

# AAPL Newsletter

American Academy of Psychiatry and the Law



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## The Guttmacher Award Lecture: Forensic Fundamentals and the Forensic Frontier

Brian K. Cooke MD



From L-R: Michael Champion, MD, Guttmacher Award selection committee member, Charles Scott, MD, Anita Everett, MD, APA President, Richard Rosner, MD and Saul Levin, MD, APA Medical Director.

The 2018 Manfred Guttmacher Award was given to the *Principles and Practice of Forensic Psychiatry, Third Edition* (CRC Press) at APA's Annual Meeting in New York City. The textbook was edited by Drs. Richard Rosner and Charles L. Scott.

At the award presentation, attendees were treated to a generous sampling of speakers at the Guttmacher Lecture. APA President Anita Everett, MD began the introductions highlighting her objectives to bring forward the role of public psychiatry at large. Drs. Liza Gold and Saul Levin (Chief Executive Officer and Medical Director of the APA) presented the Isaac Ray Award to Dr. Renee Binder. Dr. Binder was noted to be a "compassionate leader who does amazing work." Dr. Binder graciously accepted the award and shared how her experience as former APA President gave her a platform crucial for our field.

Drs. Michael Champion and Saul Levin then presented the Manfred S. Guttmacher Award. Established in 1975, this award recognizes an outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, or other work published or presented at a professional meeting. Described as "encyclopedic and user-friendly," the *Principles and Practice of Forensic Psychiatry, Third Edition* joins the efforts of over 100 contributing authors. Readers are likely familiar with the textbook as it is well used by practicing forensic psychiatrists and a required textbook in many fellowship programs.

Dr. Rosner emphasized the importance that this textbook teaches the fundamentals of forensic psychiatry. He proposes a framework for the way we approach our cases, because there is no such thing as a "general forensic psychiatric assessment." The first

step in the framework is to identify the issue – what is the specific question. Then, understand the legal criteria, as defined by the relevant jurisdiction. Next, examine the relevant data – know exactly what information is specifically pertinent to the issue. Last, there is the reasoning process – answer the referral question and support those opinions. Dr. Rosner asserted that this is a structured reasoning process, not a foolproof technique – a tool that will produce quality goods in skilled hands.

Dr. Scott focused his comments on some of the major changes in forensic psychiatry that occurred between the textbook's second edition (2003) and the third and current edition (2017). The first area involves the increasing imprisonment rate of adults and juveniles in the criminal justice system. Landmark cases of *Brown v. Plata*, *Roper v. Simons*, and *Graham v. Florida* are all relevant to these developments in the US. He identified the second major change in our field during this period as the improvement of forensic evaluation standards, especially the developments in both malingering and risk assessments. Readers likely know these topics are important to Dr. Scott, as this has been one of his platforms with presentations at AAPL, as well as his AAPL Presidential speech and later published article ("Believing Doesn't Make it So: Forensic Education and the Search for Truth").

Dr. Scott concluded with venturing into foreseeing the future of the field – the frontiers of forensic psychiatry. These areas include correctional alternatives (e.g., telepsychiatry and how to prevent relapse in substance use), death penalty challenges of those with mental illness, risk assessment pressures, behavioral genetics (e.g., the "Warrior gene") and neuroimaging (e.g., Are the brains of

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## TECHNOLOGY COMMITTEE

# Technology to Watch: Transdermal Optical Imaging

Andrew Nanton MD, Technology Committee

A recent article in *Frontiers in Psychology* details a line of research into a novel physiologic measure of basal stress. This technology attempts to measure stress as reflected by changes in blood flow, which are assumed to be due to an autonomic response to stress. This is, of course, not a new idea. These physiologic variations due to stress are also the basis for the polygraph.

The potential advantage of this Transdermal Optical Imaging (TOI) is that it's substantially more convenient, less invasive, and easier to interpret. TOI requires only a recording of the subject's face from a conventional digital video camera. By analyzing the color signature of ambient light reflected and re-emitted by the face, it's possible to extrapolate changes in blood flow. The specific technique described by these researchers separates the color signatures of hemoglobin and melanin, allowing this technique to be used regardless of skin tone.

### Baseline

To establish baseline resting states, subjects were first presented with a 2-minute video of clouds, and a digital image with uniform lighting and calibrated color were recorded. The experimental procedure also included an EKG for comparison, as a well-established measure of autonomic arousal. EKG data was analyzed for R-R interval and heart rate variability. This was compared with video images from a group of regions on the face that has been established to provide good variability in color signature based on blood flow. Interestingly, this process was further refined by applying machine learning techniques to tune the results individually. From the resulting analysis, the research group determined that the video analysis identified cardiovascular stress reactions in a way that was nearly identical to the EKG in the

study's 136 participants, but in a remote and unobtrusive way.

### Applicability

Given the limitations of TOI, and the current restricted role of polygraph data, what's the applicability of TOI to current forensic practice? Momentarily putting aside the question of admissibility, quantifiable physiologic measures of arousal could help to more objectively identify autonomic responses to emotional salience and perceived threat. Beyond applications for "lie detection," and potential extension to detection of malingering, there are likely to be other relevant applications. For example, in personal injury and disability assessment, it may be possible to objectively measure the degree of autonomic response to trauma-related stimuli, and therefore aid in supporting or opposing a diagnosis of Post-Traumatic Stress Disorder. Finally, the ability to employ this technique remotely for teleforensic evaluations opens interesting opportunities to be further studied and explored.

Given that measurement is limited to one parameter, rather than multiple measurements for which the polygraph is named, there are likely to be significant limitations to interpretation. Furthermore, this approach needs further research support before it would be likely to be considered admissible in court. This is likely to be the biggest hurdle for expert witness applications, though this does not limit use in clinical applications. At the moment, this technology is one to be aware of and one to watch, even though it's not currently ready for forensic psychiatric use. ☯

### Reference:

Wei, J. *et al.* Transdermal Optical Imaging Reveal Basal Stress via Heart Rate Variability Analysis: A Novel Methodology Comparable to Electrocardiography. *Frontiers in Psychology* 9, 98 (2018).

## Arrivederci

Susan Hatters Friedman MD

Since my daughter is a young American studying in Italy, we had watched the Netflix documentary *Amanda Knox*, about the university student from Seattle who had studied abroad in picturesque Perugia, Italy. Ms Knox, along with her Italian boyfriend of one week, Raffaele Sollecito, had spent years in prison after the 2007 murder of her British roommate Meredith Kercher. Knox was perceived to respond in an odd manner to the murder, and had been confused by lengthy interviews in her new language. International media portrayed the murder as the outcome of a drug-fuelled violent sex game. Sollecito spent months in solitary confinement. Both were found guilty in the Italian trial of the decade, and sentenced to a quarter century behind bars. A separate trial found Rudy Guede, whose fingerprints and DNA were found at the murder scene, guilty. The number of trials and appeals was perplexing to an American audience. In the final appeal, eight years after the murder, both Knox and Sollecito were exonerated by Italy's highest court related to errors in the investigation. Last summer, a decade after the murder, at the International Congress on Law and Mental Health at Charles University in Prague, an amazing panel presentation on the case (which brought some of us to tears) was given by the involved attorneys and experts, as well as Mr Sollecito.

In April, I visited my girl, and saw Venice quite differently than I had before—through the eyes of a (transported) local who was able to both avoid the heavily touristed areas, and navigate in rapid-fire Italian. (I prided myself on understanding the occasional word.) There's a small shop in Venezia's San Polo selling *Malefatte* (translated to 'wrongdoing' or 'bad deeds') goods that have been made by prisoners. I am directionally challenged—and nowhere is this more apparent than in the suddenly truncated alleyways of Venice. This was only my second time visiting the shop, though I've set out to find it on multiple trips.

*Rio Tera dei Pensieri* is a work reintegration cooperative program teaching skills to prisoners incarcerated in Venice. There are beauty products and silk screened t-shirts (my new one reads 'Better out than in'), though I suspect their biggest sellers are the many different types of carefully constructed handmade recycled bags. Prisoners engaging in work rehabilitation to make these works of art, which can then be sold in their heavily touristed city (at least to those who can find the shop) seems a beacon of hope.

We also had a lovely time visiting old-world Florence, and Italy's economic center Milan, visiting museums, shopping, and trying restaurants recommended by her my daughter's *amici*. On this trip, I was also able to spend some time visiting with our mental health professional counterparts in Milan. Dr. Alessandra Bramante is president of *La Societa Marce Italiana*, and has been making major efforts to increase education in Italy about the importance of maternal mental health and prevention of infanticide. I first met Dr. Bramante some years ago at an international conference and learned of her work in maternal mental health, and study of attachment among mothers who killed. Dr. Bramante and her colleague Dr. Gisella Congia (who practices both *psicologica perinatale* and *fotografia*) have been working on a video project interviewing experts about infanticide and maternal mental health, in their efforts toward education and prevention.

Dr. Bramante arranged for me to give a talk about some of my work to mental health professionals at *Casa della Psicologica*, in the shadow of the majestic *Castello Sforzesco*, while we were visiting Milan. She also arranged for us to meet with folks. (And I particularly enjoyed being referred to as a *Professoressa*.) Despite my presentation about infanticide prevention being scheduled on the Friday night of a holiday week, the attendance was amazing and folks asked excellent questions. As one would expect, the audience's English was worlds better than my Italian, but a translator was still employed to ensure we were understanding each other regarding this complex topic.

In sum, my trip to Italy taught me further about forensic and mental health services outside of America. It also reminded me that our fight against stigma is a moving target. It allowed me to see innovative thinking despite obstacles. And, it helped further my thinking about the importance of international understanding and relationships.

In this issue of the newsletter, you'll read about AAPL representatives' work at the APA and AMA. Committee articles in this issue include thought-provoking topics in trauma and stress, ethics, forensic training, sexual offenders, technology, international relations, and AAPL's new Committee on Government Affairs. Special articles include discussion of recommendations regarding sexual harassment of women in STEM academia and careers, competency based forensic training in Canada, and criminology. You'll also meet the new Rappoport fellows.

Lastly, I say farewell to my role as AAPL Newsletter Editor. By the time this edition reaches your hands, a new editor will have been chosen. It has been a wonderful adventure, and an honor to edit the newsletter. I have enjoyed the opportunity to work with many of you, and have been fortunate to work with an excellent Editorial Board and staff. I have learned so much from our amazing AAPL members and committees. Enjoy this issue of your Newsletter. Looking forward to seeing folks at this year's AAPL meeting in Austin! ☺



## "Mature Minors": Contradiction or Conceivable Concept?

Christopher Thompson MD



In January 2015, the Connecticut Supreme Court let stand a trial court's decision in *In re Cassandra C.*<sup>1</sup>, which essentially authorized the

involuntary medical treatment of a minor. The petitioner in the case, Cassandra Callender, had been diagnosed with Stage 3 Hodgkin's lymphoma at age 16. She and her mother were advised by her physicians that the condition was invariably fatal if not treated, but that if treated, had an 85% survival rate. Her physicians recommended aggressive uninterrupted chemotherapy, to which Cassandra and her mother initially consented.

However, over the next few months, Cassandra missed several appointments with her physicians, and her mother expressed concerns about Cassandra's physicians' giving her "poisons." Her physicians became concerned about her delay in treatment and contacted the Connecticut Department of Children and Families (CT DCF), which subsequently filed a neglect petition and was granted temporary custody. Subsequently, Cassandra agreed to undergo outpatient chemotherapy, but then ran away from home and refused to continue her treatment. Her mother supported her decision to forego treatment, though neither she nor Cassandra based their refusal on any religious objections.

In their ruling, the Connecticut Supreme Court based their decision on the rationale that: 1) Connecticut did not have a "mature minor standard;" and 2) the trial court's finding that Cassandra was not a mature minor was not clearly erroneous. Perhaps more than any other in recent memory, Cassandra's case brought to the forefront the concept of the "mature minor" as it relates to med-

ical decision-making. But what is a "mature minor," how did this concept evolve, and how is it operationalized in different jurisdictions in the US?

In most of the United States, youth under age eighteen (i.e., "minors") cannot make decisions related to educational services or general medical care (including psychotropic medication), among other things, and proxy decision-makers (e.g., parents and guardians) must be utilized. The courts have reiterated this requirement numerous times over the past fifty years, perhaps most resoundingly in *Parham v. J.R.* (1979)<sup>2</sup>. In this decision, the U.S. Supreme Court opined:

"[most] children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments."

Similarly, in *American Academy of Pediatrics v. Lungren* (1997)<sup>3</sup>, the California 4<sup>th</sup> District Court of Appeals wrote:

"[the] requirement that medical care be provided to a minor only with the consent of the minor's parent or guardian remains the general rule, both in California and throughout the United States."

Courts generally have based their decisions on political theory and constitutional doctrine, and have noted that in Anglo-American common law, rights of self-determination have been "given" almost exclusively to adults (some observers have gone so far as to refer to children as "the Achilles Heel of liberalism"). Carve-outs that considered cognitive capacity and social maturity were few and far between (e.g., criminal acts and, more

recently, abortion). Although a process existed for youth to become emancipated prior to the age of majority in their state, specific conditions generally had to be met for a court to consider a youth's petition for emancipation (e.g., being financially independent from parents, serving in the military, being married, etc.).

Despite these well-established judicial precedents, over the past thirty years, there has been the advancement of a concept that minors aged 12-14 (or older) can provide informed consent for particular medical treatment decisions, including abortion, contraception, STD treatment, substance use disorder treatment, and mental health treatment (psychotherapy, not medication). This concept assumes a neurobiological/neurodevelopmental approach and bases decision-making autonomy on social maturity and cognitive capacity rather than chronological age. Proponents of applying this approach more broadly cite data indicating that older teens and young adults have similar cognitive capacities and note that there is a societal good/public health benefit in encouraging youth to seek treatment they might otherwise not seek if parental consent were required. Certain youth, while not judicially "emancipated," could be considered "mature minors" if they were determined by a medical professional to have autonomous decision-making ability for either general or specific medical care.

States have operationalized the broad "mature minor" doctrine and concept quite differently, if they have embraced it at all (approximately 20% of states have a broad mature minor exception, 10% have conditioned exceptions, and 70% have no exceptions; as with other exceptions, statutory exceptions can be applied fairly broadly while case-law based exceptions may only be applicable in cases with analogous facts). Some have an absolute age cut-off (e.g., 14 years of age). Other require a certain level of educational attainment. A number require youth meet a "maturi-

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### In Memoriam: Steven Pitt DO

Jeffrey S. Janofsky MD



AAPL member Steven Pitt was shot and killed outside of his Scottsdale Arizona office on May 31, 2018. Subsequent media reports

identified the killer as Dwight Jones, someone Steve had evaluated for the Court in a divorce proceeding nine years earlier. After killing Steve, Jones later killed 2 paralegals from a law firm related to the case and a psychologist who occupied the office of another psychologist who had been involved in the case. After being identified, Jones committed suicide by gunshot as officers closed in to arrest him.

I first met Steve during his fellowship at the University of Maryland Fellowship in forensic psychiatry, where Steve was a fellow from 1990-1991. Jonas Rappeport was fellowship director and I was a junior faculty member. I spoke to Jonas and Maryland faculty member Neil Blumberg. We all remembered Steve as a high energy person who was intellectually curious, driven to succeed in a very positive way and who was a pleasure to supervise.

Steve's University of Maryland co-fellow, AAPL member Joanna Brandt, described Steve as, "smart, dedicated to his work and intensely driven. However, during forensic interviews, he had a unique and relaxed manner that put the evaluatee at ease. He was a very nice person and fun to be with. He will be sorely missed."

Betsy Kohlhepp, another University of Maryland fellow was taught by Steve when she was a medical student and he was fellow. She maintained a professional relationship with him when they both moved to Arizona. Betsy gave me permission to quote from an article she is writing about Steve for the Arizona District Branch:

I met Steve in 1990 when I was

a fourth-year medical student and he was a fellow in forensic psychiatry at the University of Maryland. Interested in the specialty myself, I shadowed Steve during a one-month elective while he conducted interviews of criminal defendants pleading not competent to stand trial. I remember little of those cases or defendants but have a very clear recollection of Steve from almost thirty years ago. Confident and charismatic, Steve exuded an ease with criminal defendants; a curiosity for the complexities of their behavior and motivations; and an obvious enthusiasm for teaching. After watching just a couple of his interviews, I thought Steve also had a flair for getting and telling a good story. He made this work look fun.

Five years later, having completed the same fellowship, I accepted a position he offered me on one of the forensic units at the Arizona State Hospital in Phoenix, where he served as my first supervisor and an early mentor. Steve was an exceptional role model. Contagious enthusiasm, relentless drive, and intensity of purpose characterized Steve's professional persona. Kindness, generosity, patience, and genuine respect for staff lacking his training and expertise characterized Steve as a human being. He inspired everyone he worked with to do their best and he offered me, a lifelong Baltimorean and newcomer to the Southwest, his insights into the legal and psychiatric communities in Phoenix to help me get started on my career.

I have many fond memories of Dr. Pitt, the professional and Steve, the human being. Work-

ing late at the State hospital one evening and forgetting it was a Jewish holiday, I called him at his home when he was having Seder with his family, to rant about a problematic hospital policy as it related to the chaos a sociopath was causing on the GEI/NGRI unit I was assigned. This individual did not belong in a hospital and his NGRI finding was based on no mental disorder other than a paraphilia and several rape charges. After listening to me as I unloaded my frustrations at that inappropriate hour, Steve offered me his restraint, perspective, validation, and dark humor (he knew the patient very well), when he easily could have said, "You think this could wait until tomorrow?"

Over the years, our career paths diverged. Steve did less clinical work and immersed himself in the emotionally hard stuff: criminal evaluations, consultations to law enforcement, threat assessments and the occasional custody evaluation. Steve took a deep, personal pride in accepting those tougher cases many of us would prefer to avoid. Notorious, serial, and mass killers were his bailiwick; "high profile" was his playground. Steve was a high-wire act. He relished the action of profiling criminals at large, and the adrenaline of face-to-face encounters with the darkest souls, strained by life's circumstances to the limits of their coping. The more salacious the charges, the tougher the case or the character in question, the higher the stakes, the better. He seemed to thrive under that pressure and even to revel in the focus of public interest and media attention.

