

# AAPL Newsletter

American Academy of Psychiatry and the Law



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2018 Presidential Address

## Christopher Thompson, MD: A Seat at the Table

Renée Sorrentino, MD



Dr. Thompson's presidential address began with introductory remarks by Charles Scott, MD. Dr. Thompson, one of AAPL's youngest Presidents, was building foundations from childhood, quite literally. "Pass me the drywall and some nails," requested his father, as Dr. Thompson worked alongside him rebuilding run-down properties. Not unlike his work today, Dr. Thompson's vision is building foundations.

To begin, Dr. Thompson remarked how the 50th anniversary of AAPL was a time to "take stock of the priorities and the missions of the organization." As part of this endeavor Dr. Thompson proposed that we view AAPL's educational mission and audience more broadly to include more policymakers, the media and the public. More specifically he challenged AAPL to become involved in the development of forensic standards and practices that will inform judicial, regulatory and legislative processes. Additionally, as the title of his talk suggests, Dr. Thompson invites

AAPL to move forward with other organizations in shaping policies and law around forensic mental health issues. Towards this end, Dr. Thompson has created several new AAPL committees, as well as outlined Presidential initiatives in accordance with this mission.

The rationale for an expansion in AAPL's educational mission, according to Dr. Thompson, is multifactorial. Historically, organized medicine and psychiatry have a long tradition of governmental advocacy. Such involvement has resulted in educating the legal system about a variety of issues. Next, AAPL as one of the preeminent forensic professional organizations is in a position to promote such education. Dr. Thompson noted that in the first three decades of AAPL's history the primary focus was on the establishment of a subspecialty and education of its members. These goals have been met. Furthermore other mental health organizations will be more involved in shaping policies and the potential risks of

such involvement already exists. Lastly, science and technology are advancing at exponential speed.

AAPL has historically engaged in some advocacy including amicus briefs, delegates to organizations and fielding calls from media outlets. Today, AAPL, according to Dr. Thompson, has the capacity to move forward and broaden the educational mission to shape public policy and opinion as they relate to the interface of psychiatry and the law. Dr. Thompson asserts, "we can do this while holding fast to scientific literature and collective experience." He asserts that we can avoid being political if the primary goal is advancement of scientific understanding.

Dr. Thompson's vision of how AAPL's educational mission can be broadened includes the following steps: reinforcing ties with APA, tasking Committees with specific judicial, governmental and media/public relations initiatives, and joining an existing forensic science consortium. Dr. Thompson referenced the June 2018 JAAPL article, "Role of Forensic Psychiatry in Legislative Advocacy" by Gulrajani and Realmuto, which outlines the role of physicians as leaders in legislative advocacy as well as the need for training in this neglected area.

Dr. Thompson suggested that we run the risk of other organizations making our practice decisions for us if we aren't proactive in broadening AAPL's educational mission. He referenced the 2009 National Academy of Sciences' National Research Council's Report titled, "Strengthening Forensic Science in the United States: A Path Forward," which recommended improvements in the forensic sciences that would primarily be based on certifications and standards. Forensic psychiatry was not named, but was not excluded, and likely will be subject to externally imposed stan-

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## COVER STORY

### President's Address

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dards at some point in the future. According to a 2017 Department of Justice (DOJ) Press Release, the DOJ outlined objectives including developing uniform language for testimony and reports as well as developing standards including forensic examiner testimony monitoring programs.

In conclusion, Dr. Thompson summarized that revolutionary technological advances and significant regulatory and "standard of practice" changes related to forensic psychiatry loom large on the horizon. He outlined how AAPL is uniquely qualified to positively shape policy and public opinion as they relate to the interface

of psychiatry and the law, and to ensure technological advances are implemented and utilized in an appropriate fashion. As an organization and as individuals, Dr. Thompson implored AAPL to offer expertise on selected issues relevant to forensic mental health directly to policy makers and the public. He interpreted AAPL's bylaws and educational mission to include such advocacy. He closed with a question: "What kind of organization do we want to be going forward?" He suggested the answer with a quote from William James, "Act as if what you do makes a difference, it does." ☯

## CONGRATULATIONS 2018 AWARDEES!

### Red Apple Award

*For those who have provided outstanding service to AAPL.*

**Barry W. Wall, MD**

### Golden Apple Award

*For those over age of 60 who have made significant contributions to the field of forensic psychiatry.*

**Graham D. Glancy, MB, ChB**

### Award for Outstanding Teaching in a Forensic Fellowship Program

*For outstanding faculty member in Fellowship program.*

**Kaustabh G. Joshi, MD**

### Seymour Pollack Award

*For those who have made distinguished contributions to the teaching and educational functions of forensic psychiatry.*

**Debra A. Pinals, MD**

Nominations for 2019 AAPL Awards must be received by June 1, 2019. Please contact the AAPL Executive Office for more details.

## Your Organization, Your Newsletter

Joseph Simpson, MD, PhD



Most of the people reading this have heard AAPL described as our “professional home” as forensic psychiatrists.

While some reading these words have been involved in AAPL for half a century, I’m sure there are others for whom this is their first look at an AAPL Newsletter. AAPL has a tremendous amount to offer all of us, and the organization strives to be that professional home for forensic psychiatrists in the U.S., Canada, and beyond. As your new Newsletter editor, I would like to discuss what types of information appear in the Newsletter, and how you can get the most out of it.

The Newsletter is published three times per year, in January, April and September. The corresponding deadlines for submissions are November 15<sup>th</sup>, February 1<sup>st</sup>, and July 1<sup>st</sup>. It is easy to forget such details in the hustle and bustle of our busy lives. Luckily, the dates are listed at the bottom of the masthead on page two of each issue, so if you want to submit an article but don’t remember the publication timeline, just refer back to a copy of the Newsletter on your bookshelf or on the AAPL website ([www.aapl.org/newsletter](http://www.aapl.org/newsletter)).

The Newsletter features several regular columns, including the President’s Report and Medical Director’s Report. (Check out Dr. Janofsky’s Report in this issue for a very informative explanation of AAPL’s governance structure.) Other staples include the Child Column, Ask The Experts, and Faces of AAPL (a brief profile of an AAPL member who has made significant contributions to the organization and the field). Other special reports are tied to the schedule of professional organization meetings, including the Annual Meetings of AAPL (with summaries of the Presidential Address and luncheon presentations appearing in the January issue), APA and AMA.

Dispatches from other important groups such as the National Commission on Correctional Health Care (NCCCHC), the U.K.’s Royal College of Psychiatrists Forensic Faculty, Canadian forensic psychiatry and AAPL chapters also appear regularly. Such reports offer a quick way to educate yourself about current topics of interest (or debate and controversy!) in organized medicine, and to learn about legislative, regulatory and judicial activities which have the potential to affect your forensic and/or clinical practice.

The Newsletter is also an easily accessible source of information regarding awards given by AAPL and APA. In its pages appear requests for nominations for awards in forensic psychiatry, such as AAPL’s Golden AAPL, Red AAPL and Seymour Pollock awards. Even if you can’t make it to the APA’s annual meeting, you might later discover a key book to read from the AAPL Newsletter’s cover story on the Manfred S. Guttmacher Award lecture, appearing every September.

AAPL Committees are tasked with contributing an article every year. Each such article is approved by the Committee chair, but that doesn’t mean he or she is expected to write it! So if you’re a Committee chair, this is a great area in which to delegate and to give your members an opportunity to showcase their knowledge and writing skills. Many Committees publish summaries of their last AAPL Annual Meeting presentation. This is perfectly acceptable; with so many simultaneous presentations, many meeting attendees won’t have seen yours, not to mention those members who did not attend the Annual Meeting. With roughly 40 committees, these articles are a wonderful source of information about forensic practice. If you are relatively new to our organization, it is a good bet that these contributions will help you identify Committees you will choose to join.

The Fellow’s Corner is a great

place for forensic psychiatry fellows to publish in a non-intimidating venue. Another new feature, the Rappaport Retrospective, profiles former Rappaport Fellows, offering an interesting look at the career paths of these doctors, many of whom have been very active in AAPL ever since being chosen for that prestigious honor.

The Newsletter also publishes Special Articles – contributions from our members that don’t fall into any of the above categories. If you have an interesting reflection or perspective, the Newsletter is a great way to share your ideas with a wider audience of forensic psychiatrists.

No description of the Newsletter would be complete without a mention of the photographs. Official AAPL photographer Dr. Eugene Lee has done a fantastic job over the past several years capturing the vibrant activity at AAPL meetings. In addition to showing the camaraderie and excitement of the meetings, the images also help members put faces to the names of colleagues they have corresponded with or want to connect with.

Perusing the pages of the Newsletter, one gets a sense of the dynamism and vitality of AAPL as a preeminent forensic psychiatry organization that is nonetheless welcoming and encouraging to trainees and other newcomers to the field. If you devote a little time and pay attention to the various announcements and bulletins that appear in its pages, you will have a good idea of what is happening in AAPL, and when.

I hope this summary has demonstrated how the Newsletter can help you stay up to date about AAPL activities, and the value it can add to your professional life and your engagement with our organization. I welcome your suggestions for how we can more effectively accomplish this mission via email at [NewsletterEditor@aaapl.org](mailto:NewsletterEditor@aaapl.org).

In closing, I would like to thank my predecessor Dr. Susan Hatters-Friedman for her wonderful work on the Newsletter, and wish her the best of luck in her new position as Deputy Editor of the Newsletter’s “big brother,” the *Journal of the American Academy of Psychiatry and the Law*. ☪

## AAPL at 49 Years and 3 Months

Richard L. Frierson, MD



I am both honored and humbled to be the new President of AAPL. When I was informed that I had been nominated to be AAPL President-

Elect, I had no idea that at the Annual Meeting in Baltimore in October 2019 our organization will celebrate its 50th anniversary. However, my excitement about this achievement for our organization is growing. We hold the AAPL Annual Meeting every ten years in Baltimore, in part as a celebration of our founding and, in part, in respect for our founding President, Jonas Rappaport, M.D. AAPL has shown consistent growth since its beginning, with approximately 2000 current members and over 40 active committees. After speaking with AAPL Committee Chairpersons before the 2018 Annual Meeting, I am convinced that the vast majority of AAPL committees are vibrant and active, with regular submissions to the AAPL Newsletter and submission of questions to the Self-Assessment Examination Committee.

Milestones in any organization can provide a time to reflect on the past, but also a time to prepare for the future. I have decided to use my Presidential year as a time to review the functioning of AAPL leadership, AAPL Committees, and AAPL as a whole, to make sure that we are prepared to continue to serve as a vital and worthwhile organization for those engaged in the practice of forensic psychiatry over the next fifty years. To this end I have begun several initiatives regarding AAPL By-Laws, Committee functioning, and the annual program. My hope is that each of these will provide a constructive review of the overall functioning and future needs of AAPL.

### By-Laws

First, I have appointed a Presiden-

tial Task Force to review the AAPL By-Laws (which were last revised in 2009). This Task Force, consisting of two former AAPL Presidents, along with the Medical and Executive Directors, will recommend changes that are necessary to help continue the mission of AAPL – to foster excellence in the practice, teaching, and research in forensic psychiatry. Having read through the By-Laws, I have encountered several questions that may need to be addressed for the future of the organization:

1. Should corresponding members also have to be APA members, or only a member of a professional organization in their own country?
2. Should members-in-training serve on AAPL committees and, if so, should they be voting members?
3. Should AAPL Executive Council continue to include two Vice Presidents?
4. Should the current AAPL President continue to appoint two AAPL members-at-large to the Nominating Committee?
5. Are there ways to make AAPL more transparent in the way people can assume positions of leadership?

Additionally, I noticed that the description of the Education Committee is written to sound as if its purpose is to help form forensic psychiatry fellowships, which, possibly true in 1969, is far from its current task of maintaining ACCME accreditation, soliciting courses for the Annual Meeting, and assisting AAPL members with Maintenance of Certification activities, including the AAPL Self-Assessment Examination in Forensic Psychiatry which is offered to members four times a year.

