



Guttmacher Award

A Model for Assessment of Psychiatry Disability

Susan Hatters Friedman MD



Drs. Liza Gold (left) and Cheryl Wills. Dr. Wills presented the Award on behalf of the Guttmacher Award Committee.

Dr. Liza Gold's Guttmacher Award Lecture at the 2011 Hawaii APA meeting was based on her book, authored with Daniel Shuman, JD, entitled *Evaluating Mental Health and Disability* (2009). Gold, a clinical professor of psychiatry at Georgetown School of Medicine, was also awarded the Guttmacher Award in 2006. Sadly, Professor Shuman passed away weeks before the APA meeting after fighting a lengthy illness. He too was a former recipient, in 1988, of the Guttmacher Award. Dr. Gold described that though the current book was published in 2009, it was the product of work dating from 2003. Dr. Manfred S. Guttmacher, after whom the award was named, was a prodigious writer in the law and psychiatry.

Dr. Gold's lecture was based on

the book, and described a model for assessing psychiatric disability claims. Clinical and forensic psychiatrists alike often find their training lacking in performing disability evaluations. She suggested that utilizing her model and case formulations helps offer reasoned opinions. Dr. Gold began by describing differences between models utilized by Social Security (based on the medical model) and Americans with Disability Act evaluations. ADA evaluations are based on the social model, which considers work requirements and individual impairments. Social Security utilizes an all-or-none medical model and requires total and permanent impairment in order to qualify for benefits. Once going on SSDI, most stay on it for life.

Various questions referral sources

ask include not only diagnosis, symptoms, causation, and treatment, but also those with which we may have less familiarity and comfort – disability, motivation, prognosis, limitations, and maximal medical improvement. Dr. Gold repeatedly stressed that impairment does not necessarily equal disability. While impairment is describable and related to a health condition, disability is a legal term of art which is defined differently depending on the specific context.

It is important to consider the impairment separate from the diagnosis—and its relationship to a specific set of work skills in this case. To understand this relationship between the symptoms and the impairment, a case formulation can be helpful. Interestingly, Dr. Gold discussed the process by which individuals begin to consider themselves disabled as central to the evaluation. The evaluatee's internal world (psychiatric issues and belief) as well as their external world (job demands, and social/ cultural/ family and health issues) should be considered.

Typically the severity of symptoms is correlated with the degree of impairment. Similarly, the claim of disability is correlated with the value of work to the person. Work can be positive because of income, identity, self-esteem, and social contacts. Yet, on the negative side, internal conflicts may occur over competing responsibilities, and burnout, interpersonal conflict and occupational stress may occur.

Therefore, Gold's and Shuman's model encompasses a spectrum, balanced on the individual's work supply and work demand. Work demand includes the physical, cognitive, affective, and social requirements for the job, whereas work supply includes the person's ability, skill set,

(continued on page 26)



American Academy of Psychiatry and the Law

Editor

Charles Dike, MD, MPH, MRCPsych

Associate Editors

Philip Candilis, MD
Steven H. Berger, MD
Susan Hatters Friedman, MD
Neil S. Kaye, MD
Stephen Zerby, MD

Former Editors

Victoria Harris, MD, MPH (2003-2008)
Michael A. Norko, MD (1996-2003)
Robert Miller, MD PhD (1994-1996)
Alan R. Felthous, MD (1988-1993)
Robert M. Wettstein, MD (1983-1988)
Phillip J. Resnick, MD (1979-1983)
Loren H. Roth, MD, MPH (1976-1979)

Officers

President

Peter Ash, MD

President-elect

Charles Scott, MD

Vice President

Debra Pinals, MD

Vice President

Robert Weinstock, MD

Secretary

Michael A. Norko, MD

Treasurer

Marilyn Price, MD

Immediate Past President

Stephen B. Billick, MD

The AAPL Newsletter is published by AAPL, One Regency Drive, PO Box 30, Bloomfield, CT 06002. Opinions expressed in bylined articles and columns in the Newsletter are solely those of the authors and do not necessarily represent the official position of AAPL or Newsletter editors.

Manuscripts are invited for publication in the Newsletter. They should be submitted to the editor via email to charles.dike@yale.edu.

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

www.aapl.org

© 2011 AAPL. ALL RIGHTS RESERVED.

AMA ANNUAL MEETING

American Medical Association 2011 Annual Meeting Highlights

Robert T.M. Philips MD PhD, Delegate; Barry Wall MD, Alternate Delegate; Katya Frisher MD, and Ryan Hall MD, Young Physician Delegates; Howard Zonana MD, Medical Director

The House of Delegates elected four psychiatrists to AMA leadership positions at its annual meeting in Chicago, Illinois in June. Jeremy Lazarus, MD, former APA speaker of the Assembly and current speaker of the AMA House of Delegates, was elected president-elect by acclamation. He will be the second psychiatrist to become AMA President, the first being Rock Sleyster MD from Wisconsin in 1939. Patrice Harris MD, an APA delegate and Chair of the Council on Legislation was elected to the AMA Board of Trustees. John "Jack" McIntyre MD was re-elected to another four-year term to the Council on Medical Services. APA member Stuart Gitlow MD was re-elected for a second four-year term to the Council on Science and Public Health.

At this policymaking meeting, intense debate about some elements of the Patient Protection and Affordable Care Act (PPACA) mirrored political debate in the country. In the end, the House of Delegates reaffirmed policy calling for "individual responsibility" to have health insurance, an element of the Patient Protection and Affordable Care Act (PPACA). The policy specifies that families with an income over 500% of the federal poverty level must buy medical insurance containing preventive and catastrophic coverage. By doing so, the House of Delegates rejected a policy change that would have supported states' abilities to set their own policies, including the ability for states to opt out of the federal mandate. AMA had "individual responsibility" policy before the 2010 passage of PPACA. Despite such intense debate, there was more cohesion over addressing other elements of health system reform, including: finding a permanent solution for the Sustainable Growth Rate (SGR) formula, which determines physicians' Medicare payments; repeal of the Medicare cost-cutting Independent Payment Advisory Board, and, permission for full private contracting with

Medicare patients.

Other meeting highlights include the following:

Financial Relationships with Industry in Continuing Medical Education: The House approved new ethical guidelines for financial relationships with industry in continuing medical education. AMA's Council on Ethical and Judicial Affairs wrote this report, which urges transparency by CME providers on financial ties

"...the House of Delegates reaffirmed policy calling for "individual responsibility" to have health insurance, an element of the Patient Protection and Affordable Care Act (PPACA)."

that might influence educational activities.

Physician-Assisted Regulation of Firearm Access by Suicidal Patients: The House of Delegates adopted a report examining the regulation of firearm access by mentally ill patients, the role of physicians in regulating that access, effectiveness of statutory restrictions on firearm access, patient privacy, physician liability and increasing the physician's role in minimizing the potential harm by firearms to patients.

"Government Interference in Patient Counseling"/ Talking to Patients About Firearms: AMA delegates voted to oppose all government efforts to interfere in the content of communication when clinicians treat patients. AMA took this action in response to a new Florida law that

(continued on page 20)

Medication (Mis)-Management

Charles C. Dike MD, MPH, MRCPsych



I would not have believed it if I had not seen it with my own two eyes: the 30-day supply of one psychotropic medication was

billed as \$370, while a 90-day supply of the same exact medication was \$65! I know - fuzzy math, right? Has your jaw dropped in surprise as mine did? I remember saying, "Wow!" a few times before catching myself. If the patient had not brought in the bill from the pharmacy and shown me, I would not have believed him. Before then, I had concluded he was telling me stories in order to manipulate his way into coming for follow up visits every 3 months instead of every month.

The issue? When I wrote a 30-day prescription of a psychotropic medication for my new patient, he insisted I write a 90 day script instead, for insurance reasons. After much discussion, I reluctantly agreed, convincing myself that he was not suicidal anyway, and in addition, since I was starting him on a low dose, perhaps it did not matter as much. One week later, the patient called to say he had stopped the medication due to side effects (legitimate) and asked for an alternative prescription. When he again insisted on a 90-day prescription, I balked; who is to say he would not have other side effects to the new medication that would cause him to stop it prematurely, thereby leading to unnecessary stockpiling of medications? I did not believe him when he said his insurance company would only subsidize the 90-day prescription, after all I was familiar with other situations where insurance companies allowed two consecutive 30-day medication trials to establish efficacy before insisting on 90-day prescription. Who was he kidding? How shocked I was (and how stupid I felt/looked for arguing with him)

when he came in with the bills (from a reputable pharmacy no less!); his insurance company approved 90-day mail order prescriptions only! Despite my better judgment, I was 'forced' to prescribe a 90-day supply, all the while wondering if I had done the right thing. I mean, what if he had not been truthful about not having thoughts, plans or intentions of committing suicide? What if I needed to change the dose in 3 weeks, would he need another 90 day prescription?

