AAPL presidency. He expressed how honored he was to be AAPL President and shared that his presidential membership theme is Correctional Psychiatry. He emphasized that he has a strong commitment to bring correctional psychiatrists into AAPL, make AAPL their professional home, and increase AAPL membership. Dr. Norko explained, “The correctional psychiatrists, I think in particular, are more prone to isolation, and they don’t often belong to other groups of psychiatrists. They are often on their own and do the best they can under difficult circumstances...one of the things that I try to emphasize is that they are treating the same people we are treating in forensic hospitals.” Dr. Norko mentioned that there will be a separate one-day track of presentations on correctional psychiatry at the 2017 AAPL meeting. I expressed that I and other AAPL members are looking forward to the meeting in Denver and this exciting new special track of correctional psychiatry presentations. ☞

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## Proposal

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## AMA 2016

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Affairs (CEJA) held a session that addressed ethics arguments offered in support of, in opposition to, and a “neutral” perspective toward a physician is taking an active role in ending life. A neutral stance neither encourages nor prohibits active physician participation, but supports allowing such decisions to be made individually by patients and their physicians. This topic generated significant testimony at a subsequent forum in the meeting. CEJA will review the data and literature, and remains open to receiving member input about this matter. Our delegation anticipates that CEJA will release its first report and recommendations at a meeting in 2017.

*Dr. Tobias Wasser participated in the Young Physician Section’s Maintenance of Certification/Maintenance of Licensure Committee, and reviewed proposed resolutions related to this topic before the meeting. For the fourth consecutive meeting, Dr. Jennifer Piel served as Chair of the Young Physician Section Reference Committee.* ☉

## Reorienting

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patients. The committee is in its infancy, but it has already contributed to expanding AAPL’s mission, designing a panel presentation for the 2016 Annual Meeting to highlight state-of-the-art practices in community forensic treatment.

In many ways, the criminal justice system has been quicker than psychiatric organizations to adopt an enthusiastic attitude toward treatment of mentally ill offenders. Mental health courts, substance abuse courts, and jail diversion programs have grown rapidly across the country, as court personnel see benefit in providing alternatives to incarceration for individuals with mental illness. Several prominent judges, including Steven Leifman in Florida and John Kane in Colorado, have advocated a more

humane approach to mental illness than the criminal justice system traditionally allowed. These judges, together with legal and social science scholars, have developed the field of therapeutic jurisprudence, which takes a holistic approach to studying the impact of courts on the individuals they serve. In recent years, psychiatry has formed partnerships with legal professionals already involved in therapeutic jurisprudence, including the Judges’ Criminal Justice/Behavioral Health Leadership Initiative (JLI), sponsored by the American Psychiatric Foundation.

As we consider the future of AAPL, I hope that we will commit ourselves as an organization—some may say for the first time—to serious involvement in initiatives that improve the treatment of people with mental illness in the criminal justice system. For 48 years, AAPL has championed the highest standards in forensic evaluations and expert testimony, and it is time now to turn our attention to what happens to evaluatees after adjudication of their court cases. We must realize that forensic evaluatees often become forensic patients, and we as forensic psychiatrists have a professional duty to ensure that they receive high-quality, compassionate treatment in correctional facilities, forensic hospitals, and community settings. I am pleased that AAPL is making this commitment, beginning with the establishment of three new committees that focus on treatment and public policy for forensic patients. I look forward to the day when American trainees echo the sentiments of our English colleague Dr. A, embracing a professional ethic that moves forensic psychiatry well beyond the walls of the courtroom. I invite others to join in exploring this exciting new frontier. ☉

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## MUSE & VIEWS

"I told my psychiatrist that everyone hates me. He said I was being ridiculous - everyone hasn't met me yet."

**Rodney Dangerfield - Comedian**

*Submitted by William Newman MD*

## The Tell-Tale Trial

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layperson on mental illness and crime in that historical context. While more details were needed to conclude that the protagonist had a psychotic or affective-spectrum diagnosis as conceived by the DSM-5, Poe painted him in this short story as a person with monomania – a singular preoccupation, sometimes to the point of delusion and sometimes accompanied by agitated delirium.<sup>5</sup> Both medical and legal writers questioned the application of monomania, or partial insanity, in forensic settings.<sup>6</sup> As Hannequin, a lawyer in the 19th century wrote, “The need to murder to satisfy passions or perhaps a system is not illness or insanity. The doctrine of monomania tries to excuse crime by crime itself.” [Ref. 6, p. 74] The concept of monomania fell out of favor in the mid-19th century.<sup>5</sup>

As forensic psychiatrists know quite well, public (and even professional) views on the insanity defense are still inconstant.<sup>7</sup> While some form of the M’Naghten Rule is the most common standard for the insanity defense in the United States, such variability of public opinion is reflected in that some states use different tests, and some do not allow the insanity defense at all.<sup>8</sup> While I think that the overall quality of presentations by the students in both classes was similar, the two adult juries came to different opinions. The jury returning an NGRI verdict took longer in deliberations, and I spoke to the resource officer afterwards who shared that he was the dissenting vote. I certainly wish that the jury members had stayed to hear my input, though the business of education must go on.