### AAPL Committees

Second, at our October meeting

the AAPL Executive Council appointed a Task Force to study the role and functioning of Committees. I have heard complaints from chairpersons that many Committee members attend meetings, but do not substantially contribute to the work of the Committee. For example, many chairpersons report that they have to write the MOC Self-Assessment Examination questions for their own Committee because no one will volunteer to do so. Also, many chairpersons have difficulty getting members to volunteer to write an article for the AAPL Newsletter. Finally at the meeting with AAPL Council, many chairpersons complained that their Committee members cannot attend their meeting due to conflicts with other Committee meetings. The sheer number of AAPL Committees has presented challenges for scheduling meetings of all Committees on the Wednesday afternoon before the Annual Meeting. This presents an organizational dilemma and poses several questions:

1. Should AAPL members be limited in the number of Committees to which they may belong? If so, how many Committees should a member be allowed to join, and does a limit hamper the professional development of AAPL members?
2. Should there be a limit on the size of a Committee? For example, one Committee currently has 45 members. Can such a large committee function efficiently and, if so, can each of the 45 members meaningfully participate?
3. Should there be term limits for Committee chairpersons? Could such limits provide an opportunity for younger AAPL members to gain leadership experience by becoming a Committee chairperson?

### Annual Program

The theme for the 2019 Annual Program is “AAPL at 50: Teaching and Advocating for Forensic Psychia-

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

Jeffrey S. Janofsky, MD



At this year's Annual Meeting in Austin several members told me that it was not clear to them how to get involved in AAPL's governance structure, and that the process

on how to become involved did not appear transparent. To address this problem I am reprinting a modified version of an article I wrote for the Newsletter in 2015.<sup>1</sup>

AAPL governance structure is outlined in Bylaws which vests executive authority in a Council consisting of a President, two Vice Presidents, a Secretary, a Treasurer, the Immediate Past President and nine Councilors. The Bylaws also outline a Committee Structure. AAPL now has 39 Committees. Committee Chairpersons report to the AAPL Council. Committees write articles for our Newsletter and submit presentations for our Annual Meetings, as well as advise the Council on topics specific to their Committee.

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

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

The first step to becoming involved in AAPL Governance is to join a Committee. A listing of current committees can be found at: <http://www.aapl.org/committees.htm>. You might consider phoning the Committee Chair of a Committee you are

interested in for more information, or just dropping in to a Committee meeting held at the Annual or Semi-Annual Meeting. Once you have identified which committee interests you, let the Committee Chair know, and then send an e-mail to AAPL's current President<sup>2</sup> and ask to be placed on that committee. Once placed on a Committee please try your best to help with Committee work, and try to attend as many of the committee meetings as possible.

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

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*"The first step to becoming involved in AAPL Governance is to join a Committee."*

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

The Nominating Committee meets at AAPL's Semiannual Meeting in May. Prior to that meeting a request for applicants will be sent to AAPL members, requesting that any member interested in a Councilor or Officer Position inform the Nominating Committee of their interest. I have served as a voting member of the Nominating Committee on five occasions. From my perspective it is important that the

letter expressing interest be well thought-out, outlining what the applicant has done for AAPL in the past. Information about the applicant's committee participation, presentations at Annual Meetings and Journal and Newsletter articles are important. What the applicant has done for forensic psychiatry outside of AAPL (APA, ABPN, child psychiatry, home university), and what the applicant hopes to accomplish on the Council may also be useful for the Nominating Committee.

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

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

Please e-mail me directly with any questions. Email: [jjanofsky@gmail.com](mailto:jjanofsky@gmail.com). I would also be happy to speak to you personally by phone. Just send me an e-mail and we can set up a time. ☎

### References:

1. Participating in AAPL's Governance: How to join the AAPL Core. *AAPL Newsletter*. 39:1, 2015.
2. <http://www.aapl.org/governance>

## Richard Rogers, Ph.D., ABPP: Clinical Assessment of Malingering: A Continuing Journey for Advancing Forensic Practice

Brian K. Cooke, MD



On the first day of the 2018 AAPL Annual Meeting luncheon attendees were delighted to hear Dr. Richard Rogers. Most readers of the *AAPL Newsletter* are familiar with his work, but here is a summary from the program – He is a Regents Professor of Psychology at the University of North Texas and a malingering expert with four decades of experience. In 1988, he edited *Clinical Assessment of Malingering and Deception*, which was recognized by AAPL and APA with the Manfred S. Guttmacher Award. He is the principal author of the *Structured Interview of Reported Symptoms (SIRS)* and its second edition (SIRS-2). His impact has been recognized by both the professions of psychiatry and psychology.

Dr. Rogers' talk was a relaxed discussion with, admittedly, a couple of research tables snuck in for good measure. Throughout, Dr. Rogers both entertained the audience and gave practical advice. For example, "If you want to malingering something, don't malingering paralysis!" When his laptop rebooted in the middle of his

presentation, he calmly laughed, "If it doesn't work, I can fake it." Discussing why it is important that the SIRS does not allow follow-up questions, he quipped that when the test asks if examinees believe automobiles have their own religion, a clever (prohibited) follow-up question would have been, "What religion – the Holy Rollers?" Groan from the audience.

He began by providing insight into his professional journey studying malingering. What lessons are there from the history of malingering assessment? His research goal was to examine detection methods and strategies. In reviewing historical methods of assessment he showed examples from the 19th century (e.g., the whirling chair, shocks from a battery) and analysis of war-related malingering.

Dr. Rogers' personal foray into malingering began with his position at Chester Mental Health Center, a maximum-security hospital in Illinois. His only study while there was to examine patient violence – when did it happen, which shift, which

staff? In 1978, he began his malingering research at the Isaac Ray Center in Chicago, with Jim Cavanaugh, MD, Barbara Weiner, JD, and Bonnie Price, MSW. In 1984, he conducted a comprehensive review examining 11 case studies, 44 experimental and 10 other studies; he concluded that most measures can be malingered; beyond the MMPI there was a hopeless mish-mash of methods, and although the MMPI reigned supreme, there was no integration of findings.

Dr. Rogers' modern conceptualization of feigned cognitive impairment looked at detection strategies (e.g., floor effect, magnitude of error, performance curve, and violation of learning principles) and a critique of malingered neurocognitive dysfunction (e.g., bias, *Daubert* limitations, and broader implications).

By this point, Dr. Rogers was primed to initiate a fundamental change. He felt there was a need to move away from the MMPI as the standard of malingering detection due to issues with examinees' literacy, possible confusion leading to inconsistent responses, and problems maintaining motivation.

His idea was to create a multi-scale inventory, and he began with 300 inquiries. The SIRS was then developed as a structured interview, which would make it easier to detect confusion and to prevent examinees from being asked follow-up questions. Notable detection strategies from the SIRS include unlikely (implausible) strategies and amplified (magnitude) detection strategies.

Despite the widespread use of the SIRS, Dr. Rogers admitted there are at least three challenges to this work. Can we use inconsistencies? (Or do inconsistencies stem from confusion and impairment?) Can we detect what is being feigned? Do overly precise cut scores cause more harm than good? Dr. Rogers concluded that the bottom line is that most feigning measures tell us only that something is being feigned. More research is needed to fully answer these questions. ☪

## Dr. Anna Lembke: The Opioid Epidemic: How We Got Here, Where We Are Now, and How to Get Out

Adrienne Saxton, MD



Weaving together fascinating historical information, witty quotes, humorous videos, alarming statistics, and practical tidbits to take home, Dr. Anna Lembke’s Friday AAPL luncheon seminar on the opioid epidemic was engaging and well-received.

Dr. Lembke is an Associate Professor of Psychiatry at Stanford who has published many articles and chapters, including in the *NEJM* and *JAMA*. She has given talks about addiction around the country in an effort to influence policy and educate health-care providers and the public. She has testified before Congress, consulted with governors and senators in several states, and has been a guest with various media outlets including NPR’s *Fresh Air*, the *Today Show*, CBS, and MSNBC. Her luncheon talk was based on her best-selling book, *Drug Dealer, MD – How Doctors Were Duped, Patients Got Hooked, and Why It’s So Hard to Stop* (2016). She received a robust round of applause, even before her talk began, with the announcement that she generously gifted a copy of her book to all of the luncheon attendees.

Dr. Lembke began by reviewing some historical information related to the development of the epidemic. Prior to the 1980s, doctors were reluctant to prescribe opioids due to two prior opioid epidemics. However, in the late 1990s, a shift occurred and doctors began prescribing opioids to everyone with pain. She discussed Big Pharma’s role in the perpetuation of three myths that trickled down into medical training: #1 Opioids work for chronic pain; #2 No dose is too high; #3 Less than 1% of patients become addicted if opioids are prescribed by a doctor. Dr. Lembke then reviewed the data that debunked these myths, including a lack of randomized controlled trials to support efficacy of opioids for chronic pain and studies that show 10-15% of people given opioid prescriptions will develop an opioid use disorder. She discussed the “Pain is the 5th Vital Sign” campaign and the effect that it had on widespread overprescribing of opioids. She reviewed some powerful statistics, including that four million people are currently addicted to opioids in the United States.

Dr. Lembke discussed factors fueling the perpetuation of the current opioid epidemic and some ideas about potential solutions. She views the opioid problem as a “systems problem” in need of a systems solution. Drivers of this problem include “The Toyotaization of Medicine,” in which private practices are shutting down in the wake of the formation of large health-care entities that tie patient satisfaction scores to promotion and advancement. She described the “Medicalization of Poverty,” in which doctors are asked to take on serious social problems such as homelessness, unemployment, and multigenerational trauma. Doctors, often well-meaning, in an effort to alleviate suffering are pressured to prescribe pills to try to dampen down the distress stemming from such issues. Because reimbursement is heavily tied to “procedures and pills,” doctors feel a push to continue prescribing medicines to treat issues that are social rather than medical.

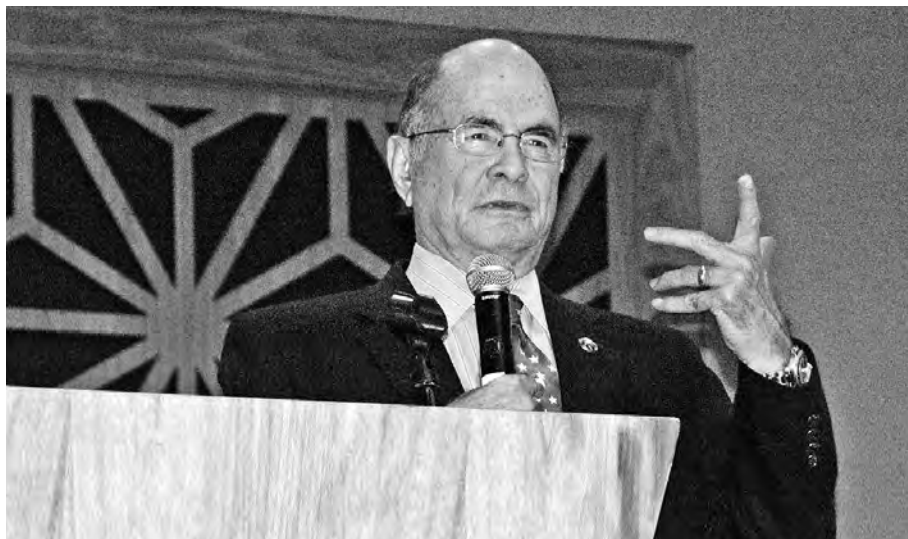
Dr. Lembke pointed out the explosion of the number of individuals on Social Security Disability for chronic pain and mental health reasons compared to the 1950s. She called for building a better social safety net so that patients are not incentivized to take on the sick role and seek pills to validate their disability status. She also discussed the shift in cultural narratives in which pain is now viewed as bad or dangerous, when historically it was viewed as part of the healing process.