After the phone call, I wondered how I would have responded had the patient had a slightly elevated risk of committing suicide. Would I have insisted on a 30-day supply (or better still, a 7-day supply without refills) knowing full well he could not afford it? Would I have been comfortable prescribing 90-day supplies of more than one medication had he needed a combination of medications? What about giving a 90-day supply of a medication such as a benzodiazepine to a patient relatively unknown to you? Another new patient had informed me earlier, much to my surprise and disbelief, that her insurance company approved a 90-day supply of high doses of stimulant medications used to treat her ADHD, and showed me her bottle to prove it. Are discussions such as these going on with residents getting ready to jump into real world psychiatry?

Retail pharmacy is a multi-billion dollar industry driven by intense competition between community pharmacies and mail order pharmacies. While there are pros and cons for using either pharmacy, the autonomy of each individual patient to decide which would work better for him or her has been taken over by insurance companies whose primary objective is financial gain. Insurance companies now determine what pharmacies a patient should patronize often without due regard to what is in the best interest of the patient. The rapid growth and prominence of mail order services in the past 10 years is

not necessarily because it is more convenient to the patient than community pharmacies but rather because they are relatively cheaper when medications are ordered 3 months at a time. There are studies that suggest mail order medications exposed to extreme temperatures could lose efficacy. A US Postal Service study in the late 1990s showed that sixty-five percent of the packages left in the mail box were exposed to temperatures between 84 and 104 degrees.

Back to my dilemma. How liable are psychiatrists when their patients, mandated by the insurance companies to obtain only 90-day prescriptions of medications, commit suicide via overdose when one of the primary incriminating factors is access to excessive amounts of medications? No matter how I looked at the issue, a mandatory 90-day prescription for new patients puts both the psychiatrist and patient in a bind. For patients with some risk of committing suicide, the psychiatrist may not have a choice but to prescribe small quantities of medications at a time, which may then be too expensive for the patient thereby encouraging non-adherence with consequent worsening of symptoms. The patient is caught between the rock and the sea. Once again, the patient is the pawn in a seemingly uncaring system. With such risks, it seems 90-day prescriptions for patients not yet stable on their medications could be a case of penny wise, pound foolish. ☹

MUSE & VIEWS

When a pun earns death by a gun!

A pun does not commonly justify a blow in return. But if a blow were given for such cause, and death ensued, the jury would be judges both of the facts and of the pun, and might, if the latter were of an aggravated character, return a verdict of justifiable homicide.

Oliver Wendell Holmes

Submitted by Phillip Resnick

A Year of Moving Forward

Peter Ash MD, President



It has been an honor and privilege being President of AAPL these past months. While I have known for years that

AAPL members and staff are a wonderful group of people, my feeling has only been strengthened through my enjoyment of working more closely with many of you. Jackie Coleman, the AAPL office staff, and our Medical Director, Howard Zonana MD, do an outstanding job keeping the organization humming along. A great deal has been accomplished in the past year, and special thanks go to Jackie Coleman and the Education Committee for their many hours of work leading to AAPL's successful passing of the ACCME accreditation review. While there is much more going on in AAPL than I have space to write about, as we approach the Annual Meeting, I do want to share my views of how AAPL is moving ahead on a number of initiatives that will affect us all.

Maintenance of Certification (MOC) continues to be only partially charted territory, and AAPL is committed to helping members navigate this new terrain. The self-assessment test that we gave last year at the Tucson meeting was an excellent first step in helping AAPL members meet the MOC requirements. That test will be given again at the Annual Meeting in Boston for those members who did not have an opportunity to take it in Tucson. The test was also made available to the directors of forensic training programs to administer to their graduating fellows to assist both the fellows and the training programs in assessing how they are doing. The MOC Task Force is coordinating efforts to constantly improve and revise the test. Good tests need their questions continually updated. The Association of Directors of Forensic

Psychiatry Fellowships (ADFPF) and the Education Committee have asked each of their members to contribute questions to the question pool. Many AAPL committees focus on a topic area that the test covers, and I have asked those committees to contribute questions as well.

I have long thought that the field of forensic psychiatry needs more research. Robert Trestman MD, and the Research Committee have been working on ways of facilitating collaborative research between members of AAPL and members of the Ameri-

“the Journal data will be stored on multiple continents and reposted in the unlikely event of a disaster befalling the publisher or the server farms in California.”

can Psychology-Law Society. They are surveying members and developing a list of researchers interested in collaboration. If you are interested in collaborative research, be sure to let them know. The AAPL Institute for Education and Research is working on developing policies about how to help fund such collaborative research.

As we all know, AAPL's practice guidelines have been very well received by AAPL members, lawyers, and the general public. Graham Glancy MB, is heading a Task Force that is writing a new practice guideline on forensic assessments, and that group is progressing well. We have also begun a process of reviewing older practice guidelines. In order for a health practice guideline to be acceptable to the National Guideline Clearinghouse (an agency of the U.S.

Dept. of Health and Human Services), a guideline must be reviewed and updated every 5 years. While guidelines in forensic psychiatry may go out of date less quickly than those in some other fields, I think a periodic review process is a good idea, and have appointed task forces to review our two oldest guidelines. Richard Frierson, MD, is chairing the review of the videotaping guideline, and Jeffrey Janofsky, MD, is chairing the review of the insanity defense guideline. Next year it will be time to review the 2007 guideline on competency to stand trial.

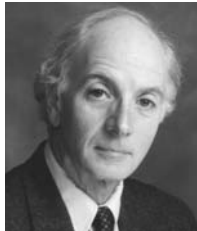
I remember back in 1995, when I was coding the first AAPL website pages, programming the web template for posting abstracts of articles from the *AAPL Journal* and dreaming of the day the full text of the entire *Journal* would be on the web, available to everyone. Now, 16 years later, thanks to Neil Kaye MD's generosity in donating his back issues and the technical expertise of our website editor Mark Hauser MD, that day is coming soon, and may even have arrived by the time you read this article. And, just to make sure all that knowledge stays available, we have reached an arrangement with an information insurer that the *Journal* data will be stored on multiple continents and reposted in the unlikely event of a disaster befalling the publisher or the server farms in California. The *AAPL Journal* will be there for the ages!

I always look forward to AAPL meetings and the chance to learn and interact with colleagues. Charles Scott MD, Christopher Thompson MD, and the Program Committee have assembled a terrific smorgasbord of intellectual delicacies for the Annual Meeting in Boston. In addition to a packed schedule of papers, posters, panels, and workshops, we will have a debate, a mock trial, and four courses: on risk assessment, depositions, sex offenders, and child murder by parents. For years, I have always gone to the lunches to talk with colleagues and hear the lunch

(continued on page 24)

Expert Witness Testimony in Medical Malpractice Cases in Florida - New Legislation

Howard Zonana MD, Medical Director



For at least 15 years the Florida Medical Association has expressed major concerns about the quality of testimony in medical malprac-

tice cases within Florida, and has proposed many resolutions in the AMA House of Delegates to have the AMA track all such testimony nationally as well as to make these databases easily available. They also wanted to insure that state medical licensing boards could discipline those physicians who lied or gave fraudulent testimony. They proposed and set up panels to “peer review” such testimony in Florida. The AMA Board of Trustees, in a report responding to one of the proposed resolutions, pointed out some of the difficulties in conducting such reviews.¹ Some resolutions were passed, such as affirming that the provision of expert testimony was, in fact, the practice of medicine.

Many of these proposed resolutions never made any distinction between expert witness testimony in malpractice cases and expert testimony in the myriad of other legal questions that arise for medical experts, e.g. criminal responsibility, competency to stand trial, presentence evaluations, disability evaluations, psychic harm or damages in accidental injuries etc. AAPL’s delegates to the AMA were active in floor discussions to point out that not all expert testimony was related to malpractice.

One of the consequences of expert testimony being formally deemed the practice of medicine was that it opens up the question as to whether a state license was necessary when experts testified in states other than ones in which they hold an active license. State licensing boards had to now

consider whether a full license was required when experts came from out of state to testify. Unsurprisingly, the responses varied from state to state. Physicians often got different answers from the same state, depending on the person they were talking to. Attempts to develop uniform rules were unsuccessful.