Steve left behind many loving friends and loyal associates, as well as a few adversaries and probably many ruffled feathers. Steve was not a fly-under-the-

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## Ask the Experts 2018

Neil S. Kaye MD, DFAPA

Graham Glancy MB, ChB, FRC Psych, FRCP

Drs. Kaye and 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:** Do you ever take cases pro bono, and if so, how do you keep from appearing biased toward “your side?”



**A: Kaye:**

Throughout my career, I have occasionally taken cases pro bono.

There are a number of reasons for so doing, some of which include: 1. A case may involve issues or areas of law that I find particularly interesting or novel and thus may afford me an opportunity to further my own education; 2. A case may involve a victim who would otherwise be unable to secure a competent expert; 3. The referral may come from a good source and it makes good business sense to try to work with the referring party; 4. I gain perspective into an area of law that may be challenging and unfamiliar; 5. I learn to appreciate limited resources and to help decide how they should be used; 6. The case may allow for networking; 7. Helping others can be a reward itself or; 8. Teaching the trier of fact can be fun.

But, as Dr. Glancy will address below, pro bono work can create significant exposure for the expert as well.



**A: Glancy:**

**Opposing counsel:** Good morning Dr. Glancy.

**GG:** Good morning

**Counsel:** I believe you are doing this case pro bono?

**GG:** Yes

**Counsel:** That is very laudable

**GG:** (*Preening*) well thank you

**Counsel:** It is like giving to a good cause?

**GG:** (*Finally this guy realizes what a good guy I am*) exactly

**Counsel:** You are the type person that gives to charity?

**GG:** (*this is great*) you betcha

**Counsel:** And I am sure there are a lot of good causes that you believe in?

**GG:** (*this guy is giving me the credit I deserve*) yes there are

**Counsel:** And you would advocate for these charities?

**GG:** Yes I would

**Counsel:** This particular case comes down to the issue of X and Y?

**GG:** Yes, that is true

**Counsel:** So, you are an advocate for the issue of X and Y?

**GG:** Well—er

**Counsel:** That is why you are not charging for it.

**GG:** er —well

Whenever I accept a case I try and think through the issues upon which I might be cross-examined. As I am sure all of you are aware, this can include any issue from the original

phone call from counsel to how you walked up to the stand minutes ago. This exercise helps if you are a pessimist, although I like to call myself a realist. This is a part of the cross-examination that I could imagine in a pro bono case. As noted above, taking a pro bono case could change your good intentions to having your blood spattered all over the court room. In other words, there is a real problem with taking pro bono cases.

Dr. Kaye has outlined the positive aspects of accepting pro bono cases, and I agree that these are legitimate. However, I should caution the unwary that this could get you into a difficult situation as described above. My advice would be to consider a strategy to mitigate this possible attack. The simplest strategy would be not to accept pro bono cases, but as Dr. Kaye has outlined, there may be advantages to accepting some cases. Therefore, you should consider a specific policy, which you can present if challenged.

One such policy may be to accept a certain number of pro bono cases each year. One might have a stated policy that you accept x number of cases each year and after that you refuse to get involved. If this is your policy, you would have to accept cases that deal with issues in which you were not particularly interested. In fact, it might involve you accepting a case about an issue with which you disagree.

You could also have a policy that pro bono cases make up a certain percentage of your practice. Again, you would have to accept cases no matter which side you are on. By having a policy, you can adhere to the ethics principle of striving for objectivity and honesty, and also enjoy the aforementioned benefits of accepting pro bono cases. Be aware of peer group pressure in this regard. Sometimes you are persuaded to take a pro bono case because some of your peers are involved in the case. You should consider this carefully in the light of my above statements.

Another problem that I have encountered is that in pro bono cases

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# Campus Sexual Assault: The Dilemma for Forensic Psychiatry

Maria Lapchenko MD



The rate of reported sexual assaults occurring on college campuses in the United States has been steadily increasing over the past decade<sup>1</sup>.

While it is unclear whether the rise is due to increased incidence or increased reporting, the number of men and women between ages 18-24 who experience sexual assault is alarming. According to the Rape Abuse Incest National Network (RAINN), about 23% of college-aged women and 5.6% of men are victims of sexual assault based on self-report<sup>2</sup>. Sexual assault is defined by the Department of Justice as any “nonconsensual sex act proscribed by Federal, tribal, or State law” and includes fondling, stalking, voyeurism, exhibitionism, and rape<sup>3</sup>. Victims of sexual assault may suffer both immediate and lasting effects, including physical injury, pregnancy, exposure to sexually-transmitted infections, impaired performance in the classroom, feelings of alienation from their campus community, decreased earning potential, PTSD, depression, anxiety, substance use disorders, and increased risk of suicide<sup>4</sup>.

Interestingly, the campus crime statistics that colleges and universities are required to publish yearly under the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act or The Clery Act of 1990, do not reflect the above rate of sexual assault that occurs on or near college campuses. For example, approximately 9 out of 10 schools reported zero campus sexual assaults on their campuses in 2014<sup>5</sup>. These low numbers are more reflective of errors in reporting due to numerous factors including, but not limited to, schools misinterpreting reporting

mandates (e.g. some schools only reporting those sexual assaults that were reported to outside law enforcement), reporting exclusions for behavioral health professionals and pastoral services, and lack of agreement about whether a certain offense constitutes reportable sexual assault<sup>6</sup>. This underreporting has been corroborated by audits conducted by numerous states and by the Department of Education<sup>7</sup>. A Center for Public Integrity study further highlighted the issue in a survey of 152 crisis-service programs on or near college campuses. In 49 out of the responding 58 centers, the number of sexual assaults reported in one year was higher than the yearly average reported by nearby schools between 2002 and 2006<sup>8</sup>.

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*“...about 23% of college-aged women and 5.6% of men are victims of sexual assault based on self-report.”*

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An additional problem with the Clery Act statistics relates to underreporting of campus sexual assaults by victims. According to RAINN, only about 20% of all campus sexual assaults are reported to either law enforcement or campus officials<sup>2</sup>. A smaller minority, about 12%, are reported to off-campus law enforcement according a 2007 study that surveyed U.S. women attending college/university<sup>9</sup>. Most reports go to campus officials rather than law enforcement and are therefore addressed through internal investigations handled by campus tribunals or investigative boards. Campus boards are mandated by federal law, under Title IX of the Educational Amendments of 1972 which prohibits gender-based discrimination including

sexual assault at federally-funded institutions, to investigate any sexual assault allegations, prevent their recurrence, and address their effects<sup>10</sup>. A criminal investigation can also be initiated and occur in parallel with a campus investigation, but it does not obviate the requirement, under Title IX, for the school to conduct their own investigation. Furthermore, the investigations are somewhat different in their goals; campus investigations serve to determine whether their school’s sexual misconduct policy was violated while law enforcement seeks to determine whether a criminal act was committed<sup>11</sup>.

The Clery Act mandates some of the procedures that campus investigative boards must follow. These mandates include an impartial investigation and affords both parties, accuser and accused, the opportunity to adequately present their case with appropriate witnesses and evidence, have legal representation, and be able to appeal the decision of the campus board<sup>12</sup>. It also gives the board jurisdiction to take disciplinary action, if warranted, that includes relocation from dorm/campus housing, changes in classes, suspension, and/or expulsion of the accused. While campus proceedings are not legal proceedings, the standard for finding the accused guilty of sexual assault has recently been elevated to “clear and convincing,” by U.S. Secretary of Education Betsy DeVos from the lower standard, “preponderance of the evidence<sup>13</sup>.” This elevation in the standard of proof has been praised by advocates for the rights of the accused and slammed by victims’ rights advocates<sup>14</sup>.

However, despite numerous federal laws that mandate investigation and guide proceedings, the current policies at many colleges and universities fall short of meting out justice. Critics of campus investigative boards cite numerous concerns with the disciplinary process, including actions that curtail the due process of both the accuser and the accused<sup>15</sup>. The media has reported on campus

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## The Shift to Competency-based Training in Canadian Forensic Psychiatry

Joel Watts MD, FRCPC, DABPN  
CAPL President

Forensic psychiatry has been practiced in North America for well over 150 years, yet it was only in the later part of the 20<sup>th</sup> century that it was formally recognized as a subspecialty. In Canada, the Royal College of Physicians and Surgeons of Canada (RCPSC) (our national body that sets the standards for residency education, program accreditation and specialty certification) formally recognized forensic psychiatry in 2009 and the first subspecialty examinations were held in September 2013. Since then, residents wanting to become subspecialized and certified in forensics need to complete a one-year (PGY-6) residency in an accredited forensic psychiatry training program, similar to ACGME accredited fellowships in the U.S. We now have 7 RCPSC accredited forensic PGY-6 programs in Canada, many of which have been running for at least 5 years. It was a major effort for these programs to create their training programs and a major change in medical education is already shaking up the way we structure this training.

Many involved in residency training are familiar with Competency Based Medical Education (CBME) principles. In the last 10 years, medical education has been transforming around the world to align with CBME. I will share the progress we are making north of the 49th parallel to transform Canadian forensic psychiatry residency training standards to align with this new philosophy. For those intimately involved in residency training, the mere mention of CBME can sometimes cause involuntary twitching and sighs of resignation. We sympathize north of the border, but we're moving forward. The RCPSC has been guiding us through this and it is forensic psychiatry's time at bat. As a member of the RCPSC Forensic Psy-

chiatry Specialty Committee, I find it exciting and gratifying to be involved in shaping training standards for the future of our profession.

As a quick refresher, medical education has been using a "tea-steeping model" of educating future physicians for many decades now; it has been time, structure and process-based. The acquisition of knowledge was a core element of training and in order to become certified, one has had to pass a high stakes end-of-training certification exam. Residency programs have been organized around a prescribed number of training years, a series of rotation experiences including lectures, clinics and procedures. Accrediting and certifying organizations have aligned with this method. For several years now, several factors have led medical educators to question this method and rethink what trainees need to learn and develop as they move through their career. Increasing complexity of health care and increased societal expectations of oversight and accountability have led to educators needing more effective tools to address poor physician performance early in training, especially before a trainee enters practice independently. Training programs have also sometimes struggled to fail individuals who educators feel have been unable to pass their training. Increased time pressures on supervisors and reductions in resident duty hours have also made the time ripe for a philosophical shift in medical education.

CBME promotes learner centeredness and outcomes, emphasizes abilities (rather than focusing on knowledge) and de-emphasizes time-based learning as a marker for successfully completing training. The organizing framework, *competency*, is an observable ability of a health professional, integrating multiple components such

as knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition. Competencies can be assembled like building blocks to facilitate progressive development. However, each specialty must first identify their required competencies, which requires asking big questions, such as, who we are, what do we do, who do we serve, where do we practice? Training programs must have a framework to facilitate the resident's progression of ability over time, including stages of training and assessment in the workplace environment. A whole new educational lingo has developed, such as the development and use of Milestones and a new assessment tool, Entrustable Professional Activities (EPA's). But how is this transformation actually taking place?

In Canada, the RCPSC has recognized the enormity of this task and has developed the catchy phrase, "Competency by Design" (CBD) to describe the process of transforming residency training using CBME principles. A few medical specialties in Canada, such as anaesthesiology, have already completed their transformation and are now training residents using a CBME structure. General psychiatry has begun its transformation, but given the enormity of the task of defining the competencies of a general psychiatrist, the deadline for these programs to be active with CBME has been delayed a year to 2019. As you can imagine, reaching consensus about what a general psychiatrist must be able to do and what population they should serve is a debate that could take an enormous amount of time to resolve. In forensic psychiatry, this has proved to be less complicated given, in part, the relatively cohesive identity of forensic psychiatrists in Canada. We are also lucky to have many excellent practitioners on our committee. We are only about 130 certified forensic psychiatrists in Canada and we have long benefited from good collegiality and cooperation in our ranks. Our Specialty Committee completed the first of 3 workshops at the RCPSC in May to

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## It Happened in the Southwest: Part One

Stephen P. Herman MD, DFAPA, LFAACAP



On Thursday May 31, 2018, at 5:20 PM, it was 97° in Phoenix, Arizona. Dr. Steven Pitt, 59, a well-known forensic psychiatrist in Maricopa

County, was leaving his office. (I had visited him there about three years ago. His office bespoke his unwavering dedication to his work. He had an elaborate video recording system, showing the interviewee and himself in split-screen view.) Dr. Pitt had been involved in several high-profile cases in Arizona and beyond. He was associated with Dr. Park Dietz and other forensic specialists in Colorado and Louisiana. He specialized in criminal psychopathology and often assisted law enforcement. He was the go-to forensic psychiatrist for local and national media.

On that typically hot Phoenix evening, Dr. Pitt was found shot to death outside his office. Witnesses had heard an argument just before the sound of gunshots. Police Officer Vincent Lewis postulated that Dr. Pitt and the killer may have known each other.

Friday afternoon, at about 2:15 PM, two paralegals were shot at their office, the firm of Burt, Feldman and Grenier. Laura Anderson, 49, was found dead with a bullet wound to her chest. Veleria Sharp, 48, shot in the head, managed to run out of the office, cried for help, collapsed, and died at a hospital.

On Saturday morning, just after midnight, police found the body of Dr. Marshall Levine, a life coach, hypnotherapist and counselor. He had been shot in his office.

And about 12:30 AM on Monday, June 29, 2018, in a home in nearby Fountain Hills, police discovered the bodies of a couple. Mary Simmons, 70 and Byron Thomas, 72 had been shot to death.

Six murders, all committed within

5 days, just miles apart. Were they connected?

Yes, tragically, in a bizarre constellation of nightmares when matrimonial cases go bad. Here's how:

Dwight Lamont Jones, 56, and his wife Connie Jones, M.D., a Scottsdale radiologist, had been married for 21 years. They were together when Dr. Jones was a resident at the University of North Carolina School of Medicine. Dwight had a history of losing one job after another. He had refused mental health care. Dr. Jones later said, "Looking at his eyes, there was nobody there."

However, in Arizona, and by agreement, Dwight became a stay-at-home dad, while his wife worked.

Dwight regularly abused his wife and son. On May 6, 2009, Jones screamed at his son for poor performance during basketball practice. His son had an asthmatic attack during his father's tirade. Connie, frequently hit and threatened by her husband, had placed tape recorders throughout their home. They recorded Dwight yelling at his son, "If you get smart with me, I'll knock your fucking head off." When his wife tried to intervene, Dwight threatened to kill her, saying, "I'll take you out to the motherfucking pool and drown you . . . you'll be a dead piece of shit." He heard his wife calling 911 and told her, "Pick the phone up and call the motherfuckers. I'll show you what's going to happen, bitch."

Connie escaped from the house and called 911, but her son stayed with his father. Inside, Dwight continued the verbal abuse of his son, saying both could be killed. He made sexual allegations about Connie. He directed his son to lie to the police that his mother was the child abuser. He told the boy, "She's a nasty fucking whore . . . she's got these cops out here getting ready to kill me . . . your mom wants me to die . . . she wants you to die . . . the fucking whore doesn't care about you."

Jones emerged from the house,

using the boy as a shield.

After the horrifying incident de-escalated, Dwight was arrested and charged with disorderly conduct. He was taken for an emergency psychiatric evaluation. Two weeks later he was free. The court granted him two hours a week of supervised visitation.

Dr. Jones and her son moved. She filed for divorce and, received an order of protection which required her husband to give up his guns. Later, Connie told reporters, Dwight repeatedly threatened to kill her, kidnap their son, or kill all three of them. Chillingly, she added, "Dwight could wait for a long time before he would get his revenge."

During the divorce proceedings, Connie hired Rick Anglin, a retired Phoenix police detective, as her private investigator and *de facto* bodyguard. Later, they married.

Dr. Jones and her son lived as if they were in a witness protection program. Except they weren't. They avoided favorite restaurants, their usual grocery stores and even sat in the very last row of movie theaters. Anglin told reporters, "We had three safe houses, countless rental cars. We had attack-trained dogs that we had to bring in and 24-hour security." He taught her how to use firearms and drive defensively. Still, Dr. Jones lived in constant fear.

Dr. Steven Pitt was appointed by the court to examine Dwight Jones. He was paid \$25,000 by Dr. Jones. At the divorce hearing, Dr. Pitt testified that Mr. Jones had a mood and anxiety disorder with features of anti-social, narcissistic and paranoid personality disorders. Judge Gates took notes about Steve's testimony, writing that the psychiatrist testified, "Mr. Jones poses a high risk to perpetuate violence toward mother and child and/or himself."

Paulette Selmi, Ph.D., the court appointed clinical psychologist, reported that Dwight needed psychiatric treatment and "is going to continue to unravel . . . he will become increasingly paranoid, likely psychotic and pose an even greater threat."

In late 2009, Connie asked the

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## AAFS goes to Cuba: An Exploration of Forensic Sciences in Havana

Karen B. Rosenbaum MD

The American Academy of Forensic Sciences (AAFS), of which I am the immediate past chair of the Psychiatry and Behavioral Sciences section, has an international presence and for over twenty years who participated in a cultural travel program called the International Education Outreach Program (IEOP), which in May of 2018 was in Cuba. Cuba was my first IEOP trip with AAFS. The objective of the Cuba trip, as in all of the IEOP experiences was to meet with forensic colleagues in Havana, participate in international forensic science meetings, visit laboratories when appropriate, and to experience the Cuban culture.