Dr. Lembke encouraged physicians to talk to their patients about the way that addiction fundamentally changes the pleasure set-point in the brain. She entertained the audience with humorous cartoons reviewing many of the ways that individuals with substance use disorders try to obtain another prescription. “The senator filibuster” waits until the last 30 seconds of the appointment. “The weekender” calls the doctor on-call. “The bully” threatens to sue if his pain is not addressed. “The exhibitionist” shows the physician the location of their pain in a dramatic fashion. “The dynamic duo” involves a patient and their

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## Ranger Ramiro “Ray” Martinez: My Journey to the Top of the U. of Texas Tower

Joel Watts, MD, FRCP (C)



It was quite fitting that AAPL conclude this year’s conference luncheon lecture series with a talk about one of the first major mass shooting events in modern United States history, which occurred just over 50 years ago at the University of Texas Tower in nearby downtown Austin. We were fortunate to welcome Texas Ranger Hall of Fame inductee (the law enforcement agency, not the baseball team) and man credited with ending the tragic incident, Mr. Ray Martinez, to recount his involvement in the incident and lessons he learned in the years afterwards. Now retired, Ranger Martinez impressed with the composure and steely resolve of his actions on that fateful August 1st, 1966, when on his day off as a young patrolman of the Austin Police Department, he led the charge up the Tower bringing the incident to a close. Ranger Martinez also impressed with his thoughtful reflections and detailed descriptions of the events before a rapt audience.

Ranger Martinez gave us a detailed account of the events of August 1st, 1966, interspersed with video clips of a documentary about the incident where he led a camera

crew along the same path up the Tower that he took on that day. He also shared details about the shooter, whom he referred to as “the sniper,” explaining that he did so to prevent the latter from being glorified or receiving any special recognition he did not deserve. Ranger Martinez described how he had heard rumors just after the incident that the sniper may have seen a psychiatrist at one point, to whom he shared thoughts of hatred towards his father and ideas of going up to the Tower to shoot people. The sniper had apparently spent some time prior to the shooting planning by casing the Tower and accumulating materials. He even told friends that the Tower was “a fortress.” He gathered two rifles, a shotgun, ammunition, canned food, a transistor radio, water, rope, and gasoline, placing them on a dolly.

The sniper began the events of August 1st, 1966 by killing his mother and then his wife, apparently because he did not want to embarrass them by his later actions. He arrived on the observation deck of the Tower with his equipment, where he shot a receptionist and a family coming up the steps. He blocked the entrance to

the deck with the dolly and then began shooting down from the Tower, hitting students walking around the grounds below.

Ranger Martinez was off-duty when the shooting began and was due to start his next shift later that day. He heard about the events unfolding on the news, telling people to stay away from the Tower. He called his superiors and was told to go direct traffic on campus. After a quick call to his wife to reassure her about what he’d be doing, he left for the scene. Upon arriving on campus, he heard high-powered rifle shots, not only from the sniper, but also from members of the public who had begun shooting back at him with their own rifles. It was then that he decided he had to do more, to try and get into the Tower. Using trees for cover and running by bodies of victims while shots echoed off buildings, he zig-zagged and made his way to the west door of the Tower. Ranger Martinez told us how difficult it was for him to reconcile his previous experience and training as an Army medic to help the wounded, and then later as a police officer to “deal with the problem” by trying to end the attack. This was particularly difficult when he had to run by a wounded woman to reach the Tower.

Having visited the Tower before and knowing the layout some, he made his way up the elevator. A citizen armed with a rifle, Mr. Crum, offered to join him and the two men went up together. When they exited the elevator, people began coming out of offices that they had barricaded themselves in and one of them, a father who had witnessed his family shot in front of him, struggled with Ranger Martinez in an enraged attempt to take his gun to go after the sniper himself. Mr. Crum and Ranger Martinez were able to make their way up the stairs to the observation deck with their guns drawn and the former asked if they were “playing for keeps.” When the latter told him they were, Mr. Crum responded, “Well, you’d better deputize me,” which he promptly did. They made their way

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## Ask the Experts 2018

Neil S. Kaye, MD, DFAPA

Graham Glancy, MB, ChB, FRC Psych, FRCP (C)

Neil S. Kaye and Graham Glancy will answer questions from members related to practical issues in the real world of forensic psychiatry. Please send questions 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.:** An attorney has requested a videotaped/SKYPE interview instead of an in-person interview. I note that AAPL doesn't have a position on this and it hasn't been recently addressed in literature. Might this be something you would consider addressing in your column?



**A. Kaye:**

Ah, the marvels of technology. Telemedicine and telehealth are rapidly being adopted in all branches of medicine including

psychiatry and so it is perfectly natural to see this extend into forensics as well. Courts have adopted video technology to expedite arraignments, bail hearings, and even involuntary commitment hearings, so the law is very comfortable with using technology.

First, you need to make sure you are versed in any state laws that may apply to this procedure, as well as any licensing and malpractice issues that might exist when doing an evaluation across state lines. Currently, in the clinical domain, licensure is required in the state where the patient resides. As some states require licensure to do forensic work, this would presumably apply to doing video evaluations as well.

Just as in the clinical world, there are differences between in-person

forensic evaluations and video. I have done electronic evaluations and generally they have gone well and been without problems. However, you will have no idea who else might be present in the room with the evaluatee, acting as a coach, even though you should ask. There is a greater ease/likelihood that the evaluation will be recorded by someone else and if you aren't comfortable with that, you probably shouldn't proceed. I have also had technology issues when Internet speeds were too slow and the lag time was frustrating for both parties.

Most important, here are some things you can't do without being present in person. I do a fair number of cases where, as the evaluation progresses, I decide I would like to administer some sort of objective/standardized testing. I might decide to administer an anxiety or depression rating scale, neurocognitive screening assessments, or even a standardized test battery in a case where dementia or brain injury may be an issue. I can't do any of these without being present. You also can't check blood pressure, look for cogwheeling, check reflexes, or do the physical/neuro exam the assessment may demand.

I also find that my "feel" for the person, especially along personality dimensions and when assessing for future risk, is encumbered by the technology. People on a screen just don't always come across the same as when you are sitting with them and can "smell" the affect in the room. For those assessments I am only comfortable when I am present and can look the evaluatee in the eye.

Finally, I frequently glean additional information/insight by watching through my window as an evaluatee approaches my office, when I catch her interactions with other staff/patients, and I observe how she walks both before and after the evaluation, when her guard might be down.

None of these observations are available to me when I start the evaluation with someone who is already seated at a screen and "ready to go."



**A. Glancy**

In the interests of full disclosure, I should preface this by informing our readers that I come from a generation that is not entirely comfortable with technology. I do recognize, however, that technology is not only the future but it has arrived in the present, and we all need to accept this. I do agree with Dr. Kaye that I feel I may miss something if I cannot be physically with the evaluatee in the same room. This may well be the Luddite in me, and younger practitioners may say: "get used to it." We will all have to in the near future, except maybe licensing bodies, as Dr. Kaye points out.

Like all new technology there are pros and cons. My limited experience of Skype is that there are often glitches, and this would be unfortunate in a forensic psychiatric evaluation. It is likely that there are better technologies such as videoconferencing platforms, which would be more reliable. Further comments on the technology itself are outside my area of expertise.

There are some advantages to using some type of videoconferencing. For instance, saving the time and effort of traveling. Even traveling to a relatively local jail presents significant problems at times. These problems include the time it takes to get in and out of the detention center, the possibility of lockdowns for such things as security issues, which are common, and the availability as well as the discomfort of interview rooms. All of these could be solved by videoconferencing technology. In addition, if the evaluatee is potentially violent I can definitely see the upside to video technology. Using this technology, it would be easy to record the interview, which has advantages. One of these is that the interview can

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## Bridging the Addiction Treatment Community and the Judicial System Through Forensic Psychiatry

Brian Barnett, MD, Case Western Reserve University



Though stories concerning the opioid epidemic are now featured regularly in the media, during its infancy in Southern Appalachia,

local reporting failed to generate much interest from national media outlets. As a result, the epidemic would devastate its rural communities for more than a decade before the rest of the country began to take notice of what had been insidiously transpiring far from coastal urban centers.

The epidemic reached my hometown of Salyersville, Kentucky soon after the release of Oxycontin in 1996. It took only a few years for terms like “pain pills,” “OCs,” and “totem poles” (Xanax tablets) to enter my small town’s lexicon. By the time I started high school in 2000, I was already aware of the meanings of these words, like many of my classmates. The local newspaper’s front page began to regularly feature photos of those arrested for drug related charges, pharmacies were being burglarized frequently, and homemade signs with admonitions like “Drugs Destroy Lives” took the place of yard gnomes. We became so used to seeing pharmaceutical representatives when we went to the doctor, that many of my friends said they wanted to become “pharm reps” when they grew up.

My town and the surrounding region, which has long struggled with poverty, were unprepared for what Oxycontin heralded. In combination with the decline of the coal industry, the flood of pharmaceuticals dealt a crushing blow to Southern Appalachia. These days I live in Cleveland, having joined many of my childhood friends in the Appalachian diaspora. A large number of those

friends who stayed in eastern Kentucky struggle with addiction and divide their time between home and correctional facilities. Given the experiences of my youth, it is little surprise that I became an addiction psychiatrist. Having seen the interplay between addictions and the criminal justice system firsthand, further training in forensics seemed only natural.

Although there is strong consensus in the addiction treatment community that addiction is a disease,<sup>1</sup> the prevailing belief among the rest of society is that it results from a moral failure. Despite this misconception and strong stigma towards those with addictions,<sup>2</sup> our society is beginning to reexamine its relationship with drugs and those addicted to them. Seeing now that punishment is ineffective in curbing addiction, we are exploring how to help those with addictions while still protecting society.

There is much change afoot. Around the country recreational marijuana is being legalized and penalties for possession of other drugs have been lessened in some jurisdictions. Existing laws pertaining to drug use are also being aggressively challenged in the judicial system. The Pennsylvania Supreme Court is currently deciding whether drug use during pregnancy constitutes child abuse in the case of *In the Interest of: L.J.B.*<sup>3</sup> In Massachusetts, the state Supreme Court heard the case of *Commonwealth vs. Julie A. Eldred*<sup>4</sup> earlier this year. Mrs. Eldred posed a compelling question: If addiction is a disease, can an individual with an addiction be subjected to a probation violation if they relapse while on probation? While the Court ruled against Mrs. Eldred, the case made it clear that the judicial system’s traditional conceptualization of addiction is in

question.

Though addiction is a disease, it is not like any other disease. It is unique in its ability to drive criminal behavior, whether it be burglary or prostitution conducted in the service of purchasing more drugs or violence carried out during intoxication. There is no simple solution to addressing the role addiction plays in giving the US the world’s highest rate of incarceration.<sup>5</sup> What is certain though, is that our current approaches are ineffective. Attorneys and judges are well aware of this, and there is a growing demand among them for relevant information to inform their practice.

Several months ago, during my addiction psychiatry fellowship, I spoke about addiction to a group of law students. They asked me challenging questions, particularly about addiction and voluntariness. *When exactly does an individual with an addiction transition from voluntary substance use to involuntary? Once their disease goes into remission, how long would they have to be substance-free before a relapse would be considered voluntary? Can we quantify the level of erosion of voluntariness regarding drug use and compare it among individuals?* They wanted specific answers, but I informed them that the science was not yet so precise.