On June 27, 2011 Florida Governor Rick Scott signed House Bill 479. The Act authorizes the Department of Health to issue a certificate enabling physicians licensed in another state (or Canada) to provide expert testimony in a medical malpractice case in Florida. In order to obtain the certificate, a physician must submit an application containing the physician’s legal name, mailing address, tele-

“...bad testimony gives a bad name to the profession, harms practitioners, and raises medical costs.”

phone number, business locations, names of jurisdictions where an active license is held, and the license number. An application fee of \$50 is required. Once the application and fee are submitted, the Department has 10 business days to approve the application and issue the certificate, which is valid for 2 years. If the Department does not act within the 10 days the certificate is deemed approved by default. The certificate is valid only for the evaluation and testimony in the case and not for the full practice of medicine in Florida. The certificate seems to be required for only medical malpractice cases as written but may be open to other interpretations by the

licensure board.

This limited “license” opens the door for disciplinary action by the Medical or Osteopathic licensing board. Grounds for denial of a license or disciplinary action are: “Providing deceptive or fraudulent expert witness testimony related to the practice of medicine.”

Is this a good idea? As with many proposals, the devil will be in the details. Procedurally, it appears quite streamlined and user friendly: an application, a \$50 fee, and a 10-day response time with an automatic limited license if the Department does not respond within the ten days. The rationale is that while the admissibility and credibility of expert witness testimony is a judicial function, maintaining the integrity and quality of the profession and physicians, including those providing expert witness testimony, is within the purview of licensing boards and organized medicine.

Some forensic physicians have argued that since there is no physician-patient relationship in forensic work it is not the practice of medicine. The AMA has adopted a position that it is² and, in my view, the practice of medicine is broader than just direct patient care and includes research, training, and forensic work. In addition most forensic practitioners carry “malpractice” insurance, which they expect to provide coverage for their forensic activities.

There are many problems associated with doing an adequate review of testimony to determine whether it is fraudulent or misleading. First, who will be the “peers” to review the testimony? Clearly, they should be in the same specialty and have experience in the area in question. Second, will the necessary documents be available, e.g. medical records, trial transcripts, exhibits, tapes of the testimony, etc.? Who will pay to obtain them and under what auspices, the state medical society or the licensing board? What happens if there are no transcripts?

Some issues may be easy to review e.g. misrepresentation of credentials,

(continued on page 20)

Miranda for Minors: *J.D.B. v. North Carolina* (564 U.S. ___ (2011))

Stephen P. Herman MD



This year marks the 45th anniversary of *Miranda v. Arizona*. Former Chief Justice William H. Rehnquist said Miranda warnings

“have become part of our national culture.” On June 16, 2011, Justice Sotomayor wrote the majority (5 to 4) opinion with Justices Kagan, Kennedy, Ginsburg, and Breyer concurring, stating that under *Miranda*, children *are* different from adults and might feel coercive pressure about being “in custody,” when an adult may not.

Facts:

Police stopped and questioned petitioner J.D.B., a 13-year-old, seventh grade student, after seeing him near the site of two home break-ins. Five days later a digital camera - one of the stolen items - was found at J.D.B.’s school and in his possession. Police Investigator DiCostanzo went to the school and a uniformed police officer regularly assigned to the school took the boy from his classroom to a closed-door conference room. There, they questioned him for a half hour. Before the questioning began, the police did not give J.D.B. a *Miranda* warning. They did not give him the chance to call his grandmother, his legal guardian, nor did the investigators tell the boy he was free to leave the room at any time.

The child finally confessed after the officials told him to tell the truth and then described the alternative: juvenile detention. After that, DiCostanzo informed J.D.B. he was free to leave the room. The child was asked if he understood, nodded his head, and then provided more information about the location of the stolen items. At DiCostanzo’s request, the boy wrote a statement

and then was permitted to take the school bus home.

J.D.B. was charged with breaking and entering and with larceny. His public defender moved to suppress his admissions, arguing the child had been in custody without being given a *Miranda* warning and had made involuntary statements.

The trial court denied the argument and adjudicated J.D.B. delinquent. The North Carolina Court of Appeals and the State Supreme Court affirmed. The latter court decided the child’s age irrelevant for determining whether he was “in custody.”

U.S. Supreme Court Findings:

Justice Sotomayor delivered the opinion of the Court. She wrote, “It is beyond dispute that children will often feel bound to submit to police questioning when an adult in the same circumstances would feel free to leave. Seeing no reasons for the police officers or courts to blind themselves to that commonsense reality, we hold that a child’s age properly informs the *Miranda* custody analysis.”

The Majority noted that the assistant principal had told J.D.B. to “do the right thing . . . [and] the truth always comes out in the end.” Investigator DiCostanzo told the boy he could face juvenile detention if he refused to make a complete confession.

The Justice reviewed the U.S. Supreme Court finding that *Miranda* protects a subject against self-incrimination. Under *Miranda*, as is well known by most Americans, the suspect “must be warned that he has the right to remain silent, that any statement he does make may be used as evidence against him, and that he has the right to the presence of an attorney either retained or appointed.” 384 U.S. 436 (1966)

Justice Sotomayor cited *Thompson v. Keohane*, 516 U.S. 99, 112 (1995)

when she wrote, whether a suspect is “in custody” is an objective inquiry, to wit: ‘first, what were the circumstances surrounding the interrogation; and second, given the circumstances, would a reasonable person have felt he or she was at liberty to terminate the interrogation and leave.’”

The Majority did not agree with the State of North Carolina that “a child’s age has no place in the custody analysis, no matter how young the child subjected to police questioning . . . a reasonable child subjected to police questioning will sometimes feel pressured to submit when a reasonable adult would feel free to go.”

Sotomayor continued, “A child’s age is far more than a chronological fact . . . and [this Court] has observed that children generally are less mature and responsible than adults.” *Eddings v. Oklahoma* 455 U.S. 104, 115 (1982) She wrote, “. . . describing no one child in particular, these observations restate what ‘any parent knows’ - indeed, what any person knows - about children generally.” *Roper v. Simmons* 543 U.S. 551 (2005)

“Like this Court’s own generalizations, the legal disqualifications of children - e.g. limitations on their ability to alienate property, enter a binding contract enforceable against them, and marry without parental consent - exhibit the settled understanding that the differentiating characteristics of youth are universal . . . the common law has reflected the reality that children are not adults,” she wrote.

Continuing, the Opinion stated, “In other words, a child’s age differs from other personal characteristics that, even when known to police, have no objectively discernible relationship to a reasonable person’s understanding of his freedom of action. . . [Courts cannot] reasonably evaluate the effect of objective circumstances that, by their nature, are specific to children without accounting for the age of the child . . . ‘ignoring a juvenile defendant’s age will often make the inquiry more arti-

(continued on page 7)

Miranda for Minors

continued from page 6

ficial . . . Just as police officers are competent to account for other objective circumstances that are a matter of degree such as the length of questioning or the number of officers present, so too are they competent to evaluate the effect of relative age . . .”

Getting to the heart of the matter, the Justice wrote, “To hold, as the State [of North Carolina] requests, that a child’s age is never relevant to whether a suspect has been taken into custody - and thus to ignore the very real differences between children and adults - would be to deny children the full scope of the procedural safeguards that *Miranda* guarantees to adults.”

The Majority remanded for North Carolina to address whether or not J.D.B. was in custody when interrogated by the police, taking into account the boy’s age at the time.

Dissent:

Justice Alito wrote the dissent, joined by Justices Scalia, Thomas, and the Chief Justice. Alito wrote, “The Court’s decision in this case may seem on first consideration to be modest and sensible, but in truth it is neither. It is fundamentally inconsistent with one of the main justifications for the *Miranda* rule: the perceived need for a clear rule that can easily be applied in all cases. And today’s holding is not needed to protect the constitutional rights of minors who are questioned by the police.”

The Dissent held, “Today’s decision shifts the *Miranda* custody determination from a one-size-fits-all reasonable-person test into an inquiry that must allow for at least one individualized characteristic - age - that is thought to correlate with susceptibility to coercive pressures . . .” The Dissent held that the Court might have to take into account other variables when considering devising subsets for the *Miranda* rule, for example: intelligence, education, occupation or prior experience with law enforcement.

Justice Alito wrote, “For at least three reasons, there is no need to go down this road. First, many minors subjected to police interrogation are near the age of majority. Second, many of the difficulties in applying the *Miranda* custody rule to minors arise because of the unique circumstances present when the police conduct interrogations at school. Third, in cases . . . where the subject is especially young, courts applying the constitutional voluntariness standard can take special care to ensure that incriminating statements were not obtained through coercion.”

“...the police did not give J.D.B. a Miranda warning. They did not give him the chance to call his grandmother, his legal guardian, nor did the investigators tell the boy he was free to leave the room at any time.”