On this trip, we accomplished the above goals. The Cuba Educational Travel facilitated the experience and arranged for meetings with the top forensic scientists in Cuba, tours of facilities including a forensic psychiatric facility inside a large psychiatric hospital called the Hospital de Mollet, and cultural experiences in Cuba including visiting an artist's loft, great meals including at a restaurant where the Obamas dined, a walking tour of old Havana, and music and dance concerts. Viejo Havana, or old Havana, has over 900 historical and cultural landmarks. Our group stayed at the Hotel Nacional de Cuba which is also a landmark and where many famous members of the mafia and Hollywood celebrities have stayed. I was on the same floor as the room Frank Sinatra had frequented.

The Cuban forensic scientists were very excited to have us learn about their practices and culture and are hoping that we will be able to collaborate with them in a more accessible manner in the future.

They proudly explained that article 50 of their constitution states that health care in Cuba is a right of the people and the responsibility of the state. Any patient can go to a hospital in Havana and no one asks where they are from or cares about racial or reli-

gious preferences.

They explained that there is one family doctor for every 120 families anywhere in the country and that health care is aimed toward preventative medicine. If someone goes to the hospital, the family doctor goes too. Everyone has access to health care no matter how financially disadvantaged. They explained that Cuba is an aging country. They believe that elderly people should remain with their families and the state pays attention to help them improve and keep up their health for as long as possible.

The Institute of Forensic Medicine in Cuba was established in 1958. Our visit happened to coincide with the second day after a plane crash that killed 100 people, mostly Cubans. While we were visiting, they were analyzing the DNA of fragments of humans and the numbers of identified victims were continually growing. Because of the incident, some of our meetings were moved around. We were still able to observe some of their forensic science laboratories.

During the visit to the Psychiatric Hospital de Mollet, it was explained that in Cuba, they have worked to lower stigma of mental illness and to divert mentally ill patients in trouble with the law to mental hospitals and then work with the community to facilitate their transition back into good mental health treatment so that they do not end up back in the system. This was in stark contrast to my research (through articles, speaking with scholars, and visiting the DR) into mental health care in the Dominican Republic for a case that I was involved in. In the DR, mental illness is considered shameful and it is much more difficult to access mental health care there, and the mental health care is not adequate for the population.

The psychiatric hospital in Cuba was clean and seemed to have appropriate amenities and skilled staff and physicians. The goal is to transition

patients into the community as soon as they are stable, and most hospital stays are under ten days. There were two forensic psychiatric wards, a male and a female. We visited the female ward which was modest but clean and safe. There were pretrial detainees and also people convicted of crimes. The lead psychiatrist said that inmates in prison if they are suffering from a mental disorder and need treatment have to go into the health system. One of their methods to assess dangerousness is also the Hare psychopathy scale.

In Cuba, there are no firearms allowed, and there are not many illicit drugs. However, alcohol is a staple and extremely accessible. They explained that in Cuba they think of someone intoxicated on alcohol as having three phases: The Monkey Phase where someone is happy and jovial; the Lion phase where the person becomes aggressive and violent and accuses people of things like looking at their significant other; and finally the Pig Phase where the person is "puking on the floor." There was a study in Cuba that revealed that every third accident has alcohol present, and there was almost always alcohol present in homicides. Overall they described Cuba as a peaceful society and Havana felt very safe while we were there. They said their main problem as a society was access to technology.

Overall, the Cuban experience was informative and fun and I look forward to going on the next trip with AAFS. It might be an interesting idea for AAPL to consider embarking in an international program as well. Exchanging ideas with other countries is always a worthwhile and rewarding opportunity.



Dr. Rosenbaum with a staff psychiatrist at Hospital de Mollet

# #ScienceToo: The National Academies of Science Report on Sexual Harassment

Liza Gold MD

On June 12, 2018, the National Academies of Science, Engineering, and Medicine (NAS) published a report entitled, “Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine”<sup>1</sup> (available at [www.nap.edu](http://www.nap.edu)). In early 2017, the NAS Committee on Women in Science, Engineering, and Medicine authorized a study by a multidisciplinary committee of scientists, engineers, physicians (including one forensic psychiatrist) and experts in sexual harassment research, legal studies, and social psychology to conduct a study of sexual harassment in academic sciences. This report brings together, for the first time, behavioral research on types of sexual harassment and their prevalence, data on legal and policy mechanisms, and new approaches for changing the climate and culture in higher education.

The Committee conducted an in-depth review of the social science literature regarding sexual harassment. In addition, we commissioned new studies to obtain the most recent data on incidence of sexual harassment in academic science settings. We utilized this in-depth analysis to make evidence-based recommendations to effect meaningful, systemic change in science, technology, engineering, and medical (STEM) fields to reduce and prevent sexual harassment in academic settings, while outlining the significant opportunities and challenges in doing so.

When the committee began its work in 2017, we had no idea that the #MeToo movement would change the cultural climate in which we would be conducting our study and releasing our report. Given the disclosures of the widespread prevalence of sexual harassment in public and private sectors, we were not surprised to find that sexual harassment is a serious

issue for women at all levels in academic STEM training, especially medicine. Rates of sexual harassment in the workplace and academia generally are high, and are higher among women of color and sexual and gender minorities. The rates of sexual harassment in STEM academia and workplaces are no different.

Sexual harassment is a broad term that includes three categories of behaviors:

1. Gender harassment: sexist hostility and crude behavior;
2. Unwanted sexual attention: unwelcome verbal or physical sexual advances; and
3. Sexual coercion: when favorable professional or educational treatment is conditioned on sexual activity.

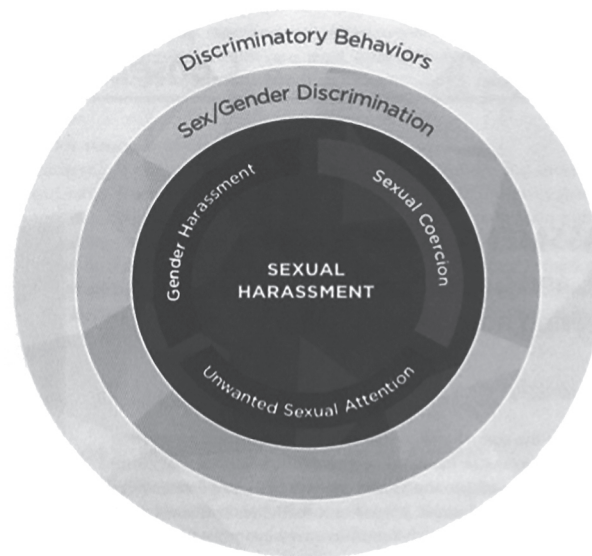
The diagram below illustrates how these behavioral categories map onto the legal categories of quid pro quo and hostile environment harassment.

Although instances of sexual

assault and coercion receive the most media attention, the most common form of sexual harassment is gender harassment, such as sexist insults or crude jokes referring to women. Most of the time, sexual harassment is a put down, not a come on. The legal system alone is not an adequate mechanism for reducing or preventing sexual harassment. Moreover, when frequent or severe, gender harassment can result in negative outcomes as intense and damaging as one instance of sexual coercion.

More than 50% of women STEM faculty and staff and 20-50% of women STEM students experience sexually harassing conduct in academia. Women students/trainees also experience sexual harassment perpetrated by other students/trainees. Women students in academic medicine experience more frequent gender harassment perpetrated by faculty/staff than women students in science and engineering. Women students, trainees, and faculty in academic medical centers also experience sexual harassment by patients in addition to harassment from colleagues and those in leadership positions.

The consequences of sexual harassment in these fields is a signifi-



Legal Classifications:  
 ● Quid pro quo sexual harassment  
 ● Hostile environment harassment

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## RAPPEPORT FELLOWSHIP AWARDS, 2018-2019

*Britta Ostermeyer MD, MBA, and Susan Hatters Friedman MD, Co-Chairs, Rappeport Fellowship Committee*

The prestigious AAPL Rappeport Fellowship was named in honor of AAPL's founding president, Jonas Rappeport, MD. It offers the opportunity for outstanding senior residents with a dedicated career interest in forensic psychiatry to receive mentorship by senior forensic psychiatrists. Rappeport Fellows will receive a scholarship to attend the AAPL Forensic Psychiatry Review Course and the annual AAPL meeting, and a one-year mentorship by two Rappeport Fellowship Committee members. We wish to thank the AAPL executive leadership, the Rappeport Fellowship Committee members, and all Rappeport preceptors for their ongoing support of this superb training opportunity!

This year we had an unprecedented number of 37 applications. The Rappeport Fellowship Committee and AAPL are excited to announce the 2018-19 Rappeport Fellows: Dr. Viviana Alvarez-Toro, Dr. Robert Ellis, Dr. Alexandra Junewicz, Dr. Selena Magalotti, Dr. Meghan Musselman, and Dr. Hassan Naqvi. Congratulations!



### **Viviana Alvarez-Toro, MD**

Dr. Viviana Alvarez-Toro is a chief resident at the University of Maryland/Sheppard Pratt Psychiatry Residency Program in Baltimore, Maryland. She attended Georgetown University and graduated cum laude with a degree in Psychology. She then pursued her medical degree at the University of Puerto Rico School of Medicine, where she graduated magna cum laude and was part of a research track. Dr. Alvarez-Toro first became interested in psychiatry and the law while taking psychology courses in college. In order to further explore these interests, she did an elective rotation at Saint Elizabeths Hospital in Washington, DC during her fourth year of medical school. At that time, she became interested in understanding the intersection between mental illness and the criminal justice system, particularly by

studying the phenomenon of false confessions. She continued her research and went on to present at AAPL's Annual Meeting in 2015 and published an article in JAAPL in March 2018. Most recently, she has been studying the association between mental illness and violence, leading her to present a workshop at the 2018 APA Meeting. All of these experiences have ignited her passion for academia, advocacy, and public policy. Dr. Alvarez-Toro will pursue her forensic fellowship at Yale's Law and Psychiatry Fellowship Program upon completion of her general residency in 2019. Her Rappeport Fellow mentors are Dr. Susan Hatters Friedman and Dr. Alan Newman.



### **Robert Ellis, MD, JD, MA**

Dr. Robert Ellis completed psychiatric residency at the Medical University of South Carolina and is currently completing a Child and Adolescent Psychiatry fellowship there. During medical school at the University of Chicago, he received the Alpha Omega Alpha Research award. Prior to medical school, Dr. Ellis graduated Order of the Coif from Northwestern University School of Law and was a practicing litigation attorney in the State of Illinois. Also, he received a Master's degree in Forensic Psychology from the City University of New York.

His research interests include: child custody evaluation; assessment of dangerousness and criminal responsibility evaluations. Dr. Ellis plans to begin forensic psychiatry fellowship training in 2019.

His Rappeport Fellow mentors are Dr. Ryan Hall and Dr. Renée Sorrentino.



### **Alexandra Junewicz, MD**

Dr. Alexandra Junewicz is a child and adolescent psychiatry fellow at the New York University School of Medicine. She graduated magna cum laude from Yale University, where she majored in psychology. She received her medical degree and a Master of Arts in Bioethics from Case Western Reserve University School of Medicine, where she developed an interest in forensic psychiatry and began exploring ethical issues specific to providing healthcare in criminal justice settings. She completed her general psychiatry residency at New York University, where she has stayed to pursue her child and adolescent psychiatry fellowship. During her general psychiatry training, she received an the APA Public Psychiatry Fellowship, the Rudin Fellowship in Medical Ethics and Humanities, and the

Institute for Psychoanalytic Education Fellowship in Psychoanalysis. She also conducted original research on the impact of trauma and incarceration on patient-physician trust, and co-led an LGBT group at the Program for Survivors of Torture at Bellevue Hospital. Recently she has been inducted into the Gold Humanism Honor Society and has maintained active interests in the intersection between psychiatry and the law, specifically the identification and management of intellectual/developmental disabilities in criminal justice settings. Dr. Junewicz has authored articles on various topics in forensic psychiatry, child psychiatry, and medical ethics. She plans to begin a forensic psychiatry fellowship in 2019. Dr. Junewicz's Rappeport Fellowship mentors are Dr. Sara West and Dr. Joseph Penn.

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### Selena Magalotti, MD

Dr. Selena Magalotti is a Chief Fellow in the child and adolescent psychiatry fellowship at University Hospitals Cleveland Medical Center/Case Western Reserve University. Prior to entering psychiatry residency at the University of Toledo, she completed a 6-year BS/MD program through the University of Akron and Northeast Ohio Medical University. She has been involved in several research projects over the years, including investigating how state law affects the use of prescription drug monitoring programs. Dr. Magalotti has co-presented national workshops on teaching psychiatry residents suicide risk assessments and patient handoffs. She is the New Research Editor of the Child and Adolescent Psychopharmacology News. In addition to teaching and research, Dr. Magalotti is also passionate about advocacy and organized psychiatry. She has met with state legislators to advocate for issues important for the safe care of patients with mental illness. She received the President's Award for her contributions as Secretary of her local psychiatric association. She has also held numerous state-wide organized psychiatry leadership roles in Ohio, including serving as Chair of the Resident-Fellow Committee and Secretary of the Foundation Board. Dr. Magalotti plans to complete a forensic psychiatry fellowship at Case Western Reserve University upon completion of her child and adolescent psychiatry fellowship in 2019. Her areas of interest include suicide and violence risk assessments, and also child forensic psychiatry. Dr. Magalotti's Rappeport Fellow mentors are Dr. Jackie Landess and Dr. Catherine Lewis.




### Meghan Musselman, MD

Dr. Meghan Musselman is a fourth year general psychiatry resident at Massachusetts General Hospital, where she is Chief Resident of the inpatient psychiatric unit, and McLean Hospital. She is also a member of the MGH/McLean Clinician Educator Program (CEP), a specialized track within the residency program designed to prepare residents for a career as clinician educators. At her graduation from medical school, she was awarded the John Fryer Memorial Endowment Prize for her commitment to psychiatry and behavioral health. Dr. Musselman developed an interest in psychiatry and the law while in medical school, through her interactions with patients with significant legal involvement. In residency, Dr. Musselman has cultivated this interest further. She has given presentations on multiple forensic issues, including malingered psychosis, capacity, and cultural aspects of suicide risk. As a member of the CEP, she has taken a particular interest in forensic education. She has worked with residency leadership to create a more formalized forensic curriculum for psychiatry residents, which has been introduced for the 2018-2019 academic year. Dr. Musselman's current projects include a review of the ethics of physical restraint use in medical/surgical settings and development of further didactics and educational resources in psychiatry and the law. Following graduation from residency in 2019, she will begin a forensic psychiatry fellowship with Case Western Reserve University. Dr. Musselman's Rappeport Fellow mentors are Dr. Jessica Ferranti and Dr. Britta Ostermeyer.



### Hassan Naqvi, MD

Dr. Hassan Naqvi is a Psychiatry Chief Resident at Emory University in Atlanta, Georgia. Prior to residency, Dr. Naqvi received his undergraduate degree from the State University of New York (SUNY) at Albany where he became interested in Forensic Psychiatry and graduated with majors in Biology and The Psychology of Terrorism. He went on to medical school at SUNY Upstate Medical University. As a medical student, Dr. Naqvi continued his work from his undergraduate thesis, titled "Situational Crime Prevention Applied to Ricin and Bioterrorism," which was published in the form of a book chapter. He has presented at numerous AAPL conferences since medical school on topics including sex offenders, suicide terrorism, international gun violence, forensic training of general psychiatry residents, and the use of the Dark Net in various forms of criminal behavior. On an international level, he has discussed state sponsored torture and recruitment of terrorists by international organizations. Dr. Naqvi is a member of the AAPL International Relations Committee, and both the psychotherapy track and research track at Emory University's psychiatry residency. He plans to begin forensic psychiatry fellowship training in 2019. Dr. Naqvi's Rappeport Fellow mentors are Dr. Robindra Paul and Dr. Ryan Wagoner. 

**AAPL is pleased to announce the 32nd Annual Rappeport Fellowship competition. Registration to the Forensic Review Course and 2019 Annual Meeting along with travel, lodging, and educational expenses are provided to the winners. Contact the AAPL Executive Office for details.**

## APA Assembly Report

Cheryl Wills MD

The APA Annual Meeting, held in NYC from May 5 - 9, 2018, was an excellent learning and networking opportunity for 16,325 attendees, including 13,473 psychiatrists. President Anita Everett's theme, Building Well-Being through Innovation, was prevalent throughout the program. The APA facilitated training Amazon's Alexa to respond to hundreds of mental health-related questions and placed Alexa devices in various locations in Javitz Convention Center. Attendees were encouraged to interact with Alexa and to appreciate how artificial intelligence can be conducive to disseminating mental health information to the public.

Physician's well-being was the focus of several lectures and workshops. The needs of medical students, residents, fellows and attendings were explored with recommendations for preventing and managing burnout at every stage of professional development. Data indicates that at least half of practicing psychiatrists meet criteria for burnout and this can lead to lower quality of life as well as physical and mental health concerns.

The APA offers educational and therapeutic resources to psychiatrists, including E-couch, a self-help program with interactive modules that contain evidence-based interventions for depression, anxiety and loss. There is information about promoting resilience for mental health providers, TED talks by experts in burnout science, and other useful items. They may be accessed at <https://www.psychiatry.org/psychiatrists/practice/well-being-and-burnout/well-being-resources>.

The APA will be celebrating its 175th anniversary in San Francisco at the 2019 Annual Meeting. The program will include a history track that examines the evolution of psychiatry since the APA was founded in 1844. President Altha Stewart, who is a public psychiatrist, has three major goals for her presidential year: planning for the future of psychiatry by

increasing the number of younger APA members, expanding the APA's reach in global mental health and advocating for protecting and extending parity and collaborative care arrangements. During her year as President-Elect, Dr. Stewart visited several psychiatry residency programs to meet residents and fellows and to learn more about their concerns, including, but not limited to, their workload, education and mentoring opportunities, burnout, and educational debt. She also focused on recruiting early career psychiatrists to the APA. Dr. Stewart also traveled to Africa and the Caribbean with the goal of increasing the APA's global alliances that may facilitate the exchange of ideas regarding effective models of care, evidence-based research concepts and effective patient care and training programs. She received an enthusiastic reception in each country and they welcome opportunities to collaborate and network with the APA.