A few months later I participated in a workshop for judges who were interested in learning about addiction. They spoke of funding problems for treatment in jails and prisons, as well as the difficult decisions which arise when probationers relapse. I did not envy their position. The questions they asked were much less theoretical. They sought practical, real world guidance. *What drugs cause fatal withdrawal? What are the different medication treatment options available for addictions? How well do they work? If I preside over a rural area and there are no therapists available for defendants to see, should I really compel them to drive long distances to see one? Is there evidence that therapy even helps with addiction?* Although I could answer

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## Breaking News

Ryan Wagoner, MD, Barry Wall, MD and Praveen Kambam, MD,  
Media and Public Relations Committee

A tragedy strikes...how could this have happened? What would compel someone to do this? Was the perpetrator mentally ill?

Sadly, these headlines have become an all-too-common occurrence in our modern world. An event occurs which leads to people seeking answers, fueled by widely available and constant media coverage. Often, questions arise about the role of mental illness in legal situations and experts are sought to teach the public at large. But what does the American Academy of Psychiatry and the Law have to do with this?

In 2017, AAPL President Christopher Thompson formed the Media and Public Relations Committee, with a stated mission to “establish AAPL as the premier and primary forensic mental health organization which the media and the public approach for objective, expert information about forensic mental health issues.” Since its inception, the committee has focused on three major roles.

The first is to assist and promote AAPL’s interfacing with and providing educational and organizational expertise to the media and the public. This includes responding to media inquiries and apprising various media sources about AAPL’s availability. At this point, the Committee has begun to coordinate experts willing to talk with the media when an inquiry is made through AAPL. A careful balance is needed, though, to identify experts who can speak with sufficient knowledge, but do not represent themselves as “speaking for AAPL,” as this is a role fulfilled by our Medical Director. The next step will be to coordinate outreach to various media outlets to let them know of AAPL’s availability to comment on issues pertinent to forensic psychiatry.

The second role of the Committee has been to develop AAPL’s social media presence, in collaboration with the AAPL Technology Committee. Since 2018, AAPL has had its own Twitter handle: @AAPLorg. To date, the sole “tweet” from this account was made regarding the unfortunate death of one of our members, Dr. Steven Pitt. The Committee is in the process of coordinating with the AAPL Council on future tweets, to approve messages that AAPL is able to stand behind as an organization, while still maintain the objectivity our members strive for. A future newsletter article will delve more deeply into “What is Twitter?” and how members can participate in this social media platform.

The third role of the Committee has been to educate members on the appropriate way to engage the media in their own practices. At the 2018 Annual Meeting, the Committee presented on the topic of “The Media Interview: Keep It Interesting, and Truthful.” This was well-received by attendees, and future presentations from the Committee will continue to explore training opportunities for members wanting to interact with various types of media.

As Dr. Thompson discussed in his Presidential address at the 2018 Annual Meeting, AAPL must decide if it is an organization that wants a “seat at the table.” As public perception is increasingly affected by the media in multiple areas, including online, radio, television, and print, one seat of vital importance is the ability for AAPL and its members to communicate with the public at large. The Media and Public Relations Committee is poised to further that mission and welcomes any interested members to consider standing with us in front of the camera. ☯

## President’s Report

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try.” Susan Hatters Friedman is serving as Program Chair, and we encourage submissions regarding innovative teaching strategies and advocacy efforts for both our forensic clients and to promote our profession. In addition, we plan to continue an initiative first started by Michael Noriko, MD: a dedicated Correctional Psychiatry track at the Annual Meeting. We will review the “Flash Talk” format, first utilized this past year, to see how it was received at the 2018 Annual Meeting and we hope to continue this format to promote presentations by younger AAPL members. As many of you may know, obtaining acceptance of a submission for the Annual Meeting has become much more competitive over the years. While this is a good thing and has led to an increased quality of presentations, it has made it more difficult for younger and less well-known individuals to have proposals accepted. The review process has not been blinded, as the Program Committee reviews past ratings of speakers when deciding on ratings for new proposals. However, for the Education Committee has proposed limiting the number of program submissions to a maximum of five per AAPL member (NOT counting posters). This will require some logistical adjustments that couldn’t be worked out for the 2019 meeting. We hope this supports our younger members’ chances of getting submissions accepted – they are, after all, AAPL’s future.

I look forward to a productive year for AAPL and I am open to constructive feedback from all AAPL members regarding ways we can strengthen our organization for the future (richard.frierson@uscm.edu). I hope that all of our members will make plans to attend our 50th Anniversary Annual Meeting in Baltimore. For those members who have not attended an Annual Meeting in the past few years, 2019 is the time to return and help us celebrate this important organizational achievement. ☯

## A Clarification Regarding HIPAA

Steven H. Berger, MD

The evaluations I have done for XYZ Corporation by Skype are not HIPAA compliant. Here is the explanation of why HIPAA compliance is not required for these evaluations.

1. Not a Covered Entity. HIPAA (Health Insurance Portability and Accountability Act) compliance is required only for covered entities. My forensic psychiatry practice is not a covered entity. My practice (business) is Steven H. Berger, M.D. It is a sole proprietorship. It has no employees. It has no Tax ID number. It does not do the things that qualify an entity as a covered entity. For example, it does not transmit patient financial data or health insurance data electronically. It does transmit the bill for my services electronically. However, that is my financial data, not the evaluatee's financial data.

2. Not for Treatment: My evaluations and reports in these cases are administrative, not medical. No medical treatment is offered, rendered, or recommended. Although I evaluate medical as well as other aspects of the evaluatee, my involvement is not medical intervention or medical treatment. My involvement is not for treatment purposes.

3. Not the Practice of Medicine: HIPAA applies to "the practice of medicine". The evaluations that I do for XYZ Corporation are not the practice of medicine and they are not for treatment purposes. Whether such evaluations are the practice of medicine is debatable. I hold that such evaluations are administrative, and not medical. Such evaluations are the administrative evaluation of questions that are partly medical. An example is: Does the employee's depressive disorder fulfill the employer's definition of disability? Other examples address competence to stand trial, criminal responsibility (the insanity defense), psychiatric injury (civil lawsuits), disability, fitness for duty, dan-

gerousness, competence for any specific purpose, reasonableness of accommodation under ADA (Americans with Disability Act), compliance with FMLA (Family and Medical Leave Act), fitness for child custody, and medical malpractice.

4. Not patients: Doctors treat patients (sometimes called clients or consumers). The people that I evaluate for XYZ Corporation are not my patients. They are not called patients. They are my evaluatees. They are called evaluatees, not patients. Patients are people whom doctors treat. Evaluatees are people whom evaluators evaluate, but don't treat, just as a teacher or work supervisor evaluates an evaluatee but does not medically treat the person.

5. Not insurance: HIPAA (Health Insurance Portability and Accountability Act) regards health insurance. These evaluations have nothing whatsoever to do with health insurance. For these evaluations, health insurance is not billed, queried, or involved in any way.

If I am asked to do these evaluations in a HIPAA-compliant fashion, I will be glad to do so. HIPAA compliance will add nothing to the accuracy or reliability of the evaluations, but it will add expense and make the process more cumbersome. HIPAA compliance for these evaluations would require:

1. HIPAA-compliant Skype (or equivalent), which is not free. Ordinary Skype is not HIPAA-compliant. Ordinary Skype is free.
2. Encryption of print materials transmitted over the Internet if they include PHI (protected health information).
3. Notice of how the protected health information will be used. HIPAA requires that this notice be in writing.

The notice that I give evaluatees, about how the gathered information will be used, is only a verbal notice. Also, the information that I release is not protected health information. ☯

## Opioid Epidemic

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mother tag-teaming their request. Dr. Lembke was understanding and empathic regarding the difficult position a physician is in during the appointment with a patient due to the numerous pressures to prescribe, both in and outside the room.

Dr. Lembke called for large-scale (hospital-wide, state-wide) guidelines that would provide an impetus for the prevention of "new start" opioid prescriptions and tapering down at-risk patients who are already prescribed opioids. She emphasized the importance of this task not being left to the already overburdened primary care physicians and instead shifted to interdisciplinary "de-prescribing teams." She called for changes in reimbursement schemes to allow for billing for education and time, instead of just medications and procedures.

Dr. Lembke encouraged use of the BRAVO approach in working with patients to get them off of opioids. Briefly, the BRAVO model involves (B) *broaching* the topic, (R) engaging in a *risk*-benefit discussion regarding an opioid taper, (A) normalizing addiction (*addiction* happens), (V) slowly tapering off and validating associated distress (*velocity* and *validate*), and (O) offering *other* non-opioid treatments for pain.

She encouraged very slow tapering (over months or even a year or more) to help the patient better tolerate the taper and associated distress. Dr. Lembke urged the use of a multimodal approach to treat chronic pain issues including massage therapy, exercise, and mental health interventions.

Overall, Dr. Lembke did an excellent job highlighting a number of complex factors powering the ongoing epidemic and describing practical future steps to begin to contain the damage. ☯

## Education Committee Report

Liza H. Gold, MD and Annette Hanson, MD, Co-Chairs

Education Committee leadership has witnessed multiple comings and goings in the past year. Last year, Dr. Christopher Thompson stepped down as co-chair to take up his duties as President. This year, Dr. Richard Frierson stepped down as co-chair for the same reason: to take up his responsibilities as AAPL President. The Education Committee's losses have been AAPL's gains. Dr. Liza Gold and Dr. Annette Hanson are now serving as co-chairs of the Education Committee. We thank Dr. Frierson for his years of thoughtful and capable leadership and welcome Dr. Hanson. As of the 2018 Annual Meeting, the Education Committee has 28 members including the two co-chairs.

2018 has been a productive year for the Education Committee and for AAPL. As many of you know, earlier this year, the Accreditation Council for Continuing Medical Education (ACCME) accredited AAPL for another four years. The accreditation process is both labor-intensive and anxiety-provoking. As they have before, Jackie Coleman, AAPL's Executive Director and Marie Westlake, AAPL's Associate Executive Director, worked hard to get all the paperwork in order. Richard Frierson and Liza Gold traveled to AAPL's offices in Connecticut to participate with Ms. Coleman and Ms. Westlake on the conference call with ACCME; Christopher Thompson participated via conference call. Jackie, Marie and their staff deserve our thanks for a job well done.

There were 227 proposals submitted for the 2018 Annual Meeting, of which 154 were accepted. Of the accepted proposals, 8 were scientific papers, 10 were research-in-progress, 31 were panels, 16 were workshops, and 11 were "flash talks." The new "flash talk" presentation format seemed to be popular, and we look forward to seeing members' evaluations and comments regarding this new format. Of 36 committee propos-

als, 28 were accepted.

In addition to the many panels and workshops, the 2018 Annual Meeting reviewed seven course proposals. Of these, four were selected: "#MeToo in Court: Psychiatric Evaluation in Sexual Harassment Employment Litigation," "Contemporary Forensic Evaluation of Posttraumatic Stress Disorder," "Fundamentals of Threat Assessment," and "Insanity Defense Evaluations." All were well-attended. We look forward to utilizing the evaluations of the Annual Meeting and the courses in helping us improve our offerings for the 2019 Annual Meeting in Baltimore.

The online CME course offering is moving forward. Dr. Charles Scott and Dr. Barbara McDermott volunteered to provide the pilot series of lectures that will be available for members to review. They are preparing four one-hour presentations on the assessment of malingering. Members will be advised when and how they can take advantage of these online CMEs, but we expect that these will be available soon.

The Maintenance of Certification Self-Assessment Examination continues to be updated annually and also continues to be offered four times a year. The MOC self-assessment program has grown substantially since it was first offered in 2010 and many members have taken advantage of its availability. As of October 2018, 230 members enrolled to take the exam. There is no new information available regarding the ABPN's pilot program offering an alternative to its current 10 year MOC examination.

The Education Committee discussed a variety of issues raised by committee members. One discussion centered on whether the Annual Meeting review process would benefit by submissions being "blinded." Currently, they are not blinded, that is, they bear the authors' names. This allows reviewers to reference previous annual meeting evaluations in making their decisions regarding rat-

ing the current submissions. However, some members were concerned that knowing the authors might bias ratings.