The heart of the Dissent was the argument that *Miranda* should not be based on various characteristics of the subject, but, rather, on the required inflexibility of the rule, as it relates to an established custody standard. Alito wrote, “I have little doubt that today’s decision will soon be cited by defendants - and perhaps by prosecutors as well - for the proposition that all manner of other individual characteristics should be treated like age and taken into account in the *Miranda* custody calculus.”

The Justice concluded, “Under today’s new, ‘reality’-based approach to the doctrine, perhaps these and other principles of our *Miranda* jurisprudence will, like the custody standard, now be ripe for modification. Then, bit by bit, *Miranda* will lose the clarity and ease of applica-

tion that has long been viewed as one of its chief justifications.”

Discussion:

The Majority did not decide whether J.D.B. was “in custody” or not. Instead, it remanded the case to the lower courts to make that finding. It did, however, find that a child’s age is a relevant variable that must be taken into account, and that there are major differences in capacity between a child of, say, 13 and one of 17, and of an adult past his or her majority.

Linda Greenhouse, the Supreme Court reporter for *The New York Times*, wrote that the root of *Miranda v. Arizona* was the protection of the Fifth Amendment’s guarantee against self-incrimination. She noted the Court had subsequently held that *Miranda* was not based on the Fifth Amendment but, rather, as a “prophylactic rule” designed to prevent Fifth Amendment violations. The reporter expressed her dismay in a recent blog Opinionator column of June 29, 2011 (<http://opinionator.blogs.nytimes.com/2011/06/29/common-sense-and-sensibility/>), accessed July 11, 2011) that J.D.B. could be the beginning of a diluting of the protections of *Miranda* because it concluded that if the age of the subject must be taken into account, then other variables must also. Greenhouse noted the present Chief Justice, John Roberts, voted with the dissenters, while former Chief Justice Rehnquist had refused to alter *Miranda*.

Behavioral scientists, mental health professionals, neurologists, and other physicians know the obvious, that children are not just little adults. MRIs have confirmed the unique ways in which an adolescent’s brain develops. A 10-year study by researchers at the NIMH and UCLA has shown that the pre-frontal cortex does not fully develop until young adulthood. It has been known that the frontal lobes mitigate strong desires for thrills and risk-taking, but they are one of the last areas of the brain to develop completely. Paul Thompson, Ph.D. of UCLA has produced

(continued on page 8)

Forensic Psychiatry 101 for Medical Students

Ryan Wagoner MD



When can we start teaching about forensic psychiatry? A common approach is for these principles and techniques to be kept safe until

a resident becomes a fellow, with brief glimpses during the latter years of residency. I wonder, though, if we are missing a plethora of future colleagues in the eager medical students we teach every day.

Earlier this year, I proposed a lecture series for third year medical students at my institution on the topic of malingering. The goal of this series (one hour, during each clerkship rotation) is to differentiate malingering from other presentations both in psychiatry and other avenues of medicine. The emphasis is not on educating these students in legal procedure or testifying in a court case, but rather to introduce the concepts and strategies with which they may deal with the inevitable reality of patients feigning or exaggerating illness for external incentives. Many of these students have received no education on this concept (other than learning an often times inaccurate definition) and are unaware of the implications often associated with managing patients presenting with malingered symptoms. Core features of any discussion about malingering with students of this level should include a simple explanation of the correct definition, the situations in which to suspect this behavior, and the manner in which this information can be used (both as medical students and physicians). Of course, it is also a wonderful platform to introduce the concept of forensic psychiatry and possibly spark an interest in someone who has never even heard of (much less considered) the field.

An oft-cited worry of teaching this concept to medical students, though, is the idea that the topic of malingering may “poison the well,” so to speak. With impressionable learners just beginning to understand and utilize the concept of differential diagnosis, the risk of students immediately jumping to a diagnosis of malingering is a valid concern. The key to preventing this, however, appears to be the manner in which the concept is taught. For example, in the course I teach on this topic, the actual diagnosis of malingering is not central to the discussion. In fact, students are discouraged from considering this as a diagnosis, due to the aforementioned concerns. Instead, an emphasis is placed on the feigning of symptoms, which can occur (and typically do) in the context of true medical or psychiatric illness. We then utilize this approach in discussing what can be done when it is apparent that patients are displaying inconsistent or exaggerated symptoms, with a focus on understanding the possible motivations behind these actions. Frequently, there is value in this understanding, as it can reveal other areas of treatment (both medically and socially) which can benefit our patients. The other advantage to dealing with feigned symptoms and not a “label” of malingering is in teaching about documentation. In our course, learners understand that giving out a label to a patient in most instances of practice is not valuable. However, documenting the behaviors observed and their congruence/incongruence with other objective findings can be of use not only to the physician/medical student, but to any future colleagues involved in the patient’s care. Once again, a focus is placed on serving the needs of those requesting our care, which for almost all of the learners, will be the patient themselves.

Since the initiation of this lecture series at our institution, there has been an overwhelmingly positive response from medical students. Many of the comments and feedback elicited have indicated that students find this to be a valuable topic in their clinical training and an excitement to learn about a subspecialty of psychiatry which is frequently introduced much later in training. An effort to introduce forensic topics to an audience earlier in training has clear benefit not only for the learners, but also for the field of forensic psychiatry in general.

Ryan Wagoner is a PGY 3 resident at Western Psychiatric Institute and Clinic, University of Pittsburgh. ☎

Miranda for Minors

continued from page 7

time-lapse imaging tracks of the developing brain at the UCLA Laboratory of Neuroimaging. (http://www.edinformatics.com/news/teenage_brains, accessed June 11, 2022.)

Such studies were not taken into account either by the Majority or Minority because both sides argued that conclusions can be drawn from case studies alone and do not need to recognize neurological development.

J.D.B. v. North Carolina is an important decision but does not go far enough. Justice Sotomayor left it for North Carolina to determine whether or not the child was “in custody,” as long as his age is taken into account. The Court did not define how this should be done. It may have been too optimistic in stating that police would be able to do this. The dissenters ignored the fact of young teenagers committing serious crimes, when Justice Alito wrote repeatedly about 17-year-olds and their being almost adults.

Nancy Greenhouse, the reporter for the New York Times, fears this decision, as progressive as it is, could, ironically, lead to a series of decisions which could dilute *Miranda* if not reverse it entirely.

Stay tuned. ☎

The Evolving Image of the Juvenile Delinquent

Jonathan Raub MD



On April 29, 2010, a jury of seven women and five men deliberated for 12 hours, eventually determining that John Odgren was guilty

of first degree murder; Mr. Odgren, the following day, was sentenced to life in prison at the age of 19. Three years earlier, on a Friday morning in January, before classes had begun, Odgren, who carries a diagnosis of Asperger's Syndrome, stabbed to death 15-year-old James F. Alenson in the bathroom at Lincoln-Sudbury Regional High School in Massachusetts. The two boys did not know each other but Odgren had reportedly become obsessed with the number 19 which is prominently featured in Stephen King's series of books "The Dark Tower," in which a protagonist violently battles enemies. Three expert witnesses for the defense made the case that his obsession with "The Dark Tower" and the number 19 (Odgren, who was born on 9/1/90, was reportedly obsessed with the number in his own daily life) had inspired paranoia in Mr. Odgren and that, as a result, he had gone to school with a knife on that day, January 19th, to defend himself; all three witnesses testified that the number made him fear something was going to happen.

Soon after Alenson was stabbed, Odgren was seen holding himself against a wall, crying out "Oh God, what have I done" and asking for another classmate to get help. During the course of the trial it emerged that Odgren, who had been the target of bullying, had carried additional diagnoses of bipolar disorder and ADHD in the past and had also been assessed at times to be suicidal, going back to age nine. The case was made by the defense that Mr. Odgren had significant social and emotional difficulties and up for debate was whether psychiatric factors significantly contributed to his crime. Regardless of the verdict on this particular point, what was ultimately

decided was that Mr. Odgren was not amenable to rehabilitative efforts and, therefore, punitive measures were applied.