The Centers for Medicare and Medicaid Services (CMS) has invited the APA to participate in a new task force that will begin to address the health care needs of individuals with mental disorders. The APA recommended that the American Association of Geriatric Psychiatry also be involved. The task force is expected to define the term "ligature risk," and ways to contain or remedy them and appropriate plans to mitigate the risk until the solutions or remedies have been implemented. The APA is gathering data about concerns regarding the ligature risk matter per JCAHO's request. There will be a meeting to review the concerns and hopefully to craft a mutually palatable solution. There are concerns that the multimillion dollar renovations that some psychiatric units must make to meet the current JCAHO proposed ligature risk standard could force some psychiatric hospitals to close and some hospitals to replace psychiatric units which generate relatively low income, with

more profitable medical programs.

The APA advocated for the continuation of the Children's Health Insurance Plan (CHIP), which the U.S. Congress reauthorized for six years in January 2018. The \$14 billion program, which serves more than 8.5 million youths who do not qualify for Medicaid, has provided mental health services to roughly 850,000 youths.

The Medical Mind Podcast, hosted by APA administrator Ann Thomas, reviews innovations and new initiatives in mental health care in 10 - 15 minute episodes. The available list of topics grows monthly and includes disaster recovery, pain management, managing various substance use disorders and "Mobile Apps for Mental Health." The podcast can be accessed at <https://www.psychiatry.org/psychiatrists/education/podcasts/the-medical-mind-podcast>.

Ned Kalin, M.D. will succeed Robert Friedman, M.D. as Editor of the *American Journal of Psychiatry* on January 1, 2019. Dr. Kalin, who already is working as Editor Designate, aspires for the *Journal* to be a resource for readers to examine evolving topics in clinical psychiatry and their translational and neuroscience underpinnings. Holly Swartz, M.D. edits the *American Journal of Psychotherapy*, a new journal that is part of the APPI collection. The revenue from publishing journals and newspapers has declined due to the shift of advertisers to electronic media.

The Division of Diversity Health Equity (DDHE), formally known as the Office of Minority and National Affairs, has crafted a Climate Change and Disaster Mental Health CME Module, which examines how climate change can affect vulnerable populations. There is also a module on microaggressions, the unintentional discrimination of marginalized groups. The programs are available in the APA Learning Center, which contains more than 300 CME modules, including Self-Assessment modules and resources to meet the Performance in Practice requirements for the ABPN. The

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## American Medical Association 2018 Annual 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) June 2018 Annual Meeting was held in Chicago, Illinois, and focused on public health, education, and advocacy. Key topics included firearm violence prevention, physician burnout, and physician assisted suicide.

Barbara L. McAneny, MD, an oncologist from New Mexico was sworn in as the organization's 174<sup>th</sup> President and fourth woman to hold the role. In her inaugural speech, Dr. McAneny emphasized the importance of physician leadership in health delivery and policy. "[I] learned that some problems cannot be solved one patient at a time ... some require solutions that change the system."

U.S. Surgeon General Jerome Adams, MD, MPH, who addressed the AMA House of Delegates (HOD) at this meeting, also emphasized the importance of physician leadership. Dr. Adams' motto as Surgeon General is "better health through better partnerships," emphasizing the need for relationships with the public health community, businesses, and law enforcement, among others. His speech focused on three core topics: health as a matter of national security; health equity; and combating the opioid epidemic. He called for physicians to lead the nation in civil discussion, even on controversial topics.

Patrice Harris, MD, a child and forensic psychiatrist and AAPL member from Georgia was elected as President-Elect of the AMA. She will be installed as President of the AMA in June 2019. Among her recent accomplishments, she chaired the AMA Task Force to Reduce Opioid Abuse. Dr. Harris said: "It will be my honor to represent the nation's physicians at the forefront of discussions when policymakers and lawmakers search for practical solutions to the challenges in our nation's health system."

Delegates to the Annual Meeting

addressed several important and hot-button topics. Among these, the HOD considered nearly a dozen gun-related resolutions. Drawing on previous AMA policy declaring gun violence as a public health crisis, the HOD endorsed several measures aimed to reduce firearm injuries and death. AMA Delegates voted to adopt policy calling for increasing gun violence restraining orders; for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officials; supporting bans on the sale and ownership to the public of all assault-type weapons, bump stocks, and related devices; and supporting bans on the sales of firearms and ammunition to persons under age 21, except for certain categories of individuals such as law enforcement and military personnel.

The Annual Meeting took place in the wake of two high-profile suicides: Kate Spade and Anthony Bourdain. Reference to these and the AMA's role in suicide prevention was a recurrent theme at the meeting. Along with the gun-related resolutions mentioned above.


Delegates voted to modify existing policy to further recognize the role of firearms in suicides and encourage curricula and training for physicians on suicide risk assessment, including lethal means safety counseling. With physicians having a higher suicide rate than the general population, there was much discussion about physician burnout, depression, and suicide. The HOD adopted policy to reduce stigma and encourage treatment of mental health and other conditions by calling for medical licensing boards to limit the types of questions asked about applicants' diagnoses to conditions causing current impairment, if these questions are asked at all.

The AMA Council on Ethical and Judicial Affairs (CEJA) issued a

report on physician participation in assisted suicide. This report took into consideration comments from a previous CEJA open forum on the topic, during which AAPL Delegate Barry Wall, MD, and AAPL member Rebecca Brendel, MD, JD (alternate delegate for the APA), served as moderators. The recent CEJA report retained the former AMA position against physician participation in assisted suicide, but, recognizing the complicated nature and ethical considerations relevant to the topic, offered an approach in its application that would permit physicians to use their conscience in individual decision-making. Some Delegates have called for the AMA to take a more neutral stance on this issue in light of legal decisions in some states allowing for physician aid-in-dying. The HOD voted not to accept the report and send it back to CEJA for further study. Of note, former AMA President and psychiatrist, Jeremy Lazarus, MD, was appointed to serve on the AMA's CEJA.

Of particular interest to AAPL members, the AMA adopted a Board of Trustees Report that provides a framework for placement of transgender prisoners in correctional facilities in accordance with their affirmed gender.

The HOD also adopted a resolution calling for limiting the use of solitary confinement, with rare exceptions, for incarcerated adults with mental illness, and asking that the AMA encourage appropriate stakeholders to develop alternatives to solitary confinement for all incarcerated persons. Several years ago, AMA enacted policy opposing the use of solitary confinement in adolescents.

Throughout the meeting, Dr. 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 Physician Section Reference Committee. You can find more information on the actions of the AMA House of Delegates at the 2018 Annual Meeting at <https://www.ama-assn.org/about/house-delegates-hod>. 

**Faces of AAPL: Renée Sorrentino, MD**

*Philip Candilis MD*



The Institute of Sexual Wellness in Weymouth, Massachusetts, serves an unmet need well-known to general and forensic psychia-

try: the treatment of sexual behavior disorders. Founder and medical director Renée Sorrentino always planned a multi-disciplinary clinic for the famously stigmatized and marginalized population, but finding funding was a different matter. “Providers always say the field needs more medication treatment,” says Dr. Sorrentino, “but finding financial backing or even a building to rent” for a sexual wellness center proved challenging. “I learned a lot about stigma,” she adds wryly, emphasizing her dual focus on sexual behaviors and developmental disorders.

Dr. Sorrentino was finally successful at securing funding from Community Resources for Justice, an organization founded in corrections and community re-entry, which, she observes, “speaks to the inherent bias in our field. I spent nearly a year speaking to various academic and community mental health organizations to no avail. At that time the state agencies had not even recognized this problem as part of mental illness or as a treatable problem. The corrections people were willing to take the risk and understood the public health problem as well as the financial burden of institutionalizing dangerous sex offenders.”

After two years, referrals and consultations were plentiful enough to allow Renee to buy the enterprise outright. Now going strong for a decade, the Institute conducts treatment and research, simultaneously offering education to physicians interested in spending up to a year learning about sexual addictions and behavior.

Dr. Sorrentino is uniquely situated

to provide this range of expertise to the community. A former Rappeport fellow who used the fellowship award to study with John Bradford, Renée studied forensics at Case Western, returning to Boston to work with local expert Martin Kafka. Well-known for his use of serotonin uptake inhibitors for the paraphilias, Kafka began to refer Renée cases that required hormonal therapies or treatment for co-morbid intellectual disabilities. Today Renée is one of three psychiatrists prescribing hormonal treatment for paraphilias in New England, and the only female prescriber.

The development of a more complex caseload in the Massachusetts General Hospital-McLean Hospital community consequently led to a more robust presence of sexual behavior education in the renowned residency training program. A staunch advocate of better training in this underdeveloped area, Dr. Sorrentino uses her position on the board of the Association for the Treatment of Sexual Abuse (ATSA), and in the Massachusetts state chapter, to press for better training, evaluation, and risk assessment.

Renée’s introduction to forensic practice came as a medical student rotating through Bridgewater State – the historic prison hospital in southeastern Massachusetts. “I read all the great landmark cases,” she says, “and was even there when [abortion clinic shooter] John Salvi committed suicide at the House of Correction.” This was a seismic event in Massachusetts forensic history, leading to a blue-ribbon study and significant improvements throughout the system.

Dr. Sorrentino met Tom Gutheil during this time, at the height of the famed Gaughan Fellowship, and when “Marilyn Price was his fellow,” she remembers. Tom and Marilyn provided her introduction to AAPL, where Renee would join the Gender Issues Committee and obtain research support from AAPL’s Institute. Her current project is a comparison of

plethysmography and thermal imaging, whose positive results she presented at AAPL just this past year.

Nowadays, Renee lives south of Boston, dividing her time between her Institute, general forensic practice, and activities in her community. An avid equestrienne, Dr. Sorrentino enjoys her free time trail-riding along the coast. In the community, she volunteers with youth-serving organizations helping young women develop the skills to become future business leaders and perhaps even future AAPL members. ☯

**Gutmacher Lecture**

*continued from page 1*

psychopaths different?).

This presentation at the APA – a dizzying whirlwind both with the recognition of many pioneers of the field and with the important ideas that are fundamental for the work we do – drew attention to the dramatic changes related to forensic psychiatry in the past decade. The validity of our assessments will likely be challenged. Forensic psychiatry will continue to be on the front line. Dr. Scott concluded by quoting Dr. Gutmacher, “Psychiatry helps law to focus on its goal, the nurturing of freedom and fruitfulness of individual life,” a view that is perhaps just as relevant today as when written many years ago. ☯

**MUSE & VIEWS**

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

**- Thamas De Quincey**

*Submitted by  
William Newman MD*



## Ethics at the March for Our Lives

Philip J. Candilis MD, Ethics Committee

The marches against gun violence come at the same time the APA's Council on Psychiatry and Law proposes new language for its position statement on guns and mental illness. APA's advocacy against large capacity magazines resonates with the protests of young people across the country who object to the human cost of weapons in their communities.

In Washington DC, Martin Luther King Jr's nine-year-old grand-daughter echoed her grandfather by saying, "I have a dream that enough is enough." Parkland Florida students carried price tags of \$1.05 representing their senator's NRA money divided by the number of students in the state. "Is this what we're worth...?" asked Marjory Stoneman Douglas student Sarah Chadwick from the speakers' podium.

Grandparents walked with their grandkids, with two holding a sign saying "Old Person Supporting the Young People." Other signs called for the repeal of the Second Amendment, with several asking, "What About 'Well-Regulated' Don't You Understand?" Media coverage was thick, with Comedy Central represented in one corner as well: Jordan Klepper of "The Opposition" interviewed a family on the curb of 7th Street as the crowd moved past.

As politics meets the renewed public health outcry for gun control, forensic ethics again has a prominent role to play. Often cast as a matter of mental health, an approach that stigmatizes citizens diagnosed with mental illness, mass shootings traditionally pitch the rights of gun owners against those of their potential victims. Communities struggle with unhelpful arguments that trade off individual and community freedoms. One person's right to bear arms infringes another's right to a safe community. And vice versa.

In psychiatry it is Alec Buchanan's writing on human rights that is particularly useful here. Buchanan finds that the inherent dignity and worth of

individuals is the primary moral force in society, carrying obligations for citizens and professionals alike.

Embedded in an understanding of what every person is entitled to, from unencumbered religious and political freedoms to rights of fair trial and fair opportunity, human rights provide an understanding of the themes that cut across communities and peoples.

They are the themes that overlap to promote a peaceful civil existence.

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*"Rights of safety for people in vulnerable positions are foundational to a secure society."*

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Perfect for a socio-political struggle like gun control, human rights offer a level of discourse that applies across societies and cultures. Human rights thinking still requires cultural sensitivity and acknowledgement of unequal treatment, but seeks universal principles that take social vulnerabilities into account. If gun violence affects women, children, and people of color in ways that reflect the inequities of life – as it does – it comes up against a powerful force. Rights of safety for people in vulnerable positions are foundational to a secure society. And indeed, women are more likely gunshot victims because of domestic violence. Women and people of color are the more likely target of mass shootings. Young people of color are more likely to experience gun violence during childhood.

Human rights protect people from harm by others. In fact, this is a justification often used to protect people from persons diagnosed with mental illness – think of Tarasoff-type duties for example. But since persons diagnosed with mental illness are more likely to be subjected to violence than to perpetrate it, turn-about is fair play. Citizens and patients have the funda-

mental human right to be protected from the harm that arises from easy access to weapons. Indeed the APA and other public health agencies have repeatedly underscored the problem. Now, so have our kids. <sup>(1)</sup>

## Ask The Experts

*continued from page 6*

it is common for the retaining attorney to say that she just wants a short report and it will be included in a brief with all the others. Always be careful of this type of statement. The lawyer may well believe it when she says it, but they may have no control over what happens afterwards. It is possible you may end up flying all over the country, and having to do multiple hours of preparation for examination cross-examination, when you thought you just had to do a quick two-page report.

In fact, as well as the cross-examination above, the fact that your report was only two pages may also be the subject matter of an aggressive cross-examination. In the final analysis, this may lead to certain amount of bad feeling all around, linked with sincere regrets about accepting the phone call in the first place. Caution: think about these issues carefully before accepting a pro bono case.

### Take Home Points:

Doing pro bono work is admirable and consistent with our clinical work; physicians have always extended free care to those in need. One of the ways to judge the merits of the work is to see if the lawyer is also doing the case for free. Being aware of your reason(s) for taking the case pro bono is important, as you may well be cross-examined on this subject. The courtroom is not the place for you to promote your personal favorite cause as an "expert." Remember, it is okay to advocate for your scientific and impartially reached opinion. That is different than advocating for a person or a particular cause. <sup>(1)</sup>

## Sexually Violent Predator Evaluations: Tips for the Trade

Brian Holoyda MD, MPH, MBA, Sexual Offenders Committee

In 1990 Washington state became the first in the United States to enact a law allowing for the civil commitment of individuals convicted of sexual offenses following completion of their prison term. In 1997 the US Supreme Court upheld the constitutionality of the civil commitment of sexual offenders in the landmark case *Kansas v. Hendricks*. By the mid-2010s, approximately 20 states and the District of Columbia had enacted their own sexually violent predator (SVP) or sexually dangerous person (SDP) statutes. Though each jurisdiction may utilize different statutory language, SVP legislation generally requires that the individual meet three requirements to qualify for civil commitment.

First, the individual must have committed a qualifying sexual offense. Second, the individual must have a mental condition, also commonly referred to as a mental abnormality or mental disorder. Lastly, the individual's mental condition must create a high probability that the individual will commit future sex offenses because of a serious difficulty controlling his or her behavior.

From a psychiatric standpoint, the civil commitment of sexual offenders poses some challenging ethical questions. First, there is a concern regarding improper use of psychiatric diagnosis in the finding of the mental condition required for commitment. In some jurisdictions a substantial portion of SVPs have been committed under the mental condition of paraphilic coercive disorder, which is a diagnosis that lacks a strong research base and has questionable validity.

Second, the treatment offered to SVPs may be of limited utility. Individuals with paraphilic disorders may be unlikely to accept treatment and in many jurisdictions there is no mechanism by which to mandate that SVPs receive hormone-modifying treat-

ments, which themselves have limitations. As the Supreme Court held in *Hendricks*, however, the failure to offer treatment for an untreatable condition fails to make SVP legislation punitive. The hospitalization of individuals with many times questionable diagnoses for unenforceable treatment may explain why SVPs are infrequently released back into the community in many jurisdictions.

Because of the inherent ethical concerns related to SVP law, commitment proceedings can be tense and heated. For the forensic expert involved in such casework, it may be difficult to maintain neutrality and aplomb. It is therefore important for forensic experts to know about the nuances of SVP evaluation in order to be able to approach a case with confidence and understanding.

Below I describe some tips and tricks to help a forensic evaluator new to the field conduct an objective, high-quality evaluation.

The first tip relates to a foundational aspect of forensic training, specifically understanding the language of the law as it applies to your psychiatric findings. It is critical that the evaluator **understand the meaning of “mental condition” or “mental abnormality”** as it is defined within his or her state statute. For example, in its Revised Statute § 632.480, the state of Missouri defines “mental abnormality” as “a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such person a menace to the health and safety of others.”<sup>1</sup> Many jurisdictions utilize an identical or similar definition, which is broad and could include various categories of psychiatric nosology in addition to paraphilic disorders, such as psychotic disorders, mood disorders, or personality disorders. For example, an individual with a history

of bipolar I disorder and sexually violent offenses committed while manic may meet the statutory requirements for a mental condition or abnormality.

A second tip applies when considering a diagnosis of a paraphilic disorder in an SVP evaluatee. It is crucial to **identify the most recent evidence indicating that the individual has atypical sexual interest** from his self-report, collateral informants, or other sources of information. DSM-5 specifies that paraphilic disorders (except pedophilic disorder) may be “in full remission” if the individual has not acted on the atypical sexual urges with a nonconsenting person nor experienced distress or impairment in functioning for at least five years while in an uncontrolled environment. Some individuals may face SVP commitment proceedings after having lived in the community following release from a prison term for a sexual offense. Judges and juries may find that a paraphilic disorder in full remission does not meet the statutory definition of the mental condition required for commitment.