The Committee also discussed the increasing numbers of proposals and the difficulty early career members might have in getting their proposals accepted, in contrast to longtime members, some of whom have multiple presentations at an annual meeting. The Committee discussed the possibility of limiting any individual's number of submissions (excluding posters) to no more than five submissions per Annual Meeting. ☺

### 2019 RAPPEPORT FELLOWSHIP COMPETITION

The American Academy of Psychiatry and the Law is pleased to announce the 32nd Annual Rappeport Fellowship competition. Named in honor of AAPL's founding president, Jonas R. Rappeport, MD, the fellowships offer an opportunity for outstanding residents with interests in psychiatry and the law to develop their knowledge and skills.

Winners must attend the Annual Meeting and Forensic Psychiatry Review Course, in order to win the award, short of extenuating circumstances of which AAPL is notified in advance.

The meeting will be held in Baltimore, MD from October 21-23, 2019. Immediately prior to the Annual Meeting, Fellows will also attend AAPL's Forensic Psychiatry Review Course, an intensive, comprehensive overview of psychiatry and law. At the Annual Meeting, Fellows are encouraged to attend the many excellent educational sessions, and to meet with AAPL preceptors, who can assist them in exploring interests in psychiatry and the law. Travel, lodging, and educational expenses are included in the fellowship award, and a per diem will be paid to cover meals and other expenses.

Residents who are currently PGY-3 in a general program, or PGY-4 in a child or geriatric subspecialty training program and who will begin their final year of training in July 2019, are eligible. Canadian PGY-5 general psychiatry residents and Canadian PGY-6 child residents are eligible. We will accept two nominations from each residency program. Please contact the AAPL Executive Office for more information or visit our website at [www.aapl.org](http://www.aapl.org).

# PHOTO GALLERY



2018 Class of Rappaport Fellows with Committee Chairs Britta Ostermeyer and Susan Hatters Friedman



Dr. Reid signs copies of his latest book



President Thompson reacts to a question from the audience



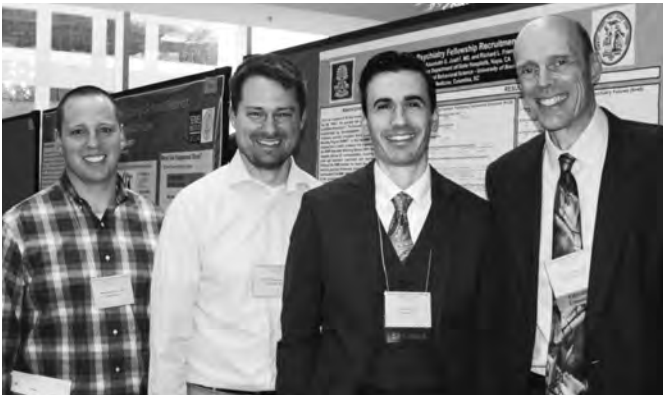
2018 Program Chairs Drs. Ferranti and Newman are excited for the meeting to begin



Dr. Binder speaks at the Women of AAPL Reception



Dr. Pinals speaks at the Women of AAPL Reception



Enjoying the first poster session of the 2018 meeting



Attendees engage with a poster presenter

# PHOTO GALLERY



The latest forensic psychiatry books on sale. Which to choose?



Attendees enjoy the Thursday night ADFPF reception



Attendees enjoy the Thursday night ADFPF reception



Attendees enjoy the Thursday night ADFPF reception



Attendees enjoy the Thursday night ADFPF reception



Catching up with colleagues



Catching up with colleagues



Catching up with colleagues

*Photo Credit: Eugene Lee, MD and Charles Meyer, Jr., MD*

# PHOTO GALLERY



Catching up with colleagues



Catching up with colleagues



Unwinding at the Friday night reception for all attendees



Unwinding at the Friday night reception for all attendees



Unwinding at the Friday night reception for all attendees



Business Meeting: President Thompson introduces outgoing *Journal* Editor Dr. Griffith



Business Meeting: Outgoing Newsletter Editor, and incoming *Journal* Deputy Editor, Dr. Hatters Friedman



Business Meeting: Dr. Thompson passes the Presidential Medal to Dr. Frierson



# PHOTO GALLERY



Drs. Berger and Resnick providing insight at the ECP Breakfast



Dr. Binder shares her knowledge at the ECP Breakfast



ECP's: The future of AAPL



ECP's: The future of AAPL



ECP's: The future of AAPL



ECP's: The future of AAPL



AAPL's Governing Body, the Council



Strong turnout for the WAAPL Reception

*Photo Credit: Eugene Lee, MD and Charles Meyer, Jr., MD*

## Myths and Realities of Intimate Partner Violence and Sexual Assault

*Susan Hatters Friedman, MD, Aimee Kaempf, MD, Renée Sorrentino, MD, Kelly Coffman, MD, MPH, Susan Ditter, MD; Gender Issues Committee*

From Harvey Weinstein to Rob Porter, high-profile cases of alleged sexual assault and domestic violence have recently made headlines, leading to increased public discourse on the topic of violence against women. The Me Too movement, started on social media to help demonstrate the widespread prevalence of sexual assault and harassment, spread virally in the autumn of 2017. TIME Magazine named “The Silence Breakers” (individuals who spoke out against sexual assault and harassment) 2017’s Person of the Year. Despite heightened public awareness, misconceptions remain about sexual assault and intimate partner violence. Domestic violence is most often portrayed as physical in nature and as perpetrated by men. More subtle forms of abuse such as possessive and intimidating behaviors, and abuse perpetrated by women may be overlooked. Expectations about how “real” victims would behave during and after an assault may result in doubts about the credibility of a victim and her allegations. Forensic mental health professionals, either in their roles as treatment providers or as expert witnesses, are likely to encounter victims and perpetrators of sexual assault and domestic violence, and thus should be familiar with relevant topics within the field. This article aims to explore some of these complexities, including bidirectional intimate partner violence, coercive control as a form of abuse, and explaining counterintuitive victim behaviors to jurors and others who may be uninformed in the area.

Myths about intimate partner violence (IPV) include that it is a singular phenomenon where the male is the batterer and the female is the victim; and that whenever the female strikes the male, it is in self-defense. While this was the state of our understanding in the 1970s, research has led to a much greater depth of understanding

of the breadth of intimate partner violence. Violence has been described in several different patterns including Coercive Controlling Violence (which is the most severe and violent form, primarily perpetrated by men; and on which early studies were based); Violent Resistance (which is akin to the self-defense type violence early reports were based on); Situational Couple Violence; and Separation-Instigated Violence. (Kelly & Johnson 2008) Situational Couple Violence, the most common type of violence, is rather gender-symmetric. In Situational Couple Violence, there is not the same backdrop of misogyny and relationship pattern of power and control. Rather, arguments between the partners escalate into violence due to poor ability to manage anger and conflicts. Finally, the fourth type, Separation-Instigated Violence, occurs when there is no prior history of relationship violence, but after public humiliation, or traumatic separation, discovery of a mistress/lover, etc. It may be perpetrated by either partner—whichever partner suddenly finds themselves being left.

These understandings—that there are various types of intimate partner violence, and that it is not only males who are violent—are critical if appropriate screening, treatment, and adjudication are to occur. Intimate partner violence is often bi-directional. When men are violent, it is not always to control and dominate; when women are violent, it is not only in self-defense.

Coercive Control (CC) shifts the context for understanding IPV from Battered Women’s Syndrome (BWS, which focuses on the victim’s psychological response to violence). BWS served to view the victim’s assault as different from other assaults, and held the victim partially responsible for her assault. CC focuses on the perpetrator. It is a pattern of

pervasive, malevolent domination of women with the goal of controlling victims by imbuing them with fear. This is achieved through gender-stereotyped violence, intimidation, isolation, humiliation, and control. Every aspect of the woman’s life may be monitored and controlled. Child and animal abuse, emotional abuse, gaslighting, property destruction, and restricting access to finances and social supports are some of the tactics used. Technology, such as GPS, key-stroke monitors, and video surveillance, have increased the severity and reach of perpetrators’ stalking. CC significantly increases the risk of severe violence, fatality, and sexual assault, especially when the woman leaves the relationship. Because of the lack of awareness of CC, faulty expectations by juries, attorneys and the courts regarding how IPV victims “should” behave may result in victim blaming and discounting of their allegations.

In 2016 there were 1.2 incidents of rape/sexual assault per 1,000 Americans (Morgan & Kena, 2016). Populations particularly vulnerable include Native American or Alaska Native women, multi-racial, non-Hispanic women, and people in the transgender community (Lonsway & Archambault, 2012). Some studies estimate that the rate of rape/sexual assault in the transgender community is as high as 50% (Lonsway & Archambault, 2012).

Stories of sexual assault allegedly committed by high-profile individuals currently dominate the media. These stories have in common that alleged victims did not report their assault immediately. In fact, the public perception that victims of rape/sexual assault frequently report their attack is simply wrong. The vast majority of sexual assaults, up to 60-80%, are never reported to law enforcement. Of those that are reported, only 25% are reported within the first 24 hours after the assault (Lonsway & Archambault, 2012).

This phenomenon of delayed reporting, or not reporting at all, is one example of a “counterintuitive

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## The Psychological Autopsy in Correctional Settings

Ariana Nesbit, MD, MBE and Elizabeth Ferguson, MD,  
Corrections Committee

Although the population of inmates in the United States has decreased, jail and prison suicide rates are on the rise (Noonan, Rohloff, & Ginder, 2015). The National Commission on Correctional Healthcare (NCCHC) Standards for Mental Health Services in Correctional Facilities and the National Institute of Corrections recommend that correctional facilities carry out a “morbidity-mortality review” after an inmate suicide as a component of a suicide prevention program (Hayes, 2017). A *psychological autopsy* is one type of post-mortem review that may help correctional staff, not only to understand the factors that contributed to the inmate’s death, but also by providing support to the grieving staff (Beckson & Berman, 2015; Spellman & Heyne, 1989).

During a wave of drug-related deaths in Los Angeles County in the late 1950s, Dr. Edwin S. Shneidman stated that, in each case, there needed to be “nothing less than a thorough retrospective investigation of the intention of the decedent” in order to determine whether the death was accidental or intentional (Shneidman, 1981). Dr. Shneidman referred to these retrospective reviews as “psychological autopsies,” thereby coining the term (Beckson & Berman, 2015; Scott, Swartz, & Warburton, 2006).

There are many different methods by which a reviewer may conduct a psychological autopsy; different agencies have developed specific protocols. However, all psychological autopsies involve an extensive review of collateral information and the consideration of six different factors: 1) the physiological cause of death; 2) the mode of death (e.g., homicide versus suicide); 3) the motive; 4) if a suicide, the decedent’s intent; 5) if a suicide, the lethality of the decedent’s behavior; and 6) if a suicide, whether the suicide was “sane” or “insane.” A suicide is considered to be “sane” if

the individual understood that their actions were likely to result in their death. In contrast, a suicide is considered to be “insane” if the decedent was so “emotionally disturbed that they [did] not rationally appreciate the relationship of their actions in causing the death” (Beckson & Berman, 2015; Scott et al., 2006).

Conducting psychological autopsies in correctional settings can present several challenges. One such challenge occurs when mental health professionals who work for the correctional institution are responsible for carrying out the retrospective review. In these cases, the correctional mental health professional may struggle to remain impartial. This is because the psychological autopsy may reveal that the facility mismanaged, or otherwise inappropriately cared for, the inmate. For this reason, some authors assert that reviewers should not be employed by the correctional facility. Instead, the correctional facility should hire independent mental health professionals with experience working in the type of correctional facility to which they will be consulting (i.e., jail or prison) (Hayes, 2010).