The juvenile justice system in the United States has seen several recent changes. In the mid 1990s (following a more than doubling in homicides and aggravated assaults committed by adolescents since the late 1980s) the political "bumper sticker," as Grisso writes, read "Adult time for adult crime." The longstanding convention of approaching juvenile justice with a rehabilitative intent had shifted. However, several years later, in 2000, the U.S. Surgeon General declared a "mental health crisis" among youths entering the juvenile

"The image of the delinquent as super-predator has been replaced by the troubled delinquent – a youth who meets criteria for one or more mental disorders and who is in need of treatment."

justice system and the pendulum began to swing back. Despite increasing juvenile offenses at the time and the resulting political movement towards punishment and away from rehabilitation, there was a concurrent effort to conceptualize and measure mental disorders within the context of adolescence as a developmental period, including the relation of these disorders to youths' aggressive behavior: "The image of the delinquent as super-predator has been replaced by the troubled delinquent—a youth who meets criteria for one or more mental disorders and who is in need of treatment" (Grisso, 2007). These competing images clearly played a role during those 12 hours of deliberation on April 29, 2010, and will remain central to the debate on how we approach juvenile

justice going forward.

During my tenure as a trainee in child and adolescent psychiatry, I have been consistently drawn to the interplay of medicine and law, of science and ethics. As the technological complexity of our society continues to increase there will be a growing demand for child and adolescent psychiatrists also trained in forensic psychiatry. A recent spate of cases involving adverse events related to "cyberbullying" provides an example of how the expanding "virtual world" is likely to provide increasing opportunity for the child and adolescent forensic psychiatrist. In addition, as we continue to better understand the biological bases of decision making, impulse inhibition, and perhaps even morality, the role of the child and adolescent forensic psychiatrist will likely be further expanded, as we are increasingly charged with relaying the implications of research findings into the courtroom setting. As forensically trained child and adolescent psychiatrists we will be in a unique position to bridge the gap between medicine and law, particularly as it applies to our unique population.

Although the utility of a debate on free will versus biological (or perhaps more appropriately "biopsychosocial") determinism is likely to be minimal in the courtroom setting, it is a debate which is intrinsic to the interface between psychiatry and criminal law and one that must have been featured prominently as Mr. Odgren's fate was deliberated. However laden with complexity this debate may be in adult forensic psychiatry, it appears to be that much more complicated in child and adolescent forensic work, where one must carefully weigh the impact of still-developing cognitive and emotional faculties. It is the intrigue and importance of this challenge that propels the next generation of child and adolescent forensic psychiatrists and inspires this author to enter our ever-emerging field.

References:

Grisso, Thomas (2007), Progress and Perils in the Juvenile Justice and Mental Health Movement. *Journal of the American Academy of Psychiatry and the Law* 35:2:158-167

Reprinted from March/April issue of AACAP News.

Dr. Raub is a Forensic Psychiatry Fellow at University of Rochester.

“What If It Were Your Kid?”

Stephen Zerby MD

Please forward any stories, comments, suggestions, submissions, or ideas for future columns to zerbysa@upmc.edu.

Sometime ago, while covering the local juvenile detention center, I received a text message from a forensic psychiatry fellow that one of her patients was detained, and I was asked to see him. The patient was an adjudicated sexual offender court-committed to a special program which operates a unique collaboration between the juvenile court and an outpatient clinic in which probation officers are part of the treatment team. Forensic psychiatry fellows work with patients in the program to provide medication management, and for select cases, psychotherapy. The patient I was asked to see was in the midst of a detention hearing, so I stopped what I was doing in the clinic and rushed over there. When I asked the guard where to find the patient, I was taken aback by his response: “Are you his father?” For a fleeting moment, an entire scene played out in my head - my older son, now a teenager in the scene, got into some kind of trouble with the law, was court-ordered to a juvenile treatment program (not necessarily a sexual-offender program), and was subsequently sent to juvenile detention. The truth be told, while far from being delinquent, my son is anything but maintenance-free (although it is a valid question as to whether such children truly exist). So, for an intense moment, I could visualize my older child, more grown-up, and getting into bigger trouble than he currently does. For a moment the experience of being the parent of a delinquent flashed through my head, associated with fear, anxiety, and anger. I suppressed the urge to gain comic relief through a wise-crack along the lines of, “Sorry, I’m not the parent of a detainee, yet...” Rather, I replied that I was the center’s psychiatrist asked to see him. The guard informed me that the patient had already been released into the custody of his parents. I thought about how it must feel for a parent to have their child released from custody

to their home where he belongs. A wave of relief for those parents, whom I had never met, came over me.

Walking back to the detention center clinic, I was reminded of an experience in a different setting sometime ago when I was at a meeting with clinical staff and a wise senior child psychiatrist who was a great mentor to me. Perhaps inspired by the presence of a juvenile offender in the waiting area, a clinical staff member

“For a moment the experience of being the parent of a delinquent flashed through my head, associated with fear, anxiety, and anger.”

jokingly proposed a mock study of juvenile offenders, the details of which have been long forgotten. However, the humorous implication of the proposal on juvenile offenders remained clear: that they were always somebody else’s problem, never ours. Although I had not perceived the joke as malicious, I sensed distaste from my mentor as he did not laugh to the joke, but rather said something along the lines of: “You have to be careful about making comments like that because one day it might be your kid who is involved with the justice system.” For some reason the comment stuck with me, and ever since, during evaluations or treatment of juveniles or young adults in forensic settings, the question repeatedly enters into my train of thought: What if this kid were my kid? How would I want him evaluated? What therapy would I want for him? How would I like the staff to treat him? What would I not want to have happen to him? My biggest fears

were silently rattled off to me: Would my kid get jumped by peers? Would the evaluating psychiatrist conduct a reasonable and fair court-ordered assessment? How would the staff comport themselves? If medications were recommended, what would be the risks? Would the recommended rehabilitative programming actually help him? If he were placed out of the home, how far and safe would the facility be, and would it really help him?

These questions have, to a certain extent, persisted in my day-to-day work in forensic settings, in both my evaluative and treatment-oriented roles, and have become a framework for my clinical style. While seeing a child who bears no resemblance to my child makes things easier, on the rare occasion that I am working with a detainee or prisoner who in some way reminds me of my children, the situation feels different; it is easier to empathize with that child’s parents and the child. We have all heard about putting ourselves in someone else’s shoes, but how often have we put ourselves in the shoes of a criminal or his/her parents? The temptation is to preserve our “good” identity by projecting our “badness” onto criminals, thereby reinforcing a world view in which “bad acts” are committed by “others” rather than us or our loved ones. But this is not reality, and as mental health professionals, we should demonstrate a certain degree of self-awareness; everyone does things that are wrong, ourselves and our kids included. We should continuously remind ourselves of this when working in forensic settings. Someday, one of our kids could do something dumb and get arrested. How would we want him/her to be treated by the authorities? A mental exercise of repeatedly asking ourselves these questions in our daily routine may not only better the lives of those with whom we work, but also ours, as it changes our perspective at the end of a long and difficult day. So, the next time you meet with a young detainee or prisoner, would it not be worthwhile to begin with the question, “What if this were my kid?” ☪

Robert Weinstock MD **AAPL Ethics Guidelines**

Leilani Lee MD

(To suggest members for this feature, email Philip Candilis MD at philip.candilis@umassmed.edu)



As a first-year psychiatry resident, current AAPL Vice-president, Golden Apple awardee, and professor, Robert Weinstock

was intrigued by the ethics teachings of his renowned Harvard attending, Alan Stone, then residency director at McLean Hospital. Stone famously challenged psychiatrists on the ethics and appropriateness of their involvement in the courtroom. Dr. Weinstock has since become one of the leading writers in the ethics of forensic psychiatry and is deeply committed to the advancement of the ethical practice of the field.

During his more than 25 years with AAPL, as an educator, mentor, and President of the Directors of Forensic Psychiatric Fellowships, Dr. Weinstock has been instrumental to the metamorphosis of the AAPL ethical guidelines. He was involved in developing the original guidelines and, during his tenure as the longest-acting chair of the AAPL ethics committee, led the 1995 revisions. These included the addition of the seminal principles of “honesty” and “striving for objectivity,” as well as the removal of the unrealistic requirement to be “unbiased.” In the 2005 revision as well, Dr. Weinstock provided important historical, organizational, and ethical expertise. More recently, in 2007, Dr. Weinstock co-authored the book *Forensic Ethics and the Expert Witness*.

In 2006, as chair of the Judicial Action Committee of the California Psychiatric Association, Dr. Weinstock was involved in changing California’s Tarasoff law. In the revision, California corrected serious unresolved problems for psychiatrists. AAPL members will recall that the Tarasoff I decision

resulted in a duty for California psychotherapists to warn their patient’s potential victims. On rehearing the case two years later, the court in *Tarasoff II* changed the duty to a duty to protect, with warning as a possible means therapists could use to protect potential victims. The California Court of Appeals subsequently stumbled, after an ambiguously worded immunity statute designed to limit liability was instead interpreted to create a new duty that could be satisfied only by warning. The Court in two related decisions, most notably in *Ewing v Northridge Hospital Medical Center*, decided that psychotherapists could be liable if they did not warn a potential victim at any time they believed there was a serious threat. Expert testimony was not even needed to establish their liability. In *Ewing*, the appellate court decided that the only issues to consider were whether the therapist considered the patient seriously dangerous and whether the therapist gave a warning. (*Ewing v Northridge Hospital Medical Center* 16 Cal Rptr. 3d 591 Cal. Ct. App. 2004).