Making a diagnosis supported by evidence is only the first step in determining if an individual may qualify for SVP commitment. Next, the forensic evaluator must link the individual's mental abnormality to his risk of sexual recidivism. The third tip, then, is to **understand the individual's history of sexual offending beyond the names of his charges**. Read all available police reports regarding the index offense and prior offenses. Is there a pattern of offending? Does the psychiatric diagnosis play a role in all of the individual's offending behavior? In cases where the mental condition is a paraphilic disorder like pedophilic disorder or exhibitionistic disorder, this may be relatively easy to determine based on the nature of the sexual offenses. In other cases, however, the link may be less clear. Understanding the motivation, offense characteristics, and situational factors can clarify the relationship between the identified psychiatric diagnosis and the individual's offense history, if any.

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## Expanding AAPL's Scope

*Tobias Wasser MD, Christopher Thompson MD, Government Affairs Committee*

The AAPL Government Affairs Committee was established in 2017 as a new AAPL committee as part of AAPL President Dr. Christopher Thompson's strategic initiative to expand the visibility and national impact of AAPL's educational mission. AAPL's primary educational mission has been devoted to the education of medical students, psychiatry trainees, forensic and general psychiatrists, other mental health professionals, and legal professionals. However, part of Dr. Thompson's vision for AAPL that he outlined in his address to the organization at the 2017 Annual Meeting included encouraging the organization to consider its educational mission more broadly, to include policymakers (e.g., legislatures, administrative agencies, the judiciary), the media, and the public. As a component of this strategic initiative, three new AAPL committees were formed – the Judicial Action Committee, the Media and Public Relations Committee, and the Government Affairs Committee (GAC).

The mission of the GAC is to assist and promote AAPL in liaising with and providing education and organizational expertise about forensic psychiatric/mental health issues to state legislatures, the U.S. Congress, and relevant federal departments and administrative bodies. The proposed primary activities of the GAC include:

1. Keeping abreast of and informed about pending state and federal legislation relevant to forensic mental health issues
2. Offering recommendations to AAPL Council regarding AAPL's potentially providing input to legislative offices
3. Serving as an educational resource for legislative offices and relevant federal departments and administrative bodies

As a component of this expanded educational mission, Dr. Thompson wanted AAPL to have the opportunity, at an "earlier point in the process," to

become aware of, review, and, if indicated, provide feedback regarding both potential federal legislation and administrative agencies' proposed initiatives and potential guidelines (e.g., Department of Justice testimony guidelines). One mechanism by which to accomplish this was for AAPL to partner with the Consortium for Forensic Science Organizations (CFSO).

The CFSO, formed in 2000, is an association composed of forensic science professional organizations, including the American Academy of Forensic Sciences, American Society of Crime Lab Directors, International Association for Identification, National Association of Medical Examiners, and the Society of Forensic Toxicologists - American Board of Forensic Toxicology. These professional organizations together represent more than 15,000 forensic science professionals across the United States. The mission of the CFSO is to speak with a single forensic science voice in matters of mutual interest to its member organizations, to influence public policy at the national level and to make a compelling case for greater federal funding for public crime laboratories and medical examiner offices. The primary focus of the CFSO is local, state and national policymakers, as well as the US Congress.<sup>1</sup>

In February 2018, Dr. Thompson obtained approval from the AAPL Executive Council for AAPL to request permission to join the CFSO and submitted a formal request to the CFSO Board of Directors requesting AAPL become one of its member organizations. AAPL's request was granted and AAPL is now the sixth member organization of the CFSO. As a component of that partnership, AAPL is now working with the CFSO legislative analyst, Beth Lavach, to track legislation relevant to our organization's mission.

In the committee's inaugural year, we were fortunate to have significant interest from AAPL members. In total,

we had 37 members express interest in joining the committee and had a productive conference call involving approximately half of that group. The committee also met during the APA 2018 Annual Meeting in NYC with similar attendance. Topics which were discussed included developing mechanisms for tracking relevant state and federal legislation, offering AAPL's expertise to state/federal legislative offices and relevant federal departments, AAPL becoming a participating member of the CFSO, and generating a mechanism for vetting legislation and providing feedback to AAPL Council.

The GAC is currently tracking several state and federal bills relevant to AAPL's mission. Below are a sample of such legislative actions and a summary outlining their significance:

- 34. U.S. Code Subchapter III - Violence Against Women (VAWA) (Federal)
  - o Development of model legislation regarding confidentiality of communication between a sexual assault victim and therapist
  - o Development of grants to research the effects of sexual assault on mental health
  - o Formation of a work group to develop, among other things, "best practices" for treating and working with sexual assault victims
- CA AB 1971
  - o Language requested by the Los Angeles County Board of Supervisors to expand the definition of "grave disability" to consider urgently needed medical treatment as a basic human need when assessing an individual's need for conservatorship.
- CA SB 1391
  - o This bill would repeal the authority of a district attorney to make a motion to transfer a minor from juvenile court to a court of criminal jurisdiction in a case in which a minor is alleged to have committed a specified serious

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# An Early Start: Forensic Psychiatry Opportunities Throughout Training

*Anne McBride MD, Marcia Unger MD, Joseph Hall MD, Sophie Rosseel MD, Forensic Training of Psychiatry Residents Committee*

I (Dr. McBride) have had the great fortune of teaching within a department that highly values education in general including forensic psychiatry specifically. The Division of Psychiatry and the Law at my institution includes some of the most talented educators I have ever met. As a former trainee, finding opportunities for early exposure to forensic psychiatry was formative for my future career. Now, as the Program Director for Child and Adolescent Psychiatry and an active faculty member within the forensic division, one of the most exciting and rewarding parts of my job is to provide mentorship for trainees ranging from within the medical school to the general psychiatry residency to the fellowship level. Opportunities for early exposure to forensic psychiatry can be abundant with the right guidance, creativity, and shared enthusiasm. The following are examples of forensic experiences across various levels of training.

### Forensic Training as a Medical Student

*Sophie Rosseel, MD, PGY-1, General Psychiatry Resident, UCLA*

I am a first-year psychiatry resident at a large academic medical center interested in pursuing a career in forensic psychiatry. I am truly fortunate to have been directly exposed to the field through experiences in my third and fourth years of medical school, as few if any medical students receive exposure to forensic psychiatry at all. I am grateful to my institution, as these rare experiences have significantly guided my educational path and training.

My initial interest in forensic psychiatry stemmed from a desire to understand individuals' internal motivations for behaviors. I saw forensics as attempting to understand another's

perspective while simultaneously searching for objective truth in a person's experience with the surrounding world. This conflict in reconciling one's objective reality — particularly in relation to the law — is what continues to attract me so much to the field.

My initial forensic experiences during my third year of medical school were correctional in nature, in which I was caring for psychiatric patients in the Sacramento County Jail. There, I was struck by the complex set of skills required to adequately care for this unique patient population, balancing both objectivity and empathy, appreciating the underlying social structure deficits leading to incarcerations, and accepting challenges to providing quality psychiatric care in an otherwise punitive environment. Overall, I witnessed a true need for the well-rounded forensic psychiatrist adept in early childhood trauma, ethics, psychotherapy, and substance use.

Later, during my fourth-year psychiatry rotation, I was fortunate to attend a faculty member's child forensic evaluation, where I gained an appreciation for the comprehensive evaluative process, from interview to testimony. I appreciated the diversity of the supervisor's roles as evaluator, diagnostician, and expert educator for the courtroom and saw her role as integral to the fair legal process. I easily connected with my own aspiration to do similar work, and I am inspired and look forward to continuing my training in forensic psychiatry.

### Forensic Training as a General Psychiatry Resident

*Joseph Hall, MD, PGY-2, General Psychiatry Resident, UC Davis*

During the second year of training

in general psychiatry, residents have the opportunity to work in a half-day longitudinal clinic throughout the year. Within medical education and training, longitudinal experiences are increasingly being implemented to provide continuity of care which is often lost in the traditional model of rotating to a new training site each month. For my clinic, I hoped to gain experience working in a forensics environment and created a resident clinic site through the Sacramento County jail system.

The resident longitudinal clinic in forensics is at a jail-based competency treatment program providing psychiatric care to patients who have been found incompetent to stand trial. Jail-based competency restoration is a somewhat novel treatment approach that has been instituted in California to decrease waitlist times for state hospitals and improve care for patients who are being restored to competency. The clinic is an interdisciplinary environment where staff provide a structured curriculum on various aspects of court proceedings and law, and psychologists perform structured assessments of competency. The treatment team meets weekly to discuss patients.

Through this experience, I had the opportunity to learn about the unique challenges of correctional psychiatry and about the statutes and processes surrounding jail-based competency restoration and incompetence to stand trial. By being immersed in a correctional setting, I treated patients with severe mental illness over an extended amount of time and became comfortable with the use of long-acting injectables. Over the course of the year, I had the rewarding opportunity to see many patients regain competency and return to court. By leading a treatment team, I gained confidence and skills as a psychiatrist and a great sense of satisfaction and engagement in my psychiatric training.

### Forensic Training as a Child and Adolescent Psychiatry Resident

*Marcia Unger, MD, PGY-4, Child Psychiatry Fellow, UC Davis*

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# The Implicit Association Test And Employment Discrimination Litigation

Stuart B. Kleinman MD, Trauma and Stress Committee

Psychological test data may be inordinately persuasive to jurors, especially those who skeptically regard psychiatry. Merely the term “test” may imbue psychological test data with inordinate credibility. The weight accorded such is especially likely to be great when they are numerically presented.

The concept of implicit bias, i.e., automatic or unconscious bias, has been increasingly considered in the criminal justice system, particularly in relation to how jurors assess witness testimony, and by police departments, with regard to how law enforcement personnel respond to individuals of a different race. The Implicit Association Test (IAT) <sup>(1)</sup>, a quantitative measure of unwitting bias, is now often utilized to attempt: 1) to improve the judgment and conduct of police officers reacting to individuals belonging to groups prone to be stereotypically perceived as violent, and 2) to support claims of discriminatory employer actions. With such recent high-profile incidents as the 2018 arrest of two African-American men who were reported to be waiting in a Philadelphia Starbucks store for a meeting to begin, and Starbucks’ subsequent closing of over 8000 US stores for an afternoon to implement training intended, it explained, to help employees recognize potential unconscious bias, it is likely that the IAT and similar instruments will become an even greater component of Title VII and related litigation. Reflecting the impetus for such, the Mayor of Philadelphia requested that the Commission on Human Relations investigate “the extent of, or need for, implicit bias training” of Starbucks’ employees.

The IAT constitutes a response latency task which was developed to measure implicit attitudes, especially implicit stereotyping, and is premised upon tasks involving regularly practiced associations being more rapidly

performed than tasks which do not, i.e., automatic thoughts or preferences generate faster responses than those requiring deliberation. For example, amongst those with a preference for dogs versus cats, pro-dog keys, which associate dogs with “good” attributes, and cats with “bad” ones, will more rapidly be pressed than pro-cat keys, which link dogs with “bad” attributes, and cats with “good” ones. Similarly, IAT testing of attitudes or stereotypes regarding African-Americans involves pressing keys which link black faces and words reflecting “good” attitudes or stereotypes, and white faces and words reflecting “bad” attitudes or stereotypes, and then keys which link black faces and negative terms, and white faces and positive terms. Typically, milli-seconds distinguish response times. Faster responses to black faces and negative terms than to white faces and the same negative terms are considered to reflect “automatic preferences,” representing unconscious bias and a predilection for discrimination against African-Americans. The magnitude of such predilection, particularly the likelihood of consequent actual discriminatory behavior (assuming that the IAT, in fact, measures such bias) is greatly disputed.

Challenges to use of the IAT to support that employment decisions were illegally discriminatory have been based on Federal Rule 702, specifically the scientific merit of the IAT and the associated Daubert criteria, and Federal Rule 403, and whether testimony invoking the IAT is more prejudicial than probative. Testimony of the IAT’s primary progenitor, Dr. Greenwald, regarding the IAT was, for example, admitted in *Samaha v. Washington State Department of Transportation* <sup>(2)</sup>, in which the Court, relying upon the Advisory Committee Notes to the 2000 amendments to Rule 702: 1) found “the con-

cept of implicit bias and stereotypes is relevant to the issue of whether an employer intentionally discriminated against an employee”, and 2) permitted testimony about “general principles” of implicit bias to educate jurors regarding a concept which the Court determined they might not otherwise understand. In contrast, Dr. Greenwald’s testimony was excluded in *Karlo v. Pittsburgh* <sup>(3)</sup>, in which the Court found his proffered opinion was not based on sufficiently reliable data, and did not sufficiently fit the circumstances of the alleged discriminating employer.

Reflecting the import of the concept of implicit bias to the judiciary, and suggesting its potential wider influence, implicit bias was specifically cited in the majority decision in *Texas Department of Housing and Community Affairs v. Inclusive Communities Project, Inc.* <sup>(4)</sup>, a case in which the Supreme Court decided in a 5 to 4 vote that Congress intended disparate impact claims to be cognizable under the Fair Housing Act, but require the plaintiff to prove that defendant policies caused the claimed disparity. Justice Kennedy wrote, “Recognition of disparate-impact liability under the FHA also plays a role in uncovering discriminatory intent. It permits plaintiffs to counteract unconscious prejudices and disguised animus that escape easy classification as disparate treatment.”

A 2009 meta-analysis by Greenwald et al <sup>(5)</sup> based on 122 studies, and 184 independent samples, estimated the average predictive validity effect size (r) across nine domains of criteria measures to be .274, which the authors characterized as “moderate.” In contrast, the average criterion correlation of self-report measures was greater, i.e., .361. However, relevant to the issue of employment discrimination, IAT measures were found to have greater predictive validity than self-report measures with regard to criterion measures of interracial behavior and of other intergroup behavior, although with only a (r) of .24 for interracial behavior, and .20 for other intergroup

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## Implicit

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behavior. Greenwald et al further asserted that the magnitude of the correlations was “inevitably attenuated,” “due to unreliability of both predictor and criterion measures,” and calculated “crudely approximated” disattenuated correlations of .409 for the average predictive validity of IAT measures, and .438 for self-report measures. In contrast, Oswald et al, <sup>(6)</sup> who have vigorously criticized Greenwald et al’s findings on many grounds, conducted their own meta-analysis of the studies employed in the 2009 Greenwald et al meta-analysis, and using different methodology found a much weaker correlation between IAT scores and criterion measures. Rather than .24 and .20 correlations for interracial and for other intergroup behavior, they found overall correlations of .15 and .12. IAT score was found to correlate only with fMRI measures of brain activity, and they note, “IATs, whether they were designed to tap into implicit prejudice or implicit stereotypes, were typically poor predictors of behavior, judgments, or decisions that have been studied or instances of discrimination, regardless of how subtle, spontaneous, controlled, or deliberate they were.” Explicit measures were also found to be weak predictors, but performed no worse, and in some instances better, than the IAT in predicting policy preferences, interpersonal behavior, person perceptions, reaction times, and microbehavior. Importantly, no empirical linkage was identified between the fMRI studies, and actual verbal or non-verbal behavior. Also significantly, although fMRI activity highly correlated with the IAT, null results are not reported in the published neuroimaging studies included in the meta-analysis.

Oswald et al <sup>(7)</sup> subsequently noted in 2015, that Greenwald et al <sup>(8)</sup> acknowledge that the overall estimates of (IAT measured) implicit bias effect size derived from meta-analysis are small per conventional standards, but regard such as societally significant, specifically, “large enough to

explain discriminatory impacts that are societally significant either because they can affect many people simultaneously or because they can affect single persons repeatedly,” and that “this level of correlational predictive validity of IAT measures represents potential for discriminatory impacts with very substantial societal significance.” Oswald et al, in contrast, assert that “conceptual and empirical support” for this conclusion is “lacking.” They observe, for example, that their own finding of a .07 mean correlation between the race IAT and microaggression toward African Americans contradicts the understanding that implicit bias is primarily expressed via subtle, negative behaviors.

A central criticism of the application of the IAT to behavior, particularly decision-making, is its ecological validity. Although, for example, the race IAT has been administered millions of times (Project Implicit), there has been virtually no study of the IAT in relation to real world decision-making, including specifically the many variables that may moderate such. The author of this article is aware of only one study, a 2015 study by Derous et al <sup>(9)</sup>, in which the IAT has been administered fully in conjunction with real world employment-related decision making. In this study, Dutch recruiters reviewed applicants’ resumes to screen for various positions. Explicit prejudice predicted greater effect against Arab applicants than did implicit prejudice. In contrast, implicit sexism regarding women produced greater effects than did explicit sexism, but only for women applying for a high client contact position. Such demonstrates the importance of ecological validity, to the extent implicit bias affects decision making, it may do so only in certain situations.

Rooth <sup>(10)</sup> in 2010 reported on a “semi-real world” study, in which employers/recruiters were asked to review fictitious resumes, and paid the Swedish equivalent of \$39 to do so. Problematically, only 193 of 729 employers, i.e. 26%, completed the IAT and a proffered questionnaire in

one of the experiments, and only 158 of 811 employers, i.e., 19%, completed the IAT and questionnaire in the other experiment. The study, which used both the IAT stereotype, and IAT attitude measures, found a statistically significant, 5% lower probability of a callback interview for “Arab-Muslim” named applicants, and “strong and consistent” negative correlations between the IAT score, and the probability of an individual with an “Arab-Muslim sounding name” being invited for an interview. Explicit measures demonstrated no such correlation. Oswald et al <sup>(7)</sup>, however, note that Rooth did not report the specific IAT-criterion correlations, but that Greenwald et al <sup>(8)</sup> obtained the correlations or data, and reported only small correlations between IAT scores and the likelihood of seeking to interview “Arab-Muslim” applicants. Additionally, they identify what they consider to be important methodological limitations of Rooth’s study.