Although an independent investigation may be ideal, psychological autopsies conducted by the facility’s psychiatric staff may still be beneficial. Similar to a hospital-based morbidity and mortality conference, an exclusively in-house psychological autopsy that is a non-punitive and confidential review may help participants in a manner that is difficult to achieve in other settings. Participants may not only process the suicide but also discuss and uncover ways to improve patient care and safety without fear of retribution. However, if the psychological autopsy is done by the facility’s psychiatric staff members, the involved staff should acknowledge that their employment at the facility could be considered a conflict of inter-

est and that this increases their risk for bias.

Regardless of whether or not an individual conducting the psychological autopsy is employed by the correctional institution, the reviewer may encounter “deliberate distortions and hidden agendas” while conducting collateral interviews (Selkin, 1994). For example, staff may distort information in order to protect themselves and their employer, whereas inmates may make false statements for secondary gain (Aufderheide, 2000; Selkin, 1994). This is another reason why it is important that the individual conducting the psychological autopsy has experience with the type of correctional facility to which they will be consulting.

Although there are challenges to conducting psychological autopsies in correctional institutions, there are also advantages. For example, in community settings, it can be difficult to determine how the individual was behaving and what activities he or she was engaged in during the time period leading up to his death. In contrast, in corrections, the reviewer usually has easy access to the people (i.e., the correctional staff and other inmates) who interacted most closely with the decedent prior to the suicide. Furthermore, in correctional facilities, the investigator has access to a wide-range of information about the decedent including telephone and visitation logs, personal belongings, health records, and disciplinary reports (Aufderheide, 2000).

Correctional staff should be aware that disclosure provisions under state and federal laws may not protect the confidentiality of the quality assurance document that results from the psychological autopsy (Hayes, 2017). This lack of confidentiality may interfere with the participating staff’s candor regarding potential deficiencies in their policies and care. For this reason, some authors have asserted that psychological autopsies should only be initiated at the request of the correctional facility’s legal counsel; this will increase the likelihood that the process will remain confidential.

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## Using Civil Commitment for Substance Use Disorders: What can we learn from Casey's Law and Similar Legislation?

Corina Freitas, MD, MSc, MBA

Addiction Committee

At the recent AAPL Meeting in Austin, Texas, the Addiction Committee presented a workshop about the use of civil commitment for Substance Use Disorders (SUD). About 95% of the people in the U.S. who do not receive substance use treatment also do not recognize the need for it.<sup>1</sup> This, combined with the rising overdose mortality rates, mostly attributed to opioids, has led to more states considering passing laws for involuntary addiction treatment. However, several states with statutes permitting civil commitment of an adult for SUD do not use or underutilize their existing laws.<sup>3</sup> Additionally, some forms of coerced treatment are already socially acceptable, such as treatments sanctioned by drug courts and employee assistance programs.

In 2004, two years after Matthew "Casey" Wethington died of a heroin overdose at age 23, Casey's Act for Substance Abuse Intervention became effective in Kentucky. Other states have passed similar laws, such as Indiana's Jennifer Act and Florida's Marchman Act, that authorize the civil commitment of individuals with SUD. As of March 2018, 37 states and the District of Columbia had statutes permitting adult civil commitment for addiction treatment.<sup>1</sup> However, these laws are complex, with variable language, procedures, and utilization processes across states,<sup>4</sup> and outcomes data are limited.<sup>2</sup>

### Ethical and Practical Considerations

Despite general support in medicine and psychiatry for approaching SUD as a biological illness, 21 states explicitly exclude SUD from their definition of mental illness. Moreover, even supporters of SUD as a biological illness raise concerns about deprivation of liberty, especially as it

pertains to 14th Amendment rights, infringements on the general principle of autonomy. Patients with SUD could also end up being hospitalized on a psychiatric unit or in a correctional setting with inadequate provisions for addiction treatment, such as medication-assisted treatment (MAT). Without appropriate follow-up care, patients who are detoxified off of substances, such as opioids, may be at elevated risk for overdose. How to enforce these laws also becomes a practical limitation.

### Special Populations

Further layers of complexity are added in matters involving pregnancy and minors. In pregnancy, substance abuse places the fetus at risk, despite the mother not necessarily being a danger to herself. The first issue to be clarified is: When is a fetus considered a person? Second, does tort law apply if the mother is pregnant? The US Supreme Court does not recognize any constitutional rights for the unborn nor have they yet addressed involuntary commitment for SUD in pregnancy. The issue of viability was settled by *Roe v. Wade*, and in criminal law, once the fetus is viable, any injury (from any cause) to the fetus by a third party is an offense if the child is born alive, or if the accused is charged under a feticide statute. On the other hand, when a woman delivers an illicit substance to her unborn child, this behavior does not become an offense under child welfare or criminal statutes until the child is physically separated from the mother, and the injury can be directly attributed to the drug use. In civil courts the issue has more precedents. State courts have found that involuntary civil commitment does not offend the due process rights of an alleged child abuser, if the commitment proceed-

ings follow appropriate procedures in the involuntary commitment of a pregnant, substance-abusing woman who poses a threat to her viable unborn child.

State policies have also been developed in many states, at a faster rate than general adult SUD commitment laws. Twenty-three states and D.C. consider SUD during pregnancy a form of child abuse under child welfare statutes.<sup>6</sup> Three of these states (Minnesota, South Dakota and Wisconsin), go even further and consider SUD during pregnancy as grounds for civil commitment. Twenty-four states and D.C. also have mandatory reporting statutes for known or suspected SUD during pregnancy, with only eight also mandating testing for suspected drug abuse, prior to reporting. Despite the strong legal repercussions, less than 20 states have adequate programs for treating these women. Of note, it is the American College of Obstetricians and Gynecologists opinion that "Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus."<sup>5</sup>

For minors, the main point of contention, especially for adolescents, is capacity. Considering that 14- to 17-year-olds are presumed as capable as adults, the question of their due process rights has been debated. What standards should apply? Should an adversarial commitment hearing be allowed as for adults? Are Constitutional rights the same? Courts have decided that if the minor is presumed to have capacity, due process is required. In *Parham v. JR*, the U.S. Supreme Court held that a parent or guardian can commit a minor to a mental institution if a physician certifies that the minor should be committed, even if the minor objects. The *Parham* Court recognized issues of civil commitment are essentially medical. The substance abuse assessment is civil and therapeutic, and thus its administration need not be challenged by the juvenile's attorney. Minors' social situations can also add to the complexity of the issue. For

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## An Autopsy of Mass Shootings

*Corina Freitas, MD, MSc, MBA; Karen B. Rosenbaum, MD; Philip Candilis, MD, Dennis Bechtel; James Knoll IV, MD Criminal Behavior Committee; Forensic Sciences Liaison Committee; Law Enforcement Liaison Committee*

Mass shootings engender significant controversy over the issues of gun violence and the role of mental health. When news of a mass shooting breaks, three questions typically arise: How many are dead? Who was the shooter? What was the motive? The last question allows the media and others to speculate, often based on inadequate information.

The media sensationalizes violent crimes committed by people with mental illness, especially after mass shootings (Varshney et al. 2016). This contributes to stigma, discrimination and ill-advised laws targeting persons with mental illness. Jorm and Reavley (2014) concluded that the vast access to firearms in the United States, and the way the media currently portray those with mental illness, have contributed to the inaccurate belief that persons suffering from mental illness threaten public safety.

The definition of mass shootings was settled by Congress in 2013: “3 or more killings in a single incident... in a place of public use.” Excluded were killings in the setting of obvious criminal activity (for example, gang killings). Overall, mass shootings cause 0.46% of annual gun deaths (Berkowitz et. al., 1999/2018). Nevertheless, their impact on society greatly exceeds their frequency. Further, it is of concern that, since the year 2000, mass shootings appear to be on the rise.

Analyses over the years, since the 1966 University of Texas Tower sniper, have led to a better understanding of shooter motivations and have also begun to reveal identifiable factors which may aid in future prevention efforts. FBI data demonstrates that mass shootings are not “impulse kills,” as 77% of shooters have spent at least a week planning and 46% of them have spent about a week preparing (Silver et al., 2018).

The shooters typically demonstrate an average of 3.6 concerning behaviors up to one year prior to the shooting. Such behaviors include problematic interpersonal interactions and leakage of violent intent (such as talking about plans or purchasing supplies). However, only 41% of people who observed these behaviors reported them to law enforcement. More common was communication directly to the future shooter (83%) or doing nothing (54%).

Studies of mass shooters suggest various motives, but most often include strong grievances and rageful envy, leading to a perception of injustice (Silver, 2018; Knoll and Annas, 2016; Knoll 2012). Unrelenting grievance results in a preoccupation with the need for revenge. Almost half do not plan to survive their attacks and proclaim suicidality up to one year prior to action (Silver et.al. 2018).

The FBI report notes that “mental illness,” of any type, which included developmental disorders, personality disorders as well as serious mental illness, had been diagnosed in 25% of the shooters, adding that, “There may be complex interactions with other stressors that give rise to what may ultimately be transient manifestations of behaviors and moods that would not be sufficient to warrant a formal diagnosis of mental illness.” Steadman et al. (2015) found that 2% of psychiatric patients committed violent acts involving a gun, with only 1% committing violence with a gun against a stranger. Baumann and Teasdale (2017) found that psychiatrically hospitalized patients were more likely to report suicidality than to perpetrate violence. Moreover, studies have found that both substance abuse and binge drinking have been implicated in firearm violence, and Wintemute (2015) concluded that restricting firearm ownership from binge

drinkers would be a more efficacious means to prevent firearm violence.

Ethical analysis of the seeds of mass shootings and their political context are complicated by the usual application of rights language. This is commonly characterized as a tension between the right to bear arms and the right to be safe in one’s community. But, recent work by Yale professor and AAPL member Alec Buchanan, MD, PhD underscores the inadequacy of autonomy-driven rights language: even if decisions serve autonomy and individual rights, the purpose to which the autonomy is turned may still undermine the dignity of persons – an essential element of human rights. Because certain rights may undermine a community’s peaceful existence, they may not be sufficient to justify policies of continued access to such items as high-capacity magazines and bump stocks. Finally, there is evidence from Sen and Panjamapirom (2012) and others of widespread support for policy measures like universal background checks.

Law enforcement officers (LEOs) and psychiatrists can help in several ways: train, collaborate and advocate. For example, by participating in active shooter training, psychiatrists can provide timely information about officer behavior and thus help prevent in-the-field “freezes.” However, should that occur, psychiatrists can be flexible in their therapy with officers and advocate with departments in order to de-stigmatize how they are perceived by LEOs and thus improve their overall health, resilience and performance.

Collaborating with LEOs in areas such as threat analysis can help schools better determine when a student poses a threat (vs. simply making one). Last but not least, responding to a mass casualty event is traumatic for everyone. This emphasizes the importance of teaching LEOs about psychological first aid for themselves and other survivors.

The issue of mass shootings remains a challenging societal problem. Even a cursory examination of the literature demonstrates that the

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## Women's Committee Proposed

Liza H. Gold, MD

On October 25th, 2018, AAPL's governing council heard a proposal to form a Women's Committee to address women's issues in AAPL and in the profession of forensic psychiatry. We believe that the active identification of visible and "invisible" gendered practices that have historically disadvantaged women and interventions in practice, culture, and organization are best addressed by a committee charged with these goals. We hope to be able to strengthen AAPL as an organization and AAPL members through a dedicated focus on the common issues that affect women in AAPL and in the practice of forensic psychiatry. We also believe that addressing such gender inequities benefits both men and women members of AAPL.

The Women's Committee agenda will include issues women commonly encounter related to practice, professionalism, career and academic challenges in forensic psychiatry. This committee will also discuss the possibilities of providing a formal and/or informal forum where women members can bring relevant issues that may arise in AAPL or at AAPL meetings. Having such a forum as well as mentoring and promoting women into clinical and academic positions of leadership are essential in the development of gender equality.