The California Judicial Action Committee was concerned that the court ignored situations in which a warning could have detrimental consequences. Prior to the 2006 changes, psychotherapists could be held liable if they temporarily believed a patient’s threat and did not warn, even if they changed their opinion after a more thorough examination. Dr. Weinstock provided an example in which a woman reported to a psychiatrist that she was going to kill her father. Initially, her threat was deemed believable and resulted in her hospitalization. However, after careful evaluation, it appeared that the threat was simply made out of anger: it was in response to her father’s threat to kill *her* if she did not relinquish her inheritance. It was also discovered that her father was

still in prison for murdering the patient’s mother. Therefore, a judicious decision was made not to warn the potential victim.

Under California law at the time, the therapist or admitting psychiatrist had a duty to warn the potential victim because the threat was once believed. However, the corrective legislation as interpreted by the Judicial Council, still allows psychotherapists immunity from liability by warning the potential victim. But, if the psychotherapist chooses not to warn, the burden is now on others to prove that the therapist did not take other necessary steps to protect. This provides flexibility for therapists to take the most protective measures and substitute more effective methods of protecting the victim, says Dr. Weinstock.

As a member of the APA’s Committee on Judicial Action, Dr. Weinstock has also been involved in writing amicus briefs in Supreme Court cases, including the landmark case of *Roper v Simmons*. Dr. Weinstock played an important role in correcting certain overstatements in the original brief. In this Supreme Court case, the Court decided that the death penalty for those younger than 18 violated the Eighth Amendment. Dr. Weinstock described how some of the attorneys’ briefs exaggerated the science, suggesting incorrectly that brain scans definitively linked adolescents’ immaturity to impulsivity. As a result, they argued, adolescents should be less criminally responsible. The APA’s Committee on Judicial Action more appropriately emphasized that adolescent immaturity was reflected in laws limiting their privileges (e.g., by not having the right to vote until age 18), and that the concept of adolescent immaturity was supported by empirical psychological testing. The APA and AAPL, among others, consequently signed on to “a more balanced brief” submitted by the AMA, Dr. Weinstock says.

Dr. Weinstock emphasizes that our job as professionals is to “state the case the way it is, not to overstate or over-interpret the science.” In Dr. Weinstock’s view, this is part of the forensic expert’s broader duty to the truth, and to avoid exaggeration to win a case. ☯

Ask The Experts

This information is advisory only for educational purposes. The authors (Neil Kaye and Bob Sadoff) 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. Please send question to nskaye@aol.com.

Q. How do I handle redacted records and pretrial stipulations that exclude what I consider to be important and relevant information?

A. Sadoff: You have a number of options: first, you can politely refuse to become involved if you feel your professional integrity is compromised. Second, you can put on the record that you requested all relevant material and have been limited to the redacted material and stipulations that limit your opinions and conclusions. Third, you can accept the assignment and send in the report with the limitations imposed. You can testify that you have a limited opinion inasmuch as the court has limited the information available for evaluation. Recall, it is the court that sets the rules. We are guests in the house of the law and must either abide by its rules or refrain from participating. If we choose to participate, we can express our opinions that some of the material withheld is relevant and you cannot give a full opinion without it. The judge may then excuse you from participating, but you have made your point. Be sure to discuss this with your retaining attorney in advance and obtain her/his approval for your expression of opinion. Good luck, keep the faith and maintain your professional integrity.

A. Kaye: This is not an uncommon situation, and one that always makes me uncomfortable. While we clearly have an affirmative duty to disclose on what our opinion is based, it is not clear that we have any such affirmative duty to disclose what was missing or omitted due to legal machinations over which an expert has no control. Further, an expert risks setting up a mistri-

al by referring to information that has been “banned” through pretrial motions. It is also important to be aware as to whether the material has been put off limits before or after you entered the case. Did you get redacted records originally? Do you know or would you want to know what is in the actual complete record or do you find it easier to work from the agreed upon redacted data base? Did you formulate your opinion based on material in a record that has now been put off limits, making it impossible for you to reference your “evidence base?” It is impor-

tant to address your concerns with the retaining lawyer. Frequently, the lawyer will want something redacted that you as an expert feel is important and further, you can explain to the lawyer why from a psychiatric perspective it might not be harmful material at all. If you feel you cannot proceed based on the limited database, it is your responsibility to inform the lawyer. In court, if I feel that a lawyer is getting too close to material that would require I address redacted material, I will look to the judge and ask for
(continued on page 26)

Ethics Dilemmas

Charles C. Dike MD, MPH, Chair, Ethics Committee

In this section, questions posed to the Ethics Committee by AAPL members will be answered. Please Note: The response of the Ethics Committee is not the official position of AAPL, or a binding opinion of the Ethics Committee. It should be seen as peer consultation only.

Question: A consultation firm who identifies experts for clients is interested in recommending me as an expert to one of their clients. But before they do this, they want to see the quality of my work by reading a redacted report from a case I have previously done. By redaction they mean removing people’s names, names of institutions, obvious identifying data.

The forensic psychologist who heads the consultation firm says the redacted report would be read by one forensic psychologist, who would then shred it. And I am told that all the experts they now recommend have previously submitted a redacted report, generally without qualms.

Nonetheless, I am concerned that providing a substantial amount of information about a case, for my own financial gain, violates my release. Even with identifying information removed, the central forensic question, progression of symptoms, past psychiatric history, diagnoses, and forensic discussion would remain and, I think, constitute a substantial release of information and a violation of the partial confidentiality I promised. Any thoughts? Any idea how others handle this?

Answer: The request for a redacted report from the hiring firm is certainly not an uncommon one, and in fact, laudable in many respects. In general, it is not unethical to submit an appropriately redacted report. The question is: to what standard of anonymity should you ascribe? The standard in which a client is not recognizable to the community, acquaintances, the individual’s family, or to the client? Most people agree that redacting information to the degree that the report is unrecognizable to the community is generally sufficient. This includes redacting names, dates, and the most personally identifying information.

Of course, no degree of redacting totally absolves you from liability as it is difficult to guarantee that a report could be sufficiently redacted to remain completely confidential. To decrease the potential for liability further, it is recommended that you consider submitting a redacted report of a case where the report was used in evidence, and, consequently, almost or completely public. ☪

Forensic Psychiatry in Britain – Training in the National Health Service

Dr. Mary Whittle

While forensic psychiatric institutions have been developing since 1863 with the opening of the maximum secure Broadmoor Hospital, development of the subspecialty of Forensic Psychiatry in the UK began really only in the 1970s. Prior to this, the practice of forensic psychiatry was limited to a few individuals, practicing mainly in the courts and looking after relatively small numbers of patients¹. The 1975 Butler Report paved the way for the development of medium secure hospitals for the assessment and treatment of mentally disordered offenders throughout Great Britain².

Currently there are 96 Specialty Trainees in Forensic Psychiatry throughout England, Scotland, Wales and Northern Ireland, of which 44 are in the London region³. Training schemes are approved and monitored by the General Medical Council (GMC) which oversees medical and dental registration, education and standards across all specialties in the UK. The GMC also works with the Royal College of Psychiatrists and the twenty Postgraduate Deaneries, who are accountable to it for the management and delivery of post graduate medical education and professional development⁴.

On completion of medical school training, doctors in the UK complete two Foundation years, moving between medicine, surgery, general practice and sometimes, psychiatry. After this, the fully registered doctors can apply for training in their chosen specialty. During a three year core psychiatry rotation, trainees move between general and specialist posts, working under consultant supervision and taking examinations which lead to the professional qualification of Membership of the Royal College of Psychiatrists (UK). While training in forensic psychiatry can be undertaken in this pre-membership period, completing a forensic psychiatry place-

ment is not a mandatory requirement for eligibility to take the Membership examination.

Trainees must have Membership in the Royal College of Psychiatrists, or equivalent, prior to undertaking specialty training in forensic psychiatry. Entry to the specialty training scheme is by a competitive application process. The number of applicants outstrips the number of vacancies and has done so for many years. Trainees are paid employees of the National Health Service through their employing hospitals (Trusts) and are subject

“Training takes place over a three year program and follows a curriculum set out by the Royal College of Psychiatrists for Specialists in Forensic Psychiatry.”

to contracts of employment. Deaneries devolve funds to Trusts who administer trainees’ salaries, and conditions of service and training, provide facilities for training and employ the Consultant Forensic Psychiatrists who act as clinical and educational supervisors.