Courts have expressed concern regarding using the IAT to support that specific employment decisions were discriminatory. Illustrating such, the Court in *Karlo* wrote, in precluding Greenwald’s testimony, “The Court also finds that Greenwald’s methodology is unreliable, to the extent that the IAT informed his analysis and provided a basis for his opinion that most people experience implicit bias. Although it has been taken more than fourteen million times, Dr. Greenwald cannot establish that his publicly available test was taken by a representative sample of the population Dr. Greenwald also fails to show that the data is [sic] not skewed by those who self-select to participate, without any controls in place to, for example, exclude multiple retakes or account for [sic] any external factors on the test taker.” Similarly, the *Court in Phippen v. State of Iowa* <sup>(11)</sup>, in precluding Dr. Greenwald’s testimony, wrote, “meta-analysis only allows conclusions as to correlation, not causation.”

A crucial, but relatively unexplored consideration when using the

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## Royal College of Psychiatrists Forensic Faculty Annual Conference Nottingham 2018

*Dr Mary Whittle (London), Dr Nicola Swinson (Carstairs),  
Dr John Baird (Glasgow) with Chris Cox, Medical Student (University of  
Glasgow)*

The 2018 meeting of the Forensic Faculty of the Royal College of Psychiatrists was held in Nottingham and was attended by around 400 delegates. A pattern has been established for these annual conferences to alternate between a venue within continental Europe and a venue in the United Kingdom. This year the meeting convened in Nottingham - one of a cluster of cities in a region known as the East Midlands of England, located about 150 miles north of London. Nottingham Castle goes back a thousand years and a figure from the 15th century, a local outlaw called Robin Hood, has achieved legendary and worldwide fame. With the decline of its traditional industries of lace making and bicycle manufacture, Nottingham is now known for its universities and as the headquarters of Boots, the UK pharmaceutical brand. The city is also the home of two long established association football clubs, both of which have enjoyed periods of great success during their long histories. One of them, Nott's County, is the oldest professional association football (soccer) club in the world.

The conference started with a series of sessions dealing with the plight of the mentally disordered within society and the responses of society to offenses, including public order offenses, for which these mentally disordered citizens are responsible.

A Police Service Law Enforcement officer described graphically how police officers often have to take on the role of emergency mental health service personnel when they are first on the scene when a mentally disordered person is offending or creating some sort of disturbance. We learned that 20-40% of emergency police interventions are linked to mental dis-

order and that police officers can resent the lack of training and support they receive to undertake this challenging work. Joint responses and training between correctional services and mental health are seen as the way forward. While some services have made these adjustments already, they are by no means the norm.



Professor Pamela Taylor and Dr. Reena Kapoor pose for a photo with Robin Hood. Photo credit: Professor Tim McInerney

There was an engaging presentation by the Chairman of the Parole Board for England and Wales. Under the law in the United Kingdom, the Parole Board is independent from elected politicians and is required to consider only the matter of risk when considering the case of a parole eligible individual. We were reminded that a decision about risk is a judgement, not a finding of fact. Fewer than 1% of offenders released by the Parole Board go on to re-offend, but there are no grounds for complacency because the impact of serious further offenses, albeit a small number, can

be considerable. The number of prisoners who could have been released safely, but where release is not ordered, is of course unknowable.

We then heard of services for offenders whose offending is linked to personality disorder. Criteria for entry to these services are broad and intended to be as functional as possible. The offender should have a high risk of causing harm; have a personality disorder with a link between personality functioning and offending and have links with the National Probation Service. One aim is to move away from the very detailed and lengthy assessments which were required by DSPD Units, the units previously the core of provision for these offenders in favor of Psychologically Informed Planned Environments (PIPE's). The value and effectiveness of these new services is still to be assessed.

Next came a session on problematic sexual arousal. The important finding was that those offenders who were offered medication, either antidepressants (SSRI's), anti-androgens (Cyproterone) or GNRH-agonists (Triptorelin), almost invariably described a positive response. Indeed they expressed almost a feeling of new found freedom that their sexual preoccupation had diminished. While the expectation of Parole Boards often centres on the belief that when the opportunity arises, the offender will stop the medication, there is no evidence that offenders who have engaged voluntarily and who responded well to medication do actually stop medication. It is much more likely that they will continue medication long term.

Each year the Forensic Faculty conference features a debate on a hot topic, with a vote taken before and after the presentations. This year's motion that *"This house believes that the future care of mentally disordered offenders should be shifted towards the Criminal Justice system and away from secure hospitals"* provoked a lively debate and discussion. Speakers included Dr. Reena Kapoor of Yale Medical School. Though on both occasions the majority opposed the

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### Royal College

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motion, the number of supporters increased significantly after the debate. This was a noteworthy development as, in certain respects, the motion opposed some long standing core beliefs of the Faculty over many years to the effect that prisons are intrinsically bad; secure hospitals are intrinsically good and that the most important clinical task of a forensic psychiatrist is to facilitate the removal of mentally disordered persons from one and their admission to the other. It seems that these assumptions need to be re-visited and even perhaps to be set aside.

A session on the current state of risk assessment was a highlight of the first day as predictive value and the reliability of the process was examined and challenged. The conclusion was that among large groups, trends and probabilities can be achieved, but the process must be very much more cautious and circumspect when applied to individuals.

As delegates left the conference hotel to explore and enjoy the Nottingham restaurants, for some the deep snow and blizzard conditions brought back memories of the APPL conference in Denver about twenty years ago.

The second day of the conference began with master classes. The morning began with a presentation on restorative justice, an aspect of offender rehabilitation which is becoming more popular and is best described as an arrangement wherein victims and offenders communicate within a controlled environment. The aim is to facilitate both parties to talk about the harm that has been caused and to try to find ways to repair it. Links between offenders and victims can be direct, indirect or by proxy i.e. using with figures who represent the victim. Benefits from interventions of this kind have been found with violent and prolific offenders, with offenders experiencing a significant shift in their perception of themselves.

Next came a thought provoking

presentation on strategies for preventing self-harm within a forensic service. The emphasis in the approach is to ensure that the clinical team is aware of environmental factors as well as patient specific factors. There should be an agreed, but short, model of care (in essence a formulation) for the patient. It should not be discipline specific and should be clear, practical and understandable. Ideally it should take no more than one page. The act of writing it together as a team is most important.

Continuing the varied program, a lively presentation on addiction services gave the message that a person in crisis must never be turned away from services, reminding us that such people are at significant and imminent risk of serious harm or death by one means or another. Addiction services must be willing to provide care to substance misusers who are psychotic and mental illness services must be willing to provide care to someone who is acutely psychotic but also intoxicated or addicted. Two principles of managing severe substance misuse were emphasized - free will and the power of the person to stop – but, in the meantime, it is necessary to keep the person alive.

There was a presentation on dementia, a topic of importance because of the growing number of older prisoners. We learned that dementia affects one in twenty people over the age of 65, with Alzheimer's disease being the commonest diagnosis by far. The Montreal Cognitive Assessment Test is a useful screening tool, controversially and publically taken recently by President Trump. Picks disease, a less common form of dementia, is also associated with behavior changes but also with poor judgement, disinhibition, appetite changes, loss of insight and chaotic and behavior which can mimic mania. The importance of making the diagnosis was emphasized.

Lastly we learned of problems which can arise when children and young people are online. Speakers explored problems with content, usage and conduct; children viewing adult pornography, problems with interac-

tion and communication - cybercrime, sexting, cyber bullying and grooming. While most young people are generally aware of the risks, the challenges for adults who are attempting to monitor the use of the internet by young people are considerable.

Parallel sessions were held in the afternoon. One dealt with boundary issues arising within a clinical team when a young male trainee was suspected of over-involvement with a young woman who had borderline personality disorder and recurrent self-harm. Members of the small group role-played as members of the clinical team. It was no surprise when opinions on the action which should be taken was divided and polarized.

The final session had presentations of excellent research projects by four medical students, participants in the Faculty student essay competition. We learned about the unclear links between schizophrenia and violence and the difficulties of research in this area. We learned about the lack of research into postpartum psychosis and infanticide and the varied judicial and public responses. We heard of the improved recovery and rehabilitation of patients who had suffered a schizophrenic illness in a developing country, compared with those who become ill in a developed country and the cultural and social factors associated with this rather counter intuitive but robust finding. The final research topic demonstrated objectively the significant day to day impact of financial constraints and staff shortages on the condition and lives of prisoners in Wales.

This year's conference provided a breadth of information to delegates, a forum to exchange ideas and topics for discussion and research over the next year, a chance to keep up with friends and colleagues and amazing, unexpected, snowy conditions in Nottingham – an invigorating experience all round.

The next Forensic Faculty annual meeting will be in Vienna, Austria from 6th to 8th March 2019. Does anyone really need an excuse to visit Vienna in the spring? As ever, AAPL

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## Avoiding Slippage Down a Slippery Slope: Dialectical Principlism to the Rescue!

William Connor Darby MD and Robert Weinstock MD, Ethics Committee

AAPL ethics guidelines highlight the importance of psychiatrists obtaining informed consent from their evaluatees prior to performing a forensic evaluation:

“At the outset of a face-to-face evaluation, notice should be given to the evaluatee of the nature and purpose of the evaluation and the limits of its confidentiality. The informed consent of the person undergoing the forensic evaluation should be obtained when necessary and feasible. If the evaluatee is not competent to give consent, the evaluator should follow the appropriate laws of the jurisdiction.” (AAPL Ethics Guidelines for the Practice of Forensic Psychiatry Adopted May, 2005)

The concept of this guideline is likely clear to most: forensic psychiatrists must distinguish their role from one of treatment. Forensic psychiatrists should not deceive or mislead an evaluatee into believing the purpose of an evaluation is to help them (when it may not) and/or that it is confidential. In actuality, the purpose of a forensic evaluation is to answer a particular legal question, which may bring harm to the individual being interviewed. Also, the findings that form the basis of a forensic opinion will not be confidential.

Although this guideline is helpful in many situations, grey areas remain regarding informed consent in forensic practice that create ambiguity on what is the right thing to do. For example, what should one do when informed consent was obtained at the beginning of an interview but the evaluatee later appears to assume incorrectly that you are on his side when in fact the opposing side hired you? To deal with such ethics dilemmas, we have developed Dialectical Principlism

as a method of balancing conflicting principles as defined by a person’s role and weighed by the specific context.

In applying Dialectical Principlism to this hypothetical example of “slippage” of the psychiatrist’s original advisement, we would start first by identifying the role. Psychiatrists can take on many roles such as treatment provider, researcher, managed-care reviewer, administrator, forensic practitioner, etc. For each role, a different hierarchy of principles governs ethical action that our model organizes into *primary* versus *secondary* duties.

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*“...what should one do when informed consent was obtained at the beginning of an interview but the evaluatee later appears to assume incorrectly that you are on his side when in fact the opposing side hired you?”*

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In the forensic role, the primary duties are to foster truth by answering the legal question honestly and to respect the person being evaluated. Secondary duties are related to the retaining attorney and the evaluatee, among others. In the balancing process, primary duties are given more weight than secondary duties and in most cases are determinative of our most ethical action. In rare contexts, however, a secondary duty may be so overwhelmingly important and salient as to outweigh primary duty. This occurs in the treatment role

when secondary duty to third parties trumps patient welfare in scenarios that warrant breaching doctor-patient confidentiality for child and elder abuse reporting or Tarasoff situations.

In the example of “slippage” of the initial informed consent obtained for a forensic evaluation, the primary duty principle of ascertaining truth to answer the legal question is pitted against the primary duty principle of respect for persons. By not correcting an evaluatee’s mistaken belief that you are on his side and there to help him, you may be able to generate more honest and candid responses that facilitate truth-telling in a forensic opinion. Misleading the evaluatee, however, even if passively and despite an initial advisement, would be a violation against respecting the individual’s personhood. Using Dialectical Principlism, the context of the situation defines the weights given to each principle in the balancing process.

The weight of fostering truth will outweigh the weight of respect for persons in situations in which the evaluatee incriminates himself or provides information that will hurt his case if he does so voluntarily and there is no evidence that he is confused about the forensic practitioner’s role. Thus, Dialectical Principlism does not hold that an evaluatee should be interrupted and re-advised as to the forensic psychiatrist’s purpose and confidentiality limits in the interview just because the evaluatee begins to divulge potentially harmful material. The balance for respect for persons becoming determinative of our most ethical action occurs when the evaluatee displays some indication of misinterpreting our role and purpose. Individual forensic psychiatrists may have differing thresholds for deciding what subjective signs of role confusion – short of clear, objective evidence like a statement: “hey doc, I know you’re here to help me and this is confidential so let me tell you what happened” – constitute a need to re-advise evaluatees. These differences in where individual forensic psychiatrists draw this line are permissible

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## Criminal Behavior and Social Theories

Kavita Khajuria MD

In an effort to continue to understand criminal behavior, this article summarizes select social theories. Biological and psychological theories offer insights into individual cases, but don't explain crime rate variations between neighborhoods or within groups.

The *social structure* theory considers socioeconomic disadvantage to be the primary cause of crime. It encompasses three branches: strain, social disorganization, and cultural deviance.

The *strain* theory was the name given to sociologist Merton's explanation of criminal behavior. It argues that all members of society subscribe to cultural values of the middle class, that of economic success. Those unable to obtain symbols of success through conventional means consequently develop anger, frustration, and resentment, collectively referred to as "strain" (1). Anger increases the desire for revenge, helps justify aggressive behavior, and stimulates individuals to act. Criminal solutions may consequently develop. As sources of strain vary over the life course, so do crime rates. Critics argue a generalization to the lower class (2), and question whether a multifaceted society really does have a common goal. Furthermore, Adler's study of 10 countries indicated crime rates to be relatively low in those wherein economic values had not devalued informal institutions of social control (2).

The strain theory dominated research of the 50s and 60s, but temporarily lost its popularity in the 70s. Increasing attention was paid to the relation of crime to disintegration of conventional values caused by rapid industrialization, urbanization and loss of attachment to social institutions, collectively called the *social disorganization* theory. Antisocial behavior flourished with the formation of law violating groups (1) and high incarceration rates, which further weakened disorganized communities.

Crime and delinquency occurred within the context of this changing urban environment. Research supports this concept, regardless of racial and ethnic identity (1), which subsequently paved the way for community action and developmental programs. Critics, however, argue the connection between crime and class to involve race, seriousness of the offense, education level, and other factors (2). Others cite high social class to promote an individual's delinquency by increasing risk taking. Some argue only a small minority of those in disorganized areas actually commit the majority of crime (3).

The *cultural deviance* theory claims a unique lower class culture develops in disorganized neighborhoods that maintains unique values (toughness and street smarts), and promotes illegal activity (1). Alienated adolescents tend to join, especially those with criminal experience. Deviant subcultures result. The *social ecology* theory associates community disorder with crime. Residents develop a "siege mentality" with distrust and suspiciousness, wherein the outside world is considered the enemy bent on destroying the neighborhood.

*Social process* theories view a person's dysfunctional relationship with institutions in society. Alienated children are more likely to develop feelings of frustration and rejection, seek out like-minded companions, and engage in antisocial behavior (1). This then evokes negative responses from others and solidifies feelings of inadequacy and low self-esteem, which later impacts criminality. Children of minority groups are often the target of school discipline, and are more likely to suffer alienation and drop out (1). Social process programs teach children conventional attitudes and behaviors that are designed to improve the social bond.

The *differential association* theory holds that criminality is a result of a person receiving an excess of definitions in favor of crime (1), including

motives, drives, rationalizations, attitudes and techniques (2, 4). Learning theories help explain the role of peers and families in shaping criminal behaviors across all class cultures (2) and has importance in development of prevention programs (4).

The *neutralization theory* holds that the young learn mental techniques to neutralize conventional values which enable them to oscillate between crime and conventional behavior. A set of justifications develops with occasional guilt regarding criminal acts, yet they define who they victimize, which implies awareness of wrongfulness (1). Techniques include a denial of responsibility (of forces beyond their control), denial of injury (it was just a "prank"), denial of the victim ("they had it coming"), condemn the condemners attitude (dog-eat-dog code), and a tendency to externalize blame (1).

In contrast, the *social control* theory maintains that all have the potential to become criminals, but bonds to society prevent this (1). Weakened bonds allow youth to behave antisocially (1). Critics argue causal order, as delinquency can result in weakened bonds to society, rather than vice versa. The *social reaction/labelling* theory holds that people become criminals when significant members of society label them as such (1), with crime defined by those in power (7,8) and the law applied differentially. Labels such as "criminal" and "ex-con" isolate people from society. Who is a jury to believe, and how might the label be interpreted? Long-term effects include poor self image, decreased prosocial expectations and increased delinquency. Restitution and diversion programs attempt to shield people from criminal labels.

In sum, social theories view crime as consequences of social influences, processes and dysfunctional relationships. Critics argue it to be far more complex, with the above theories failing to explain expressive crimes, the origin of criminal behavior, and a tendency to generalize crime to the lower class. (1)

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## In the Southwest

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court to terminate Dwight's visits with their son, saying her soon-to-be ex-husband was becoming more unstable. She and her son were afraid he would kill them for her \$4 million life insurance policy. She told the court he had purchased a machete, sent her a hand-written map of her work routes, covered with drawings of dead bodies, bought books about revenge and one on how to live with oneself after committing murder.

Her request to terminate Mr. Jones's visitation was denied. The next year, her petition to relocate out of state was also denied. The court stated that such a move would deprive Dwight and his son of their strong connection and "wouldn't meaningfully improve the quality of life for the mother or the minor child."

In November of 2010, Maricopa Superior Court Judge Pamela Gates granted the divorce and awarded full custody to Dr. Jones. Judge Gates did cite Dwight's violent, abusive behavior and untreated mental illness. Nevertheless, she continued Mr. Jones's supervised visitation and ordered Connie to pay him \$6000 a month spousal maintenance.