Given the time allotted and my audience, I chose to focus on a few basic points: that mental illness does not necessarily equate to legal insanity, that psychopathy does not by itself qualify as a mental illness in terms of a defense, and that the criteria (and even existence) for an insanity defense depends on where the crime happened. My opinion, based on evi-

dence in the text that Cobblepot knew what he was doing was wrong, such as his efforts to avoid detection, was that he did not qualify as insane using the strict M’Naghten standard in New Jersey<sup>8</sup> (where the class was being held) or in Pennsylvania<sup>8</sup> (where Poe resided in 1843).<sup>3</sup> This elicited a celebratory woot from one student on the prosecution team. I pointed out though that reasonable persons could disagree, especially in states with a more liberal ALI test, where it may be argued that despite knowing that killing his housemate was wrong, Cobblepot felt so intensely driven to rid himself of the “vulture eye” [Ref. 1, p. 64] that he was unable to control his conduct. As a parting word to the second class (after having looked up the BTK killer on my smartphone), I shared that wearing a mask of sanity or not, Dennis Rader is presently serving 10 consecutive life sentences in the Kansas DOC.<sup>9</sup>

Unbeknownst to me, Ms. Schmus had also invited a reporter, and the activity got a bit of attention in the local news.<sup>10</sup> While I may never know if my brief appearance in the lives of these children sparked an interest in psychiatry or the law, this was an opportunity to engage as a professional with the community in a positive way. I found the experience rewarding and fun. I might have learned something, too. ☺

*Acknowledgement: Original pencil sketch courtesy Virginia Tamburello*

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## To Jail or Not to Jail

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obtaining mental health services. Currently, in the absence of a more robust community health infrastructure that includes sustained compelled treatment for persons with serious and persistent mental disorders, provision of services via the criminal justice system is a reality, and for many, the only opportunity to stop the revolving-door cycle in and out of jail. ☺

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## Internet Crimes

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what their intended victim's life is like, potentially looking for areas to exploit. They will be slow to chat about sex, and may never get there. If they do discuss sex, they will typically not be explicit. These types of offenders may not require explicit sexual content for their arousal.

In his experience, Lt. Barton found that common defenses made by cybersex offenders when apprehended included: denial, minimization, justification (stress, alcohol, caring), fabrication (research, sex education), faking mental illness, seeking sympathy, taking the offensive position, attempting to make a deal, offering information, and suicide (particularly preferential offenders).

Dr. Paul Fedoroff discussed ten treatment interventions he found effective with Internet child offenders: The first step is to insist that any illegal activities stop immediately. Second, set the context by reminding the patient that successful treatment is voluntary. Third, explain that the problem is not sex. The problem is their decision to engage in acts that are illegal because they are non-consensual and harmful. Fourth, explain that the goal is not to end their sex life, but to improve it. Fifth, explain that sex offending is not an addiction so there is no need to "taper" illegal acts. The "pressure cooker" model is false since stopping criminal acts does not increase the likelihood of engaging in new criminal activities. Sixth, emphasize the importance of using time productively by getting a job, or doing volunteer work. Seventh, always invite the person's spouse or partner to be involved in the recovery process. Eighth, invite the person to talk about their sexual interests, fears and behaviors because "paraphilias, like mushrooms, grow well in the dark." Ninth, increase the frequency of consensual orgasms by decreasing the frequency of masturbation that does not lead to climax and consider use of PDE-5 inhibitors to enhance consensual sexual relations.

Finally, work on improving the person's non-sexual relationship with their spouse or partner<sup>3,4</sup>.

In conclusion, it is important for forensic evaluators and clinicians to accurately characterize the type of offending, assess the risk for contact offending or re-offending, understand the offender so that he/she will open up, help the Internet child pornography collector to understand that there is a real victim and help him/her develop empathy. The evaluator should then formulate treatment recommendations based on a thorough history, and the clinician should then engage the individual in treatment appropriate to the specific needs of the patient. ☯

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## Drug Policy

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mental health specifically, the risk of increased violent behavior in society is not one we should perpetuate. ☯

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## MUSE & VIEWS

"If Moses had gone to Harvard Law School and spent three years working on the Hill, he would have written the Ten Commandments with three exceptions and a saving clause."

**Charles Morgan – British Novelist**

Submitted by William Newman MD

## Dr. Robert I. Simon

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- In 1993, for Psychiatric Malpractice: Cases and Comments for clinicians, co-authored with Robert Sadoff;
- In 2005, for authoring Assessing and Managing Suicide Risk: Guidelines for Clinically based Risk management; and
- In 2010, as editor for The Textbook of Violence Assessment and Management

Other awards and recognition included:

- AAPL's Seymour Pollack Award (1994) in recognition of his distinguished contributions to the teaching and educational functions of forensic psychiatry.
- AAPL's Golden Apple Award in 1995, in recognition of his significant contributions to the field of forensic psychiatry.
- The APA's Isaac Ray Award in 2003 for "outstanding contributions to forensic psychiatry and the psychiatric aspects of jurisprudence."