Higher trainees are known as Specialty Trainees (Years 4-6). Training takes place over a three-year program and follows a curriculum set out by the Royal College of Psychiatrists for Specialists in Forensic Psychiatry⁵. The doctors join rotational training schemes in particular geographical areas and work in low, medium and high security hospitals, prisons, community facilities and other institutions in six months to one year blocks. As forensic psychiatrists in the UK treat

patients and report to the courts, trainees are expected to be proficient in the diagnosis and treatment of mental disorder, personality disorder, and sexual and other offending and to be knowledgeable on current thinking on risk assessment and management. A good knowledge of the links between Criminal Justice Services, Social Services and the Health Service is a must and training in management, leadership skills and teamwork is an important aspect of the program.

Specialty trainees are also required to become competent in the various legal frameworks applying to forensic and general psychiatric populations in the UK and to be proficient at preparing and presenting reports and evidence to the lower and higher Criminal Courts, Parole Board, Mental Health Review Tribunals (which deal with discharge of patients from hospital under the UK Mental Health Act 1983), Ministry of Justice, (which oversees the discharge and management of some forensic patients who have been placed in hospitals by the courts), and other legal bodies.

Apart from their core job, trainees spend two “Special Interest” sessions per week gaining experience in research, management, criminology, law or other areas of psychiatry.

Specialty trainees complete formal assessments throughout their training, including observer-rated clinical and legal knowledge and procedure tasks. They are required to seek multisource feedback from team members, including those of different disciplines, and to be rated on presentation and leadership skills. A trainee must be rated competent on a minimum of 8-12 assessments per year before he/she can progress along the training trajectory. The progress of all trainees is reviewed yearly through an Annual Review of Competence Progress (ARCP)⁶. An award of Certificate of Completion of Training (CCT), recognized across the European Union, is awarded after three years when competence is achieved in all domains. Trainees who have achieved their Certificate of Completion of

(continued on page 29)

PHOTO GALLERY



Computers Committee: Generating ideas about usefulness of computers in forensic psychiatry.



Rapoport Fellow Loretta Sonnier MD.



AAPL Institute reception.



Education Committee: Focused on educational content of presentations.



International Relations Committee: What's new around the world?



At the Attendees' Reception.

PHOTO GALLERY



Larry Faulkner, President, Institute of AAPL, with grantees.



Forensic Neuroscience Committee: Is the future here?



Institutional and Correctional Committee: Reviewing practice issues in unique settings.



Relax, enjoy the alluring atmosphere...until the next presentation.



Lunch Head Table (L-R): Peter Ash, Marilyn Price, Cheryl Wills, and Bob Phillips.



Private Practice Committee: Embraces an opportunity to rub minds and shoulders with colleagues.

A Forensic Psychiatric View of the Currently Proposed DSM-5 PTSD Stressor Criterion

Stuart B. Kleinman MD, Chair, Committee on Trauma and Stress

The DSM importantly influences litigation. Slovenko¹, for example, notes it is cited over 5,500 times in court opinions. PTSD may, in particular, play a central role in civil and criminal litigation. Many attorneys regard this diagnosis as an especially useful tool for seeking damages for emotional distress, because of: 1) PTSD's virtually unique, defined cause-effect relationship between external event and diagnosis, and 2) the high magnitude distress, e.g., images of bloody combat the name PTSD conjures for many. The right to recover for harm produced by a "hostile work environment" in the absence of an adverse tangible employment action, and the perceived elasticity regarding the types of events which satisfy the DSM-IV-TR PTSD stressor A1 criterion have led PTSD to often be a claimed consequence of an alleged "hostile work environment".

PTSD is also utilized in criminal litigation. Prosecutors may, for example, employ it to bolster the credibility of individuals who report they were sexually assaulted. The non-DSM-IV-TR entity, Rape Trauma Syndrome, which some consider a type of PTSD, may be utilized to argue that an individual's specific PTSD symptoms establish that a particular trauma occurred. The potential, however, for events other than extreme traumatic stressors to precipitate symptoms of PTSD renders "reverse engineering" from diagnosis to particular event type potentially (very) problematic. Another syndrome, Battered Woman's Syndrome, which some also consider a type of PTSD, may, conversely, be utilized by defense attorneys to support a defense of justification. Those suffering from such may be asserted to have reasonably believed they imminently confronted being killed and

needed to use deadly force to save their lives. When PTSD is introduced into criminal court, the stakes are almost invariably high.

PTSD is also employed in immigration litigation to support asylum seekers' claims of possessing a "well-founded fear of persecution." An individual may introduce evidence of suffering PTSD when, for example, he has been expertly physically tortured, and lacks stigmata of such.

"The proposed stressor criterion also does not sufficiently address the often legally important question of what magnitude of threat is required to satisfy it."

Problematic specificity between diagnosis and event type may, however, complicate such use of PTSD. An individual, for example, may demonstrate similar arousal symptoms whether tortured or having witnessed a beloved family member die in a motor vehicle collision. And, self-report of the content of reliving phenomena such as repetitive and intrusive thoughts, images, and dreams may not be deemed sufficiently reliable by a "trier of fact" when strong self-interest is present.

DSM-5 PROPOSED PTSD STRESSOR CRITERION (Improvements Over DSM-IV-TR)

From a forensic psychiatric perspective, the currently proposed DSM-5 PTSD stressor criterion significantly improves the DSM-IV-TR stressor (A1) criterion. Notable proposed

improvements include:

1. Elimination of the component, "other threat to one's physical integrity." This term is subject to broad interpretation, creating the potential for an event other than an extreme traumatic stressor to qualify as a PTSD inducing occurrence. This opens the door to diagnostic confusion and creates fertile territory for so-called "battle(s) of experts." For example, being unwantedly touched on the buttocks at the workplace may constitute both illegal discriminatory behavior and a type of "threat to one's physical integrity" - but in most instances does not represent an extreme traumatic stressor as described in the DSM-IV-TR text. Context, of course, importantly contributes to determining whether an event represents an extreme traumatic stressor, i.e., is a reasonably perceived actual and serious threat to physical well-being. Illustrating the problematic nature of this aspect of the DSM-IV-TR stressor criterion, a physician's negligent monitoring of a patient with known significant diabetes for development of cardiovascular complications which resulted in the patient's undergoing quadruple bypass surgery might be asserted in a malpractice claim to have produced a "threat to one's physical integrity" and a consequent PTSD. Such an event is significant, but not biopsychosocially comparable to other types of threats generally recognized as potential PTSD-inducing stressors, e.g., being raped or physically (otherwise) assaulted.
2. Modification of the component, "witnessing an event that involves death, injury or threat to the physical integrity of another person." This component is now proposed as "witnessing, *in person*, the event(s) as they occurred to others." The

(continued on page 17)

DSM-5 PTSD

continued from page 16

mode of witnessing is not currently specified.

The DSM-IV-TR specifically states that “witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster, or unexpectedly witnessing a dead body or body parts.” Neither the physical proximity nor timing of witnessing is referenced.

Yet, it is reasonably well established that generally the further distant in place and time the witnessing of a traumatic event, the less likely such is to produce a PTSD. Watching the Twin Towers collapse on television while in one’s living room in Alaska, days after first having read or learned about such, would, for example, expectedly be far less psychologically harmful than witnessing the Towers collapse from across the street. The proposed addition of the modifiers “in person” and “as they occurred to others” reflects recognition of the import of these aspects of witnessing an event. Absent these circumscribing requirements, individuals in this era of increasing bandwidth who in attenuated ways repeatedly, for example, via YouTube, witnessed manmade or man-contributed traumas, e.g., terrorist bombing (post “9/11”) of a building in the United States, or the collapse during an earthquake of a bridge filled with commuters, could conceivably, if the hurdle of third party duty could be overcome, institute civil actions alleging development of a PTSD from negligent provision of security or negligent adherence to a construction standard.

3. Improvement of the “learning about” component.

Illustrating both the importance and relative dearth of investigation of the impact of learned about traumatic events, an article by Luz et. al.² employing bibliometrics, a “tool for identifying patterns in the psychiatric literature” (p. 244), indicated that although Breslau et. al.³ found that learning about the death or disappearance of a close person is the most common trigger in the general population for PTSD, only approximately 0.5% of articles published between 1991 and 2006 about traumatic events and development of PTSD have concerned the impact of learning about such events.