Gender inequalities persist in psychiatry, forensic psychiatry, medical specialties in general, and throughout the legal system. Female forensic psychiatrists operate at the intersection of multiple male-dominated systems. Although the numbers of women in forensic psychiatry have increased, as reflected in AAPL membership (1994 - about 10%; 2004 - about 25%; 2018 - about 35%), forensic psychiatry remains a male-dominated field.

Traditionally male-dominated professions, such as medicine, the law, and the justice system reflect well-documented practices of institutionalized gender disparities that disadvan-

tage women. These practices may be "invisible," i.e., traditional practices not often examined, or may become apparent under new and unexpected circumstances. Whether visible or not, these practices continue to disadvantage women in psychiatry generally and in forensic psychiatry as well.

The Women's Committee is not intended to duplicate the Women of AAPL initiative and would serve congruous but different functions. "WAAPL" provides a network for early career women AAPL members to connect with more established women forensic psychiatrists. The Women's Committee is intended to be academically, organizationally, and institutionally focused and to provide women AAPL members with a forum to more broadly address gender inequities.

The Women's Committee also does not intend to duplicate issues addressed by the Gender Issues Committee or the Diversity Committee. Both these committees serve important functions. However, gender is a cultural and social construction that may affect both men and women in multiple ways, including, for example, LGBTQ issues. Sex, that is, the designation as male or female that typically occurs at or even before birth, is a biologically-determined assignment that is for the most part binary. Diversity covers even more categories of traditionally underrepresented groups and AAPL members than does gender. These committees are focused on gender issues in our evaluatees and patients and in correctional settings. To date, they have not directly focused on or addressed women's issues which challenge AAPL members in their own clinical practice, academic institutions, or within AAPL itself.

Although gender, diversity, and biological sex issues may overlap, they are not congruous. Those issues that are unique to women are most effectively addressed as a separate

priority. However, where the agenda of the Women's Committee overlaps with issues that might be of interest to the Gender Issues Committee, the Diversity Committee, and/or WAAPL, we hope to invite collaboration among these important groups.

We need to have at least 12 members to get this committee up and running and we hope to have strong representation of women of color, LatinX women, and other historically underrepresented groups of women. Men are of course welcome to participate in this committee. We are planning to have our first meeting in May 2019 at the Semi-Annual AAPL meeting at the APA Annual Meeting in San Francisco. We plan to prepare an agenda of ideas and action items for discussion prior to APA based on committee member input.

If you are interested in becoming a member of this committee email [office@aapl.org](mailto:office@aapl.org) to the attention of Dr. Richard Frierson. Please include a brief statement describing your interest in being a member of this committee. ☪

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# Criminal Behavior and Critical Criminology

Kavita Khajuria, MD

Much has been written recently about politico-socio-economic turmoil and its potential effects. Critical criminology is based on the view that crime is a function of social, political and economic conflict in any society. Law and the criminal justice system are viewed as instruments of power. Criminal law is believed to be designed to protect the wealthy and powerful and to control the poor.

The roots of critical criminology trace back to Karl Marx who believed that modern capitalism turned workers into a dehumanized mass. His view of economic inequality with its resultant social conflict had a profound influence on 20th century thought. Social unrest of the '60s produced criticism of the ruling class and their methods of analysis of criminal and delinquent behavior, which gave birth to critical criminology. Attention was called to the political nature of social control and its contribution to deviance. New methods of analysis and critique were called for. The unequal distribution of power and wealth were cited by numerous scholars to be the root causes of crime.

Contemporary critical criminology tries to express the connection between social class, crime, and social control. The role of the government is viewed as conducive in creating a criminogenic environment,<sup>1</sup> and the relationship between human power and the shaping of criminal law is examined. Crime is viewed as a political concept, with the economically and politically powerful controlling the definition of crime and the manner in which the criminal justice system enforces the law. Criminal behavior by the impoverished is attributed to frustration, anger and need. The death penalty, three strikes laws and the war on drugs have all resulted in mass incarceration, considered by critical thinkers to be a crime control device in of itself. Contemporary research exposes race and

class to influence criminal justice decision making, with bias in both prosecution and punishment. Criminal courts are more likely to dole out stiffer punishments to members of powerless, disenfranchised groups. Yet crimes committed by the dominant ruling class receive more lenient treatment.

Critical thinkers believe that business owners accelerate surplus value with displacement of workers into minimum wage, temporary jobs, or replacement with computer-driven machinery. Upon marginalization outside the economic mainstream, commitment to the system declines, producing another criminogenic force: a weakened bond to society. Some experts believe globalization to have replaced imperialism and colonization as a new form of economic domination. This disproportionately benefits the wealthy while increasing vulnerability of indigenous people to the forces of globalized capitalism. Technological advances and the cultural shift with free market and trade are believed to encourage criminality.

Left realism is a left leaning approach, considered realistic in its appraisal wherein crime is seen as a class conflict in an advanced industrial society. According to left realists, it's possible for community organization efforts to eliminate or reduce crime before police involvement becomes necessary. This approach may be gaining a hold in the U.S, as the more conservative states have begun to reduce their prison expenditures while funding treatment, reentry, and incarceration alternatives. More recently, concepts of left realism have been used to explain motivations for terrorist activity, which include relative deprivation, peer support subcultures, and opportunity.<sup>1</sup>

To remedy the lapse in explaining female criminality, critical feminism views gender inequality to stem from male capitalist domination. It

explains both victimization and criminality among women in terms of patriarchy and exploitation. Powerlessness increases the likelihood that women will become targets of violent acts. Women's victimization rates decline as they are empowered socially, economically, and legally.

Boys and girls have also been viewed differently. Boys who get in trouble may be considered to be overzealous. Girls who get in trouble are seen as a threat to acceptable images of femininity and their behavior is considered more unusual and dangerous. Throughout history females have been more likely to be punished for their immoral behavior rather than for criminal activities. Girls raised in the patriarchal family are socialized to fear legal sanctions more so than males. In egalitarian families where couples share similar positions of power at home and in the workplace, daughters gain freedom that reflects reduced parental control, and law violating behaviors that reflect those of their brothers.

Not all critical thinkers agree. Critics question the excessive focus on elite crime and deviance and the disproportionate victimization of poor and minority communities.<sup>2</sup> Others cite neglect of individual factors, including psychopathology, neurobiology, genetics, psychological processes, culture, random or spontaneous acts of violence, and other factors in the life trajectory.

In sum, the critical theory can be considered to be one amongst many that can be taken into account when attempting to understand criminal behavior. The latest form of contemporary critical criminology includes a variety of progressive, humanistic and radical perspectives that seek to embrace resistance to unjust social conditions and inequality.<sup>3</sup> Others envision a future oriented approach with integrated historical, libertarian, and collectivistic perspectives and seek a more just, co-operative, and egalitarian world.<sup>2</sup> ☯

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## Engaging General Psychiatry Residents: Forensic Educators as Storytellers

Tobias Wasser, MD and Katherine Michaelsen, MD, MASC,  
Forensic Training of Psychiatry Residents Committee

While forensic psychiatry fellowship may be the ideal way to expand a psychiatrist's knowledge and skills at the legal interface, we recognize that most psychiatrists will not pursue forensic fellowship. Instead, most psychiatrists are limited to their didactics and clinical experiences in residency, which vary greatly between general psychiatry training programs.<sup>1</sup> Though other ACGME subspecialties have a more clearly identified role in training through required and defined rotations, forensic psychiatry is often integrated into other clinical experiences or taught in the classroom – sometimes leaving residents with less-than-ideal practical understanding of forensic psychiatry. Perhaps unsurprising in this context, many residents express discomfort with forensic patients and topics,<sup>2</sup> which is particularly distressing when we consider that most providers continue to base their practice on what they learned during training.<sup>3</sup> However, there is hope – Booth, et al.'s recent survey suggests that greater experience with forensics in classrooms and especially in clinical settings is associated with increased comfort with and willingness to treat forensic patients,<sup>2</sup> highlighting the possibilities associated with a greater quantity of forensic experiences.

Unfortunately, in our experience residents have a variety of responses to forensic topics. Some residents are immediately attracted to the field and may consider forensic fellowship. These residents are already drinking the forensic “Kool-Aid,” and require little additional effort to make forensic psychiatry feel relevant or compelling. However, some residents become overwhelmed by complex cases or legal regulations, while others express apathy about a field they consider unrelated to their daily clinical work.

Part of our role as forensic educa-

tors is to answer the questions: what is forensic psychiatry? And, how is it relevant to my practice? Addressing these questions may ease discomfort and motivate residents to learn more and, hopefully, to improve their practice. Though we also advocate for a greater quantity of forensic training in residency programs, here we will focus on quality with a review of one approach to engaging and educating residents.

When working with residents we highlight the breadth and relevance of the field to all psychiatrists. For example, we note that state and federal laws have a significant impact on the practice of medicine and that psychiatry is one of the most legally-regulated of all medical specialties.<sup>4</sup> Therefore, it is critical for psychiatrists to become familiar with the laws governing their practice locale and setting. Further, there are inadequate forensic psychiatrists to treat all incarcerated and/or justice-involved individuals (let alone all the other forensic tasks), thus, even general psychiatrists are likely to work with justice-involved individuals with mental illness.<sup>5, 6, 7</sup>

When addressing resident discomfort, we have found developing clinically relevant stories most useful. While landmark cases may provide an important introduction to basic legal principles, without careful guidance or pre-existing interest, residents may be turned off due to their length and foreign-seeming presentation. Similarly, lectures about case law and statutes, the criminal justice system, or diversion without relatable examples may fail to captivate residents. Adult learning theory emphasizes that innovative, interactive, and case-based approaches can be particularly effective at engaging trainees.

Part of what attracts students to psychiatry is often an interest in patients' individual stories. In foren-

sic psychiatry, we are especially attentive to the complex personal histories that lead to encounters with the legal system, and we can use this to our advantage. Bringing to life patient cases is one way to inspire residents' natural curiosity and build upon their existing knowledge and experience in a way that feels relatable.

For example, we have synthesized clinical case vignettes from landmark legal cases, where residents assume the role of the case's clinician, take a stance on a legally relevant question, and develop an approach to the situation. This introduces residents to legally relevant scenarios in a manner that is consistent with their prior training. We follow with a review of the details of the actual legal case and its historical significance, which leads to a discussion of the relevant legal and clinical principles. We have developed this format in both written<sup>8</sup> and online teaching materials and believe it can be an effective approach to engaging residents in our field. We advocate for forensic educators to continue to develop such materials and to build a collection of educational resources that can be shared, tailored to meet individual needs, and improved over time.

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## American Medical Association 2018 Interim Meeting Highlights

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

The American Medical Association's (AMA) 2018 Interim Meeting was held in National Harbor, Maryland in November 2018. Physicians and trainees from around the country convened to consider resolutions and reports on current topics related to clinical practice, regulation of medicine, medical education, and public health.

AMA Executive Vice President and CEO James L. Madara, MD spoke at the opening session about the role for physician leadership, stating that there are “vast structural gaps” in healthcare delivery. “And if these large projects do not start with physicians, we’ll find a future where, once again, optimally supportive infrastructure is lacking.” He highlighted three areas for physicians to focus their attention: advancing new models of medical education, addressing the burden of chronic disease, and confronting barriers in healthcare.

Barbara L. McAneny, MD, an oncologist from New Mexico, is the current AMA President. In her presidential speech, Dr. McAneny emphasized, like Dr. Madara, the importance of physician leaders in combating challenges to healthcare access and delivery. She provided examples of pre-authorization, health industry consolidation, increasing costs of prescription medications, and deficiencies in access to health insurance in relation to poor patient outcomes. Dr. McAneny specifically advocated for policymakers to address gun violence in the United States. “Friends, these deaths — from mass shootings, from suicide, from children gaining access to a parent’s firearm — are preventable.... Policymakers at the state and federal level must act on common-sense, data-driven measures to prevent yet more carnage.”