In 2010, Judge Gates ordered Mr. Jones to have a psychiatric evaluation. Four years later, he hadn't done so. In court records, Mr. Jones accused Drs. Selmi and Pitt of accepting Connie's account of their relationship as true because she is a doctor. His attorney wrote, "Father does not have the resources that Mother has spent to manufacture a case against him."

The years went rolled on. Mr. Jones posted YouTube videos accusing the professional evaluators of conspiring against him. His attacks were threatening and personal.

His anger escalated and finally overflowed. On May 31, 2018, he waited for Dr. Pitt to emerge from his office and shot him in the head. Steve died instantly. The next day, he drove to the office of his ex-wife's attorney, Elizabeth Feldman. She wasn't in, but

the two paralegals, Laura and Veleria, were. He murdered them. Police said the same .22-caliber handgun was used to kill the three victims.

His rage unabated, Dwight traveled to the office of his son's evaluating mental health professional. She, too, wasn't there, but Dr. Marshall Levine was. He had rented space in the office suite. He had nothing to do with the case, but Dwight killed him anyway. He used the same gun.

There was no doubt now that all these murders were related. A reward was offered and tips flowed in. Then an important message came from former detective Rick Anglin, Connie's new husband.

Police began the search for Dwight Jones. On Sunday, he was spotted dumping a bag into a trash can. It contained a .22-caliber handgun.

But on Monday, they found the bodies of Byron Thomas and Mary Simmons. Detectives learned from a neighbor that the couple and Dwight had met 5 years before and played tennis at local parks.

Why did Mr. Jones kill them? Police believe that over the years, Dwight shared his experiences and escalating rage with Byron. Jones seemed increasingly paranoid. Once the killings began, Byron asked Dwight if he might be involved. For that question, Byron and Mary paid with their lives.

Police traced Dwight to a nearby hotel and banged on his door. No shots were fired, they said, until one was heard inside the room. Dwight Lamon Jones had killed himself.

Police and Phoenix residents sighed in relief. Many had thought a serial killer had been on the loose. In fact, there had been, except his victims were far from random.

But then the blame game began. The courts failed her family, Connie said at a press conference. She insisted Dwight's visitation should be halted, even though the supervisors had told the court they should continue. She told reporters, "It seems to me that if someone is a danger to the child, why are we putting the rights of the parent over the safety of the child? That doesn't make any sense to

me. The court gave Dwight more chances than he deserved."

But Connie's attorney, targeted by Dwight, took a different approach. She said, "I think the blame, so to speak, lies with all of us and our representatives. I certainly understand where all my clients come from, including Connie here. I think under the circumstances however, I think the court system worked pretty well this time."

In an op-ed piece in *The Arizona Republic*, the Hon. Janet Burton, presiding judge of the Maricopa County Superior Court, wrote there was nothing the court could have done to prevent Jones's massacre.

Judge George Foster inherited the matter in 2013. After the killings, he said, "I could see there was tension between the husband and the wife, but it wasn't on my radar that eight years later he would kill six people."

William Brotherton, a former Superior Court judge noted the law makes it very hard for a court to permanently sever all parental ties with their children. He said even with a history of violence, a parent has a constitutional right to be in their children's lives. He told *The Arizona Republic*, "This has been litigated all the way to the United States Supreme Court. So, the standard for taking away someone's parenting time completely is quite high."

And Tom Leavell, a Phoenix matrimonial attorney, told a reporter, "Here's the thing about family law that makes it dangerous. It's that you're taking away people's kids, you're taking away their money and you're saying things about them that nobody else needs to know. ☞"

*(Sources for this column came from various news outlets in the Phoenix area. Because this tragedy was repeatedly covered by local and national media, all names are real. Part Two will discuss the risks to professionals engaged in family law.)*

## Campus

*continued from page 7*

boards withholding the name of the accuser from the accused, not disclosing what the exact allegations are, barring attorneys for the accused from being present or speaking during proceedings, and not allowing the accused to cross-examine the accuser or witnesses. As a result, numerous lawsuits have been filed by the accused to challenge the outcomes of the disciplinary process<sup>16,17</sup>.

The procedures for handling investigations are also not standardized across all institutions. Investigators may be student life administrators, attorneys, or professors with varying degrees of training in investigating sexual assault allegations. They often act alone in interviewing the accuser and accused, reviewing evidence, and interviewing witnesses before rendering a finding to the disciplinary board<sup>18</sup>. With investigators who are employed by the university, there is potential for a conflict of interest. The factfinders, or disciplinary boards, may be composed of student or faculty members who may similarly have varying degrees of training in handling sexual assault allegations. Involvement of trained law enforcement officials may result in more objective and equitable investigations, but this rarely occurs due to the small percentage of sexual assaults that are reported. While schools are required, by the Clery Act, to notify victims of their rights to file reports with police, there may be a disincentive to report to local law enforcement<sup>19</sup> as it may open the campus to public or media scrutiny and negatively affect enrollment and donations. Additionally, victims of sexual assault may opt not to involve law enforcement due to a desire for anonymity, fear that they will not be taken seriously or believed particularly if alcohol was involved, and/or wishes to avoid protracted legal proceedings<sup>20</sup>.

As a result, investigations that are conducted by campus boards may be incomplete or one-sided, resulting in evidence that favors one party over

the other. A publicized example of this involved two Amherst College students; in 2013, the accuser alleged that she was forced to engage in multiple non-consensual sexual acts with the accused a year earlier. Amherst College hired an attorney to conduct the investigation and the accused was subsequently found guilty of violating the school's sexual misconduct policy and expelled. Sometime later, the accused discovered the presence of potentially exculpatory evidence, namely multiple text messages sent by the accuser on the night of the alleged sexual assault that suggested she initiated the sexual encounter and was looking for a "lie" to cover up for it because the accused was also her roommate's boyfriend. The accused requested the school reopen his disciplinary proceedings in light of the new evidence, but they declined. He filed a suit in federal court citing "biased disciplinary process" and the two parties came to an undisclosed settlement<sup>21,22</sup>.

Forensic psychiatrists may have a role in the campus proceedings if they are asked to do a risk assessment or make treatment recommendations. Additionally, they can be helpful in interpreting medical records or information about alcohol-induced blackouts, psychological responses to trauma, etc., if allowed to participate by disciplinary boards. Forensic psychiatrists may be used as expert witnesses in criminal proceedings or any civil action that may be a result of the campus adjudicative process. In these proceedings, they may be asked to opine about the veracity of the accuser's statements, the risk of the accused committing a future sexual offense, the degree of psychological harm that has occurred because of the sexual assault, and treatment recommendations and prognosis<sup>23</sup>. However, with an inadequate campus investigation serving as a foundation for their work, forensic psychiatrists may find themselves unable to render a competent opinion. They may find it difficult to conduct their evaluations without an appropriate "paper trail" of evidence and testimony from the involved parties and any witnesses. To date, campus inves-

tigative policies make it difficult for forensic psychiatrists to effectively answer relevant forensic questions. However, with the large amount of national attention focused on the issue of campus sexual assaults and legislative changes to make the process of campus investigations approximate criminal proceedings, the role of forensic psychiatrists may become more relevant and meaningful. ☐

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## In Memoriam

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radar kind of guy: he lived in the open with all his ambition, striving, and strong opinions on the surface for everyone to see, like it or not. This is who he was. Each involved in our own practices, our lives got busy, lunches became less frequent, and we sometimes went several years without seeing each other. But I always thought of him during my tougher cases and my calls to him never went to his voice mail. I'd get Steve, busy always; but always available.

Steve is survived by two sons Asa and Beau, his partner Natalie, and his brother Darryl Pitt.

Steve's death gives us the opportunity to reflect on our sometimes potentially dangerous work. As I write this (with only information reported in the media) it is not clear whether Steve's killer had made previous threats or whether the attack on Steve came with no warning.

We know that healthcare workers are at an increased risk for workplace violence with a fourfold increased risk of serious workplace violence compared to private industry in general. Almost all of us have been threatened by patients and some of us have been assaulted.

However, homicides against physicians are very rare. At the Schizophrenia International Research Society (SIRS) 2018 Biennial Meeting Dr. Michael Knable presented a poster reviewing data from a systematic literature and internet search for accounts of homicides of US mental health workers between 1981 and 2014 and among US physicians between 1981 and 2017. Dr. Knable, included homicides committed by patients, the family members of patients, and coworkers, and excluded homicides that occurred in correctional settings or in agencies not focused on healthcare, as well as those unrelated to the physician's professional role. He found 31 cases of homicides of physicians. Of those,

39% of victims were psychiatrists, the most common speciality. All occurred in the context of treating patients.

My own literature search found no reports of homicides against non-treating forensic evaluators. I also contacted several senior members of AAPL who could not recall a single forensic psychiatrist killed in association with a forensic case, although all recalled being threatened by evaluators at various points in their careers.

I asked Park Dietz, an AAPL Past-President who specializes in threat assessment and violence risk reduction to provide suggestions to our members for staying safe. Park replied:

However much we might enjoy the aura of having a high-risk profession, forensic psychiatry is not a particularly high-risk endeavor, particularly when compared to law enforcement, working at any location that handles cash and is open at night, or even working in a bank or jewelry store. Professional decisions that can lower the risk even more are to avoid child custody cases, avoid high profile cases, and stay out of the press. One of the most useful lessons I was taught along the way, by my colleague Joel Dvoskin, is to treat everyone I evaluate respectfully, even sharing my opinions with them face-to-face rather than surprising them in a report or testimony. This gives them a chance to respond, to present other evidence, or even to argue their cause. I try to end exams with a handshake, with eye contact, and with good wishes.

To further decrease risk you should think about creating safe spaces at home and at work and having good action plans for home, work, and everywhere else. Except in high-security environments, you can't expect anyone else to protect you if a situation escalates toward an

attack, so your focus needs to be on techniques of de-escalation, where clinical skills are helpful, and a plan of action should that fail. Your strategies at that point are to flee or to fight, and it is up to you to decide what tools you're willing to use to protect your life in a fight. For the few forensic psychiatrists who elect to arm themselves, I'd urge a high level of training and proficiency, equivalent to that of a member of a police tactical team, bearing in mind that this investment of time is highly unlikely ever to become lifesaving, but can nonetheless better inform your analysis of any case in which shooting played a part. (f)

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## APA Assembly

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modules are categorized by core competency, core sub competency, and the type of credit (CME, ABPN Self-Assessment, AMA PRA Category 1 Physician, etc.). Many of these educational activities are offered no cost to members and all may be accessed at <https://www.psychiatry.org/psychiatrists/education/apa-learning-center>.

As APA members age, so do the costs of representing them and advocating for the profession. Historically, the Rule of 95, which waived APA membership fees for those whose age plus years of APA membership exceeds 95, has been a benefit available to senior psychiatrists. The Rule has created a problem for the long-term financial viability for APA District Branches that subsidize the membership fees of

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## Mature Minors

*continued from page 4*


ty to consent" standard in addition to a general "informed consent" standard.

States that utilize a separate "maturity to consent" standard generally consider variables such as age, level of education, life experience, separateness from parents, academic achievement, extracurricular experiences, work experience, disciplinary history, and the youth's report of future plans. In order to be considered "mature minors," youth generally must demonstrate maturity to consent by "clear and convincing evidence." Below are a few examples of different state statutes, which demonstrate the variability of states' approach to this issue<sup>4</sup>:

- AL (Al. Stat. Ann. 22-8-4): Minors aged  $\geq 14$  have authority to consent to any legally authorized medical, dental, health, or mental health services. No separate evaluation of maturity required.
- PA (35 Pa. Cons. Stat. Ann. 10101): "Minors" aged  $\geq 18$  and HS graduates have consent authority
- NV (Nev. Stat. Ann. 129 030): Minors not otherwise emancipated, who are capable of meeting informed consent standard, have consent authority, but only when a physician believes the youth is "in danger of suffering a serious health hazard if health care services not provided"
- OR (Or. Stat. Ann. 109.640): Minors aged  $\geq 15$  have consent authority; may not apply to refusal of treatment<sup>5</sup>

As can be seen by Oregon's statute and case law, legislators and courts generally require that a youth be "more mature" to refuse (as oppose to consent to) medical treatment, particularly that treatment which may be crucial or potentially life-saving. Although a strong deference is given to parental and/or youth preference, particularly when religiously-motivat-

ed (e.g., *In re E.G.* (1989)<sup>6</sup>), a youth's treatment refusal decision can be overridden by a judicial officer, particularly if the youth's decision-making capacity is suspect and/or the youth's treatment refusal decision seems based on less substantive factors (e.g., *In re Cassandra C.* (2015)).

After six months of chemotherapy, Cassandra Callender was in remission from her lymphoma. Unfortunately, it returned nine months later, and her prognosis at this point is unclear. Although her case has resolved, the "mature minor doctrine" continues to evolve and be employed in a variety of permutations across the US. Treating psychiatrists, and forensic psychiatrists who are called upon to evaluate youths' capacity to give informed consent and "maturity to consent," would be well-served to keep abreast of their jurisdiction's case law and statutes regarding this topic. As case law and statutes involving this doctrine continue to evolve, forensic psychiatrists as individuals and AAPL as an organization once again will have the requisite expertise to positively inform and shape policymakers' approach to this issue. 

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## Implicit

*continued from page 22*

IAT to assess specific litigant decision-making is potential test manipulation, specifically intentional slowing of response time. Suggesting such to be of significant concern, Fiedler and Bluemke<sup>(12)</sup>, and Steffens<sup>(13)</sup> found that without instruction, individuals were able to fake IAT responses, although in one of the studies<sup>(12)</sup>, participants were

informed of the centrality of reaction times, and significant faking effects depended upon prior test taking, i.e., test knowledge. Two "experts" could not detect faking in this study. Steffens similarly noted the difficulty of detecting faking, and wrote, "We think our findings show that caution is mandatory when regarding the IAT as a test that is not controllable by the individual performing it. Whereas it may be true that the IAT usually measures automatic behavior, test scores can be contaminated by intentional, controlled behavior."

In contrast, Schnabel, Banse, and Asendorpf<sup>(14)</sup> found that a shyness IAT could not be readily faked, and a study by Cvencek, et. al.<sup>(15)</sup> found that the use of an index of "combined task slowing" could detect faking with 75% accuracy among the 47 introductory psychology students who were instructed to deliberately slow their responses on gender identity IATs. The ecological utility of Cvencek et. al.'s measure is unknown.

Numerous factors most probably moderate the relationship between implicit attitudes and behavior, just as they influence how explicit attitudes affect behavior. Factors that likely varyingly shape employer or supervisor decision-making include, for example, accountability for production, incentives promoting effective team operation and "successful" results or outcomes, and individualizing information. The latter may importantly facilitate positive appraisal of a person who belongs to a group (or groups) which a decision-maker explicitly and/or implicitly generally negatively regards. Oswald, et. al.<sup>(7)</sup> suggest toward better determining the predictive validity of the IAT that a "productive approach to modeling the societal implications of IAT scores would be to move past abstract debates on the real-world meaning of meta-analytic estimates derived from laboratory studies to conducting large-scale, well-controlled longitudinal investigations that model IAT production of socially meaningful criteria in organi-

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## Royal College

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members will be made welcome.

“The Nottingham Conference – a student’s perspective”

Chris Cox, Medical Student, University of Glasgow Medical School

As a student not knowing anyone at the conference, I was a bit nervous that the content would go completely over my head and I would spend the time alone but I was happily proved wrong from the outset with a wide range of engaging speakers on topics from all across the field of psychiatry. The consultants were all very friendly and interested, striking up conversations with me whoever I was near and with several other students attending from across the UK. It was actually very fun.

Particularly interesting on the first day was a thought-provoking debate over whether the care of mentally disordered offenders should be shifting towards prisons and away from secure hospitals. This capped off a morning of interesting analysis of the management of mental health in the criminal justice system. Despite a landslide initially voting for secure hospitals, some well-made points saw a moderate shift towards prisons at the close.

The second day provided a fantastic opportunity for us, as students, to present our essays and projects in a small relaxed group and it was really interesting to hear the other presentations as well as get feedback on our own. There was also a lecture on the now hugely important problem that the gift of the internet and social media poses to child and adolescent mental health and the difficulty for psychiatrists in keeping up with the constantly changing trends of the tech-savvy younger generations.

The final day had a very topical and important session on migrant health and the psychiatric problems faced for asylum seekers and refugees coming to the UK. I hadn’t realised how integral a role forensic psychiatrists would play in their care and it

was great to hear about the opportunities this afforded to try and help this group. At the close, I left inspired with a new outlook on the opportunities for forensic psychiatrists, the many different areas within this very interesting career path and considering a trip to Vienna for next year’s conference! ☺

## Competency-based Training

*continued from page 8*

begin modifying the suite of training documents that frame forensic residency training in Canada. Given that forensic training is only 1 year, our task may have seemed somewhat simpler at the outset. However, we are finding out that the big questions (who we are, what we do, who we serve and where we practice) still make it difficult to choose what the essential competencies of our profession are and how to attain them in a 1-year residency. In Canada, a forensic psychiatrist’s primary role has traditionally been to conduct assessments of criminal responsibility and Competency (actually, we call it Fitness) to Stand Trial, and treat and manage violence risk of insanity acquittees (forensic rehabilitation). However, we also have a long history in Canada of being pioneers in assessment and management of problematic sexual behaviours and we have a burgeoning civil forensic arena. As in the U.S., Canadian psychiatrists have a long history of providing treatment in corrections. This is a hot topic politically and has found its way into the public discourse more and more as rates of segregation, suicides in jails and deficiencies of psychiatric care in corrections are reported on. Many Canadian forensic psychiatrists feel more and more that correctional psychiatrists should be forensic psychiatrists (like many in AAPL do), and this will likely be reflected in CBD.

We still have 2 more 3-day workshops to go, and all the residency programs have their own hard work ahead of them to transform their internal documents and programs to fit with our CBD deadline, most likely 2020.