Dr. Simon was fond of quotations, often using them to introduce the subject of his writing. In remembrance, let me share a few that apply to him. Albert Einstein said that "Setting an example is not the main means of influencing others; it is the only means." Dr. Simon lived by the advice he often gave: when given a choice, always take the high road. Dr. Simon set an example for moral character, intellectual and personal honesty, and generosity to which I continue to aspire.

The Jewish Talmud says, "The wife of a scholar is accounted one too." Dr. Simon was able to give so much of himself because of how much his wife Patricia Ann gave him. Pat's devotion and patience allowed Bob to pursue his interests and share them with others. Bob and Pat Simon were a team, and Bob was always the first to acknowledge it.

Finally, the Jewish Pirkei Avot says, "Make for yourself a Rav [a teacher] and acquire for yourself a

friend." The commentary directs us to actively cultivate these important relationships because no one is supposed to stand alone in this world; all of us need to be connected to others. I was blessed to find in Robert Simon both a great mentor and a great friend.

Dr. Simon graduated from the University of Connecticut with honors, and received his medical degree from Tufts University School of Medicine. After serving as a flight surgeon in the Air Force, he completed his psychiatry residency at Jackson Memorial Hospital and the University of Miami School of Medicine in 1966. Dr. Simon was a Clinical Professor of Psychiatry at Georgetown University School of Medicine, and for many years was the Director of the Program in Psychiatry and Law, teaching forensic psychiatry to the psychiatric residents. He was also an Adjunct Professor of Psychiatry at the Uniformed Services University of the Health Sciences F. Edward Hébert School of Medicine in Bethesda,

Maryland.

Dr. Simon was a Distinguished Life Fellow of the American Psychiatric Association and Chairman Emeritus of the Department of Psychiatry at Suburban Hospital in Bethesda. Dr. Simon was a consultant for various government agencies, the Walter Reed Army Medical Center, and other academic and medical organizations. He maintained a private practice starting in 1967 in Bethesda and later in Potomac, Maryland throughout his career. ☞

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## Ethical Issues

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al gratification. At one time, it was considered a technical mistake on the part of therapist. However, if used appropriately, it may enhance the effect of brief integrative treatment.

She argued that self-disclosure is an “ever present and unavoidable aspect of psychotherapy” and it is important to understand it within professional boundaries and the ethical framework of “do no harm.” She said that the development of social media and the ability to search personal information on therapists over the Internet have changed the stance on personal disclosure. Clients often come to the first session ready to establish a dialogue about their knowledge of professional and personal information about the psychotherapist and the meaning of the symptoms they suffer.

Paul Appelbaum, MD, was the discussant of the panel. He reasoned that there are multiple ways of handling many of these situations. Regarding Dr. Ingram’s case, he said that pedophilic thoughts or impulses do not uniformly lead to pedophilic behavior. We as a profession have accepted the duty embodied in Tarasoff to act when people are likely to be harmed by a patient. He cited a survey of psychiatrist in 1950s where a majority of psychiatrists surveyed indicated they would break confidentiality to try to protect third parties, including if their patient demonstrated a national security risk.

He said that with personal disclosure, the concern would be the blurring of boundaries in the doctor/patient relationship. He said it makes a difference what is disclosed and why. With more intimate disclosures, there is more potential for problems. In the addiction world, it is common for therapists to be in recovery and be open about that. Appelbaum said that he decided to reveal, if asked, whether he was married and if he had children. Patients need to know whether their therapist can understand them, if they treat people

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The Midwest Chapter of AAPL is pleased to introduce their new logo and website. The idea for the logo was conceived by Dr. Philip Pan. Dr. Sherif Soliman and Dr. Cathleen Cerny worked with the Dyer Group to develop the new chapter website. MWAAPL would also like to thank Doug and Mollie Mossman for maintaining the original website for many years and assisting in the transition.

**Please check out the new MWAAPL website at:**

**<http://midwestaapl.org/>.**

**Information about our upcoming chapter meeting and resident awards is posted.**



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## Ethical Issues

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like them, what are the results, how many times, and where their therapist trained. He agreed that disclosure can also have a positive therapeutic impact. However, he also cautioned about self-disclosure as it can be a slippery slope. ☹

### MUSE & VIEWS

#### The Zombie Attorney

- Lawyer: "Doctor, before you performed the autopsy, did you check for a pulse?"
- Witness: "No."
- Lawyer: "Did you check for blood pressure?"
- Witness: "No."
- Lawyer: "Did you check for breathing?"
- Witness: "No."
- Lawyer: "So, then it is possible that the patient was alive when you began the autopsy?"
- Witness: "No."
- Lawyer: "How can you be so sure, Doctor?"
- Witness: "Because his brain was sitting on my desk in a jar."
- Lawyer: "But could the patient have still been alive nevertheless?"
- Witness: "Yes, it is possible that he could have been alive and practicing law somewhere."

Source:

<http://www.rinkworks.com/said/courtroom.shtml>

Submitted by William Newman MD



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