Dr. McAneny also called out the

problem of sexual harassment within the profession of medicine. Later in the meeting, delegates to the 2018 Interim Meeting heard personal testimony of members’ experiences with harassment and voted with overwhelming support for the AMA to obtain independent consultation to better improve the systems of reporting, fact-finding, and adjudication of claims of harassment — in all forms — at meetings and programs sponsored by the AMA.

Delegates further addressed a number of reports and resolutions with important mental health considerations. Among these, delegates considered a revised report prepared by the AMA Council on Ethical and Judicial Affairs (CEJA) on physician participation in assisted suicide. Similar to its earlier report, CEJA’s revised report retained the AMA position against physician participation in assisted suicide, but aimed to balance the complicated ethical considerations (specifically addressing jurisdictions where physician-assisted suicide is legal) by offering a methodology for clinicians to use their conscience in making individual decisions on this issue. Delegates voted to refer back to CEJA for further consideration with some delegates asking the AMA to take a stance of engaged neutrality on the topic.

In the days preceding the AMA Interim Meeting, the National Rifle Association posted on Twitter that physicians should “stay in their lane” with regard to policies on firearms. The tweet came hours before the shooting in Thousand Oaks, California that killed 13 people and wounded an additional 18 at the Borderline Bar and Grill. Doctors around the country have responded with stories of treating gunshot victims and asserted that physicians can make valuable contributions to the gun

debate. Reflective of this response by physicians nationally and drawing on previous AMA policy declaring gun violence as a public health crisis, AMA delegates adopted a resolution to encourage the Centers for Disease Control and Prevention, in collaboration with other organizations, to develop recommendations for best practices for media coverage of mass shootings in an effort to reduce any contagion effect as previously demonstrated with suicides. Delegates also adopted an amended report by the association’s Board of Trustees on firearms. The amended language supports gun violence restraining orders or similar “red flag” laws aimed to prevent gun access for individuals with demonstrated signs of potential violence.

Of interest to APPL members, AMA delegates discussed topics related to detention and correctional facilities, including policies and practices of separating undocumented immigrant parents or guardians from their children. Delegates voted to support the administration of psychotropic medication to immigrant children only when there has been an appropriate evaluation by medical personnel and with parental consent, except in cases of imminent harm and to urge continuity of healthcare for migrant children once released from detention facilities. With backing by the National Commission on Correctional Health Care, Tobias Wasser, MD, testified in support of a resolution to support mental health training programs for corrections officers in all detention and correctional facilities; the resolution was adopted by the House of Delegates.

The Psychiatry delegation celebrated and said good-bye to Carolyn Robinowitz, MD, who served as Chair of the AMA’s Section Council on Psychiatry since 2010. Jerry Halverson, MD, a psychiatrist from Wisconsin, took over as the section’s Chair. Throughout the meeting, Dr. Barry Wall continued to serve as the Co-Vice Chair for the Section Council on Psychiatry. Jennifer Piel, MD, JD continued to serve on the Young

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## Ranger Martinez

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out onto the observation deck. They could hear people on the ground trying to shoot the assailant through drain pipe holes in the walls of the observation deck. Another officer, McCoy, joined Ranger Martinez and they made their way around the building. Upon seeing the sniper, Mr. Crum shot at him and missed, hitting the wall, distracting the sniper from taking a shot that might have hit Ranger Martinez. The latter was then able to shoot back himself and hit him in the chest. He continued shooting, emptying his revolver as Officer McCoy also hit him, spinning him around. Ranger Martinez then shot him with the assailant's own shotgun that was lying on the deck. Feeling light-headed and after eventually being assisted to the bottom of the Tower, Ranger Martinez reassured others that he was uninjured, and called his wife. He told her, "Dear, I'm all right," to which she replied, "Why wouldn't you be, you're working traffic!"

Ranger Martinez shared many sage reflections about the aftermath of this incident, including the lack of leadership during and after the incident. He was critical of the substandard autopsy conducted on the assailant and the lack of an official post-incident review, both of which prevented officials from learning and improving procedures. He expressed sorrow at the impact that the incident had on so many involved, including those physically injured and those who suffered PTSD symptoms. Ranger Martinez was gracious in answering many questions thoughtfully and expressed concern about some existing gun laws allowing civilians to own high-capacity magazines and automatic weapons. ☎

## Ask The Experts

*continued from page 9*

be easily transcribed, creating an accurate written record of the interview.

As has been discussed elsewhere, it is also useful in some cases to get an accurate contemporaneous recording of the evaluatee's mental state at the time of the interview. In some types of cases, for instance not guilty by reason of insanity assessments (known as NCR MD in Canada), it is very useful to have a video recording of the mental state since the evaluatee may be treated in jail during the hospital assessment prior to trial. The video recording provides helpful evidence of the previously disturbed mental state, which may be informative in court at trial.

Another issue that arises is the issue of attorneys requesting assessments and dictating how we perform them. If the attorney asks you to do something with which you are not comfortable, you should carefully consider the conditions before you accept the retainer. Attorneys may not be attentive or knowledgeable about the ethics and procedures of forensic psychiatrists. If the attorney is insistent and you are not comfortable, you should politely refuse the retainer and suggest that the attorney either modifies the conditions, or retains another practitioner to do the evaluation.

### Take-Home Points:

There is nothing unethical or unprofessional about using technology to allow an evaluation to occur. However, there may be limitations that arise with the use of videoconferencing. Careful preparation is required to assure the process goes well and without surprises. This technology may be better suited for some users than others, and certain types of cases may not lend themselves to electronic interviews. Opposing counsel may try to create the perception that your electronic evaluation is inferior to the one done face-to-face by the expert she hired. You will need to be prepared to address this issue should it arise. Our work is challenging enough, and creating opportunities to question your examination procedure on *voir dire* may not always be desirable. ☎

## Bridging Addiction

*continued from page 10*

these questions with more certainty, I wondered whether a one-time event like this one would actually change the judges' practices in any meaningful way. What if such physician-led workshops were a regular part of legal training?

Such experiences have taught me that there is a significant and ongoing role for addiction-trained forensic psychiatrists to play in addressing addiction in the criminal justice system, not just as advocates but also as expert witnesses. Our expertise makes us well-qualified to interpret information for judges and juries making difficult decisions on cases involving topics such as diminished capacity, settled insanity, mitigation, aid in sentencing and addiction treatment malpractice. Despite the great potential for collaboration between the addiction treatment community and the judicial system, they have largely been operating in parallel worlds, to the detriment of many people. However, addiction-trained forensic psychiatrists may just be the missing conduit between the two. Though I have encountered only a few addiction-trained forensic psychiatrists, I hope that more will join our field, because the legal system's demand for our knowledge shows no sign of slowing. ☎

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## Myths and Realities

*continued from page 16*

victim behavior”—a behavior of a victim, during or following an assault, that runs contrary to what society believes a victim looks like. The use of such a term suggests that a victim’s behavior is both predictable and expected, which is not true. Although there are some victim behaviors that are common, there is no universal response to sexual assault.

Understanding counterintuitive victim behavior is important for several reasons: First, to educate the trier of fact that victim behaviors occur on a continuum and may be unique to the individual; second, understanding a particular victim’s behavior may have implications for the psychological well-being of the victim, and lastly, to reduce barriers to victims reporting sexual assault. With these reasons in mind, education about counterintuitive victim behavior may lead to an overall improvement in the manner in which sexual assault victims are viewed.

For example, the phenomenon of tonic immobility, which is used to refer to the “freezing up” of a sexual assault victim, is primarily described in animals without physiologic studies in humans. Memory in trauma is a complex process that is not yet fully understood. Unusual or counterintuitive presentations of traumatic memory may occur, but it’s important to understand whether such presentations have been supported by the scientific research. Without research, such behaviors lend themselves to the “anything is possible” defense and compromise the integrity of our field.

It is imperative that forensic psychiatrists working with or testifying on behalf of victims of rape/sexual assault recognize that not every victim will demonstrate stereotypically “normal” behavior. When victims are not believed to be credible, their legal cases are less likely to be investigated properly and less likely to be referred for prosecution.

Forensic experts are commonly employed in sexual assault cases to dispel myths and misperceptions

about victim behavior as well as to explain common victim responses. Although counterintuitive victim behavior is not recognized as an area of expertise, experts are qualified based on a broader category of expertise such as sexual violence, victim behaviors and offender dynamics in sexual assault cases. Although jurisdictions vary in rules of admissibility, all 50 states have admitted expert testimony to explain victim behavior in sexual assault cases. ☉

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## Psychological Autopsy

*continued from page 19*

Hayes (2017) also recommends that the documents associated with the psychological autopsy be kept separate from the inmate’s medical and institutional records. He suggests labeling the document, “Attorney-Client Privilege: This Quality Assurance Document was Attorney Requested and Prepared in Anticipation of Possible Litigation.”

In summary, the psychological autopsy is a tool that can help involved parties to understand and process unexpected deaths. It naturally flows that it could also prevent potential future deaths. Although multiple national organizations have recommended that correctional facilities conduct post-mortem reviews after inmate suicides, the extent to which these institutions are incorporating the psychological autopsy into their suicide prevention programs is unknown.

Furthermore, no studies have empirically examined the outcomes of psychological autopsies in corrections or the most effective protocols for carrying out these reviews. Further research is needed to increase our understanding of the role psychological autopsies play in suicide risk assessment and management and to develop guidelines for conducting these evaluations in an effective manner. To further our understanding, the Corrections Committee plans to poll statewide chiefs of psychiatry to assess the percentage of United States prisons conducting psychological autopsies and, when psychological autopsies are being performed, the procedures that are being used. ☉

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**Civil Commitment**

*continued from page 20*

example, for children in foster care, parents maintain the right to consent for medical treatment unless abuse was proven, and a medical guardian has been appointed.

**Conclusion**

In summary, civil commitment allows family members or others to seek court-ordered involuntary treatment for a substance-abusing person. Moreover, coercive treatment ordered by drug courts, unions and professional boards, does not require involvement with the criminal justice system. Although these laws are understandably appealing, state statutes and their implementation are highly variable, and outcome data are limited and often not generalizable. More research and federal involvement to improve uniformity of procedure and legal language and to ensure an adequate treatment milieu after the commitment decision, are all future considerations.

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## Schedule for AAPL Semiannual Meeting 2019

**Locations To Be Determined**  
**Please Check Final Program for Updates**

**Saturday, May 18, 2019**  
8:30 AM –10:00 AM - Guttmacher Lecture  
1:00 PM - 6:00 PM - AAPL Committee Meetings  
6:30 PM - 7:30 PM AAPL Business Meeting and Reception

**Sunday, May 19, 2019**  
7:00 AM - 8:30 AM - AAPL Institute Board  
8:30 AM - 1:00 PM - AAPL Council

**Tuesday, May 21, 2019**  
8:00 AM - 11:00 AM - Invited Symposium:  
**Bringing Light to Darkness:**  
**Seldom-Examined Topics in Forensic Psychiatry**

## An Autopsy

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public holds many misperceptions about the role that mental illness plays in firearm violence. The psychiatric community, law enforcement, legislators, and the media all have roles to play in responsibly addressing this issue and using evidence-based data as opposed to biased and emotion-laden reactions to these tragedies. ☯

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**Women's Committee**

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**Critical Criminology**

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**APA Annual Meeting**  
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**Engaging**

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**AMA 2019 Meeting**

*continued from page 23*

Physician Section Reference Committee. In June 2019, Patrice Harris, MD, a child and forensic psychiatrist and AAPL member, will be installed as the President of the AMA.

You can find more information on the actions of the AMA House of Delegates at the 2018 Interim Meeting at <https://www.ama-assn.org/about/house-delegates-hod>.

**MUSE & VIEWS**

“I told my wife the truth. I told her I was seeing a psychiatrist. Then she told me the truth: that she was seeing a psychiatrist, two plumbers, and a bartender.”

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*Submitted by William Newman MD*



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