As I hope you can see, this is an exciting time to be involved in forensic psychiatry education! ☺

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## SVP’s

*continued from page 18*

A final tip relates to linking the evaluatee’s mental condition to his risk of recidivism: if you want to do SVP evaluations, then you need to **know how to score, interpret, and discuss the results of sexual violence risk instruments**. Many states mandate the use of various sexual violence actuarial tools, such as the STATIC-99R and the ACUTE-2007. Understanding the utility and limitations of these instruments is a necessity for forensic evaluators who plan to provide opinions, write reports, or testify regarding SVP commitment. The STATIC-99R is a complicated tool with an even more complicated manual. Expect to see the entire manual on both the defense and prosecuting attorneys’ tables at trial. And, more importantly, expect to be asked questions with bits and pieces quoted from the manual (if on cross, potentially out of context). I strongly recommend obtaining specialized training in these instruments beyond what is taught in forensic psychiatry fellowship before conducting SVP evaluations.

Though challenging, SVP case-work can be intellectually stimulating and rewarding. Providing an opinion as to whether or not an individual meets the statutory definition of an SVP is a multi-step process involving careful psychiatric diagnosis, close scrutiny and understanding of an individual’s offending history, and the ability to conduct a risk assessment and link the risk estimate to an individual’s diagnosis. I hope that the tips offered in this article provide some guidance for those interested in pursuing this line of work for the first time. ☺

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MO Rev Stat § 632.480 (2017)

# Application of the Bourdain Questions to Forensic Mental Health (and maybe to life): A Reflection on the Passing of Anthony Bourdain

Sandy Simpson, MBChB, FRANZCP

Anthony Bourdain possessed a unique (in the current public discourse) ability to reach diverse peoples in a very particular manner. In his two TV series (*No Reservations*; *Parts Unknown*) he approached people worlds away from mainstream audiences as someone willing to learn and appreciating what they valued and offered. Through food. He brought to our screens many people who are misunderstood or rejected (“othered” to use that sociological term) commonly in the media: poor white people from the southern US states, Black Panthers and Muslim families from Beirut, Congo, Gaza and Libya. People often condemned or rejected in common media or discourse; people with whom “we” might not share a worldview. As he sat with them, talked with them and ate with them, the clutter of what divides us seemed to melt away. We learn about people and their commonality with us. Otherness falls away. People sharing food, with their families, with their kids.

When asked how he does it, he replied that in contradistinction to a journalist, he works in a different way:

"Journalists drop into a situation, ask a question, and people sort of tighten up... Whereas if you sit down with people and just say, 'Hey what makes you happy? What do you like to eat?' They'll tell you extraordinary things, many of which have nothing to do with food.... Is it not useful to see them with their kids, to see how their everyday lives are?"

Simple questions, then, asked with a quality of genuine interest:

- What makes you happy?
- What do you like to eat?

In forensic practice we are often, indeed usually, working across a space or distance from people, often othered in our society, and distant from us. Our patients suffer from mental disorders, they have offended or are charged with serious offenses, they have life experiences very different than ours, often of different ethnic or faith community, people with experiences of migrancy and victimization.

## Stigma

Stigma arising from mental illness and offending creates wider gulfs between us that make it hard for us to develop a shared understanding of the narrative of someone's life. Like Bourdain's archetypal journalist, we go in with our battery of questions. People stiffen up. Answer as they can and escape having shared only a certain sort of truth.

Our task is, of course, to try and understand the narrative of someone else's life. We have structured assessments, and must take collateral history to ensure consistency and reliability of forensic practice. But do we by using these approaches alone get near enough to people, to their values and what matters to them?

## Trends

Trends in risk assessment and management in recent years have tried to emphasize these themes: the addition of protective factors, shared decision making system, the recovery movement and its demands, the Good Lives Model of offender rehabilitation. Cross-cultural forensic psychiatry, though limited in its literature, must also grapple with this. In an attempt to help clinicians understand our patients better, the great cross-cultural psychiatrist Arthur Kleinman

asked us to ask a series of simple questions also:

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your problem does inside your body?
4. How severe is your problem? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your illness has caused you?
8. What do you fear most about your illness/treatment?

Note they don't ask about food, or directly what makes you happy, but they ask about the person's view of themselves and their situation in a manner that is broader than a traditional clinical approach. They helped lead to the Cultural Formulation Interview of DSM5. If we are to reflect on the observations of Tony Bourdain, perhaps we should attend to asking these questions very simply. And approach the interview as a process of genuine understanding. To borrow his words again, when we approach people with our long interview schedules do we approach them as journalists, or someone who wants to know what matters to the person, what they value, what makes them happy?

I have worked with cultures with whom after the greetings have occurred (the “who are you” piece) we must sit together and share a cup of tea and food, before we can start on the why are we meeting. Sharing a cup of tea, breaking bread. A metaphor for sharing universal values.

Tony Bourdain invites us to think about how we come together, how we acknowledge the “other” and how understanding can grow. Maybe we

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**Bourdain**

*continued from page 32*

should eat with our patients more often; or at least ask about what makes them happy. ④

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**Campus**

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**APA Assembly**

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Rule of 95 beneficiaries. Annual revenue from APA member dues is declining despite the organization having the largest number of members, 37,896, in the past 15 years.

The Rule of 95 places the cost burden of dues on younger psychiatrists. This may be a barrier to recruiting younger APA members, to whom the cost of APA dues may seem prohibitive, especially if the dues increase to cover lost dues revenue. The APA appointed a Rule of 95 task force that recommended sunseting the Rule and offering a

reduced-dues semiretirement category for psychiatrists who work fewer than 15 hours per week and a retirement category. The recommendation was supported by the APA Assembly. If approved by the APA Board of Trustees, the new policy would begin in two years, which will protect APA members who plan to benefit from the Rule of 95 in that timeframe. ④

**Avoiding Slippage**

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under the Dialectical Principlism model reflecting individuals’ unique set of personal morals and values, as well as differing beliefs in the societal expectations of physicians that also influence the weight applied to the conflicting principles in the balancing process. In these grey areas, the balance may be essentially even as to warrant probing on the part of the psychiatrist to delineate whether any role confusion exists that warrants a re-advisement.

To be clear, Dialectical Principlism does not prescribe one-size fits all solutions to ethics dilemmas that are by nature complex and complicated in their nuances from one situation to the next. Although the AAPL ethics guidelines do not advise forensic psychiatrists on what to do in cases of slippage when an evaluatee evidences confusion of the psychiatrist’s nature and purpose of the examination, our analysis using Dialectical Principlism would favor re-advisement when objective evidence exists for this role confusion or when subjective evidence reaches a threshold in which the psychiatrist believes it is more likely than not that the evaluatee is confused. We are not suggesting that forensic psychiatrists re-advise evaluatees on the limits of confidentiality and nature and purpose of evaluations in situations in which a person is revealing potentially damaging information but again only when this disclosure seems to be directly related to a misinterpretation of the role of the psychiatrist as a person who will help the evaluatee. ④

**#ScienceToo**

*continued from page 11*

cant and costly loss of talent, with at least some women leaving their chosen fields as a direct result of sexual harassment experiences. Environments in which sexual harassment occurs can limit the career opportunities for targets of sexual harassment and others exposed to such behavior. Therefore, the committee concluded, academic institutions should consider sexual harassment equally as important as research misconduct in terms of its effect on the integrity of research.

We also found the fields of science, engineering, and medicine share characteristics that create conditions that make harassment more likely to occur. The four most significant of these characteristics are:

1. Male dominated work settings
2. Hierarchies that concentrate power in individuals and make students, junior faculty, and others dependent on them for funding, research direction, mentorship, and career advancement;
3. Symbolic legal compliance policies and procedures that are ineffective at preventing harassment; and
4. Uninformed leadership lacking the tools, will, and/or focus to take key actions necessary to reduce and prevent sexual harassment.

The committee recommended the institution of a broad range of policy interventions, moving beyond legal compliance, to address culture and climate going to bring about the changes necessary to address and prevent all forms of sexual harassment. The primary goal of legal compliance is to decrease liability, an approach that is not effective. We recommended the institution of specific, evidence-based policies and approaches to reduce and prevent sexual harassment by changing academic and workplace cultures and climates, including:

1. Addressing gender harassment, the most common form of sexual harassment

2. Creating diverse, inclusive, and respectful environments
3. Improving transparency and accountability
4. Diffusing the hierarchical and dependent relationship between trainees and faculty
5. Providing support for targets of harassment
6. Striving for strong and diverse leadership.
7. Conducting needed research, including measuring progress; and
8. Encouraging involvement of professional societies and other science, engineering and medical organizations.

We concluded that to reduce and prevent sexual harassment in academic sciences, our institutions and training centers must move beyond legal compliance and change our social and institutional cultures. As one forensic expert stated, “One of the lessons from the #MeToo movement is the almost universal presence of harassment in women’s work experience” (2). Changing climate and culture will require leadership from both men and women committed to effecting the changes in their academic institutions and in society recommended in our report to help us protect the next generations of women entering science, engineering, and medicine. (P)

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*Diagram reprinted with permission by National Academics of Science, Engineering, and Medicine from the report Sexual Harassment of Women, Climate, Culture and Consequences.*

**Criminal Behavior**

*continued from page 26*

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**MUSE & VIEWS**


"America believes in education: the average professor earns more money in a year than a professional athlete earns in a whole week. "

**- Evan Esar (1899 - 1995)**

*Submitted by  
William Newman MD*

**Implicit**

*continued from page 30*

zations, schools, hospitals, and other contexts in which implicit bias is of direct concern” (page 569). Such studies await. 

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**Expanding**

*continued from page 19*

offense at 14 or 15 years of age. By increasing the number of minors retained under the jurisdiction of the juvenile court, this bill would impose a state-mandated local program.

- CA SB 1276
  - o Would hold that in civil proceedings, evidence of a statement used to support the opinion of an expert is not inadmissible as hearsay unless the court determines that the statement is reliable and would require the court to consider certain factors in making its determination. The bill would also authorize, in civil proceedings, that a witness, before testifying in the form of an opinion, be examined with regard to the factors considered by the court to determine the reliability of a statement.
- HR 3356 (Federal)
  - o Directs the Department of Justice to develop the Post-Sentencing Risk and Needs Assessment System for use by the Bureau of Prisons to assess prisoner recidivism risk; guide housing, grouping, and program assignments; and incentivize and reward participation in and completion of recidivism reduction programs and productive activities.

The committee is off to a promising start and we look forward to its continued development. Any interested AAPL member should feel free to reach out to Doctors Thompson or


Wasser to express their interest in joining!

**Reference**

1. www.thecfso.org. Accessed 15 June, 2018.

**An Early Start**

*continued from page 20*

After I completed my four-month rotation at the Sacramento County Youth Detention Facility (YDF) as a first-year child and adolescent psychiatry fellow, I wished I could have extended my experience. I had group therapy time built into my schedule, but no existing group experience seemed satisfactory to my interests in juvenile forensic psychiatry. I decided to start my own therapy group at YDF. I coordinated my personal interests of psychodynamic psychotherapy and juvenile forensic psychiatry with the needs of the probation staff working at YDF. We decided a process group with a select group of long-term residents, known as “mentors,” would be the perfect combination. These young men have been detained at YDF anywhere from six months to two years, awaiting adjudication for serious, often violent, charges. They were selected by probation staff to go through the mentor program due to their natural leadership skills, known responsibility and honor status on their units. Mentors are expected to help probation staff with residents who are having difficulties on their units and guide other residents during their stay at YDF. Group therapy provides an opportunity to enhance support for mentors who are balancing their new responsibilities with their own legal challenges and possible incarcerations. The group began the first week of January and has been approved to continue through early 2019. Thus far, the group has been very well received by the mentors and the probation staff. I am very excited about this opportunity to work with these young men in a long-term therapy group and learn more about their experiences within the juvenile justice system. 



AUGUSTA UNIVERSITY  
**MEDICAL COLLEGE  
 OF GEORGIA**

The Department of Psychiatry and Health Behavior at the Medical College of Georgia at Augusta University (AU) seeks a BC/BE forensic psychiatrist to serve as the Director of our Forensic Psychiatry Fellowship Program. The position will manage forensic psychiatric medical care as well as direct the Forensic Fellowship Program at East Central Regional Hospital (ECRH)-Augusta, an AU teaching facility with a 90-bed psychiatric facility, 71 forensic beds and a developmental disabilities facility caring for 200 individuals. A highly competitive salary and a benefits package that surpasses all expectations are offered.

The Medical College of Georgia Practice Plan is able to sponsor Conrad 30 J1 Visa waivers for foreign medical graduates wishing to stay and practice in the US and obtain a medical school faculty appointment after completing their training. The Georgia Conrad State 30 J-1 Visa Waiver Program (GA 30) affords international medical graduates (IMGs) on J-1 visas the opportunity to waive their two-year home-country physical presence requirement in exchange for three years of medical service to patients in or from medically underserved areas.

**Job Qualifications:** Eligibility to obtain unrestricted Georgia medical license, board certification as a forensic psychiatrist. Preferred qualifications: experience treating persons with serious and persistent mental illnesses, providing care as a leader and member of an interdisciplinary treatment team, experience teaching in or directing a forensic psychiatry fellowship program

Contact W Vaughn McCall, MD, MS, Chair, Department of Psychiatry, The Medical College of Georgia, Augusta Georgia [wmccall@augusta.edu](mailto:wmccall@augusta.edu) 706-721-6719



Oregon Health & Science University (OHSU) has an outstanding opportunity for a BC/BE forensic psychiatrist for clinical work at Oregon State Hospital. We offer a unique 80/20 schedule which, upon approval, allows faculty one day per week to pursue academic projects. Opportunities include competency and insanity evaluations, court testimony, medical student and resident supervision, and patient care.

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We sincerely invite your interest in this very unique and rewarding opportunity.

If you would like more information, please contact Maya Lopez, M.D. We look forward to hearing from you.

Maya Lopez, M.D., Administrative Chief, Oregon State Hospital  
[lopezst@ohsu.edu](mailto:lopezst@ohsu.edu)

# PSYCHIATRIST

## Forensic Psychiatrists \* State of New Jersey

The Special Treatment Unit, a 500 bed secured forensic facility located in Avenel, NJ is currently seeking forensically experienced psychiatrists to conduct detailed forensic evaluations and provide expert witness testimony. Our inpatient units are designed to treat adult males who have been civilly committed under the NJ Sexually Violent Predator's Act. As part of the full-time position, psychiatrists also carry a small treatment caseload providing routine psychiatric care.

The full-time position offers a flexible 35-hour work week, ongoing forensic experience and training, autonomy and the ability to interact with experienced colleagues. The State of New Jersey additionally offers excellent medical, dental, and retirement benefits, and the opportunity for CME leave time. Annual salary range is from \$199,652.59 (Board Eligible), \$211,713.80 (Board Certified) to \$227,684.03 (3 years Post Board Certification).

**Requirements:**

- Possession of an unrestricted license to practice medicine in the State of New Jersey.
- Board Eligible/Certification in psychiatry from the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
- Either experience or fellowship training in forensic psychiatry
- Proficiency in using electronic medical records, Word documents, email and other forms of routine electronic communication and documentation
- Willingness to learn and a desire to achieve an expert level of knowledge in the field of criminal sexual disorders
- Applicants do not have to reside in NJ

*For more information, please contact:*

**Dean DeCrisce, MD · Acting Director of Psychiatry · Special Treatment Unit  
 15 Paddock St Avenel, NJ 07001**

**Dean.DeCrisce@doh.nj.gov · Office number: 732-499-5041**

EOE


**AAPL COMMITTEES**

AAPL members who are interested in serving on committees for a three-year term are invited to send a letter to the President, Richard Frierson, MD through the Executive Office by November 9, 2018. Committee members must be full voting members of AAPL.

Letters should indicate particular interests or qualifications for the committee appointment desired.

- ADDICTION
- AWARDS
- BYLAWS
- CHILD & ADOLESCENT
- COMMUNITY FORENSICS
- CORRECTIONAL PSYCHIATRY
- CRIMINAL BEHAVIOR
- CROSS-CULTURAL
- DEVELOPMENTAL DISABILITY
- DIVERSITY
- EARLY CAREER
- EDUCATION
- ETHICS
- FORENSIC HOSPITAL SERVICES

(continued on page 38)



## Attending Public Psychiatrists

### Zuckerberg San Francisco General Hospital & Trauma Center

The Department of Psychiatry at the University of California, San Francisco invites applications for **Faculty Forensic Attending Psychiatrists at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) and the San Francisco County Jail.**

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Find out more and apply at  
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UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. The University of California is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, age or protected veteran status.

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**AAPL COMMITTEES**  
*continued from page 37*

- FORENSIC  
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- FORENSIC TRAINING
- GENDER ISSUES
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For more information please contact **Melinda Carey, HR Specialist, at:**  
**315-765-3360** or **Melinda.Carey@omh.ny.gov.**

The **Annual Business Meeting** of the American Academy of Psychiatry and The Law will take place on Friday, October 26 at 8:00 a.m. Mountain time in Austin, Texas.

The agenda will consist of reports and election of officers and councilor. The slate as approved at the Semiannual Business Meeting is as follows:

- President-elect:**  
William Newman, MD
- Vice President:**  
Richard P. Martinez, MD
- Vice President:**  
James Knoll, MD
- Secretary:**  
Michael Champion, MD
- Councilors:**  
Renée Sorrentino, MD  
Joseph Penn, MD  
Patricia Westmoreland, MD

**Forensic Psychiatry  
Review Course  
October 22-24, 2018**

**AAPL Annual  
Meeting  
October 25-28, 2018  
JW Marriott  
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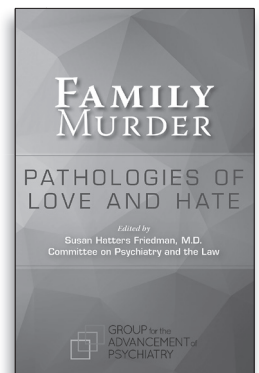
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