The DSM-IV-TR broadly states that “learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate” may produce PTSD. Learning that a spouse who was undergoing dangerous surgery died as a result of operating room personnel negligence might, for example, currently be asserted as a PTSD qualifying event. Just how unexpected or violent a learned about event must be is only minimally explicated. In litigation settings, it may be especially difficult to reliably demonstrate the extent to which an event was unexpected. An individual may misleadingly report such to support his legal position, or the defense may introduce evidence purported to demonstrate that an event was not meaningfully unexpected. It might, additionally, even be claimed that an event should have been recognized as a potential outcome, and that it was unreasonable or idiosyncratic to perceive it as unexpected. Determining whether an occurrence was (reasonably) expectable is generally much more difficult than determining whether an event significantly threatened death or serious

physical injury. The former is especially a function of personality and mental state-based perception.

Also, the “learning about” stressor component does not reference the nature of the relationship between the “family member” and traumatized individual, and does not define who is an “other close associate.” The failure to do so contributes to elastic use of PTSD in litigation settings. Disruption of a deeply held attachment may greatly contribute to producing post-trauma distress, but the status of family member is not synonymous with being significantly attached to another family member. The current DSM-5 proposed stressor criterion partially solves the above identity problems, substituting “close relative” for “family member” and “close friend” for “close associate.” This modification increases psychological accuracy and reduces the universe of individuals who can be diagnosed with a PTSD from “learning about” an event. The DSM-IV-TR “learning about” component also problematically defines the nature of the “learned about” event. An event which has produced harm must, it states, produce “unexpected or violent death” or “serious” harm. But, an event which has threatened but not actually caused harm, need only non-specifically threaten “injury,” i.e., not specifically or necessarily serious injury, to fulfill the “learned about” stressor feature. Such event supports legal actions which claim that objectively relatively low magnitude “learned about” events produced a PTSD. Requiring only the threat of “injury” is not synonymous with requiring “serious harm,” and engenders confusion regarding the magnitude of “learned about” potential PTSD generating stressors.

(continued on page 18)

DSM-5 PTSD

continued from page 17

The greater such confusion, the greater the opportunity for inappropriate, even mischievous, use of PTSD in the legal arena. The proposed DSM-5 “learning about” criterion resolves this issue by both not including the term “harm,” but rather “threatened death,” and by specifying in the modifying clause, a “threatened serious injury” as opposed to threatened harm or injury.

The proposed requirement that the learned about event, if it involved “actual or threatened death,” “must have been violent or accidental” clarifies the nature of certain potential PTSD inducing events, but may also exclude certain kinds of extreme, and potentially legally relevant, learned about stressors as sources of PTSD. Events may be high magnitude stressors, yet neither (overtly) violent nor accidental. For example, the suicide of a parent who ingested a drug which rapidly induces sedation and “gently” stops respiration, in response to being informed by a physician that his twelve year old daughter is suffering from a painful terminal illness, might not be considered violent, but would be highly traumatic for his daughter to learn about. If she were subsequently discovered to have been negligently diagnosed with a terminal illness, a claim that she suffered emotional distress from, among other sources, her father’s (causally) related suicide, might follow.

Problematic Aspects:

The proposed DSM-5 PTSD stressor criterion contains significant improvements, but is also significantly flawed. Apparently to reduce the ambiguous “other threat to one’s physical integrity” component, it substitutes “actual or threatened sexual

violation” as a type of PTSD qualifying event. However, “violation” generally, and “sexual violation” specifically, have come to signify a very broad array of events. What does, and perhaps more importantly, does not constitute a potential PTSD inducing “sexual violation” is not explicitly addressed in the proposed criterion. Consequently, multitudinous types of potentially illegal, discriminatory workplace acts which are at least in some regard “sexual violations,” but which markedly differ from such sexual violations as serious attempted or completed sexual assaults, or such non-sexual extreme traumatic stressors as being in the midst of a severe earthquake or robbed and shot, may, perhaps especially within litigation settings, be represented as sources of PTSD. Particular events which might be deemed PTSD inducing sexual violations include:

1. Unwanted e-mailing of sexual jokes to a coworker.
2. Unwanted e-mailing of nonviolent, sexually explicit photographs to a coworker.
3. Male coworkers loudly and publicly discussing female celebrities’ body parts, e.g., breasts, in crude and unwanted, but non-physically threatening, manner.
4. A male coworker’s repeated unwanted comments about a female coworker’s manner of dress, including overtly referencing body parts, such as the size of her breasts, without expressing desire for sexual activity or referencing violent behavior.
5. A male coworker unwantedly touching a female coworker’s buttocks for several seconds over her clothing in a public workplace area.

Each of these events may occur in many different ways; variables such as location, time of day, presence of others, and nature of relationship between subject and object may significantly determine the extent of violation and whether meaningful physical threat is present. However, as presently written, the term “actual or

threatened sexual violation” appears to inherently equate numerous forms of illegal, but (objectively) relatively low magnitude sexual harassment with PTSD-qualifying stressors.

Sexual harassment, of course, may produce significant emotional distress. Such distress does not, however, constitute a PTSD unless it results from a certain type of event. The addition of an “actual or threatened sexual violation” as a PTSD-inducing event would likely greatly increase the kind and number of events that could cause PTSD. If, for example, sexual violations such as crude sexual jokes or buttocks grabbing become bases for diagnoses of PTSD, many may come to question the significance, if not regard the validity of the entity of PTSD with skepticism, and socio-legally induced “second wounds” or secondary victimization will likely increase.

A diagnosis has social meaning. Diagnosing those who have suffered objectively much greater magnitude traumas, particularly much greater magnitude sexual violations, with the same condition, i.e., PTSD, as those who have suffered much lower magnitude events is particularly likely to exacerbate feelings of narcissistic diminishment already experienced by many victims of man-made, i.e., intentional, trauma, especially victims of violent crime. The narcissistic injury resulting from being helplessly reduced by a rapist to an object of cruelty-desire may be, for example, secondarily compounded by the perception that this experience is regarded similarly to that of those who suffered much lower magnitude events such as repeatedly being subjected to sexual jokes or buttocks grabbing, yet are equally diagnosed with PTSD. The role of narcissistic diminishment in mediating PTSD (and depressive) symptoms is, for example, recently observed in a study by Mancini, Prati, and Black⁴.

The proposed stressor criterion also does not sufficiently address the often legally important question of what magnitude of threat is required

(continued on page 29)

Royal College of Psychiatrists Forensic Faculty Annual Conference - 2011

John Baird FRCPsych, Jennifer Shaw FRCPsych and James Reynolds MD, International Relations Committee

The annual residential conference of the Forensic Faculty of the Royal College of Psychiatrists was held in Berlin, Germany from February 2 to 4, 2011. Despite the economic climate and the limitations on the level of support by UK employers to allow psychiatrists to attend, the conference was very well supported with over 300 delegates. A full and diverse program was prepared by Professor Jenny Shaw of the University of Manchester and Professor Tom Fahy of the Institute of Psychiatry in London.

Berlin is a city well worth visiting and many delegates included a few free days before or after the conference to allow them to explore. It is safe, relaxed, and efficient and ideal for exploring on foot or public transport. Experiencing Berlin today, it is perhaps difficult to imagine the very traumatic events which have played out on its streets within recent times. Sites with some particular American interest are the Olympic Stadium, still in use as a major sporting venue but little changed from the day in 1936 when Jesse Owens defeated all comers, and from more recent times, the Brandenburg Gate and its association with a divided city which was the scene of President Kennedy's defiant speech in 1961. Also, he is now commemorated in a small museum nearby.

As for the conference itself, the organizers' intention to highlight themes and deal with them from different perspectives became very apparent as the sessions progressed. The keynote speech which began the conference, by Professor Louis Appleby from Manchester, dealt with the mental health of offenders, acknowledging that for many citizens offending was but one aspect of life-long dysfunction and disadvantage. Professor Appleby is a UK Government advisor on these matters and confirmed that Government policy is

to raise the standards of health care to those in prison to the same level as would be available in the community. He also emphasized that many offenders are, over the course of their lives, ill done to as well as ill doing. Issues of parenting, addictions and antisocial behavior impact upon disadvantaged children as they are growing up, and predispose them to a life of offending and imprisonment.

Funding is always an important issue and there followed, from Dr. Nick Broughton of London, a presentation on the radical changes which

“The session on Avoiding Grief in Court gave valuable pointers that any expert witness, British or American, should bear in mind when preparing for court.”

are proposed in the funding of care in health and in criminal justice arising from the concept of ‘payment by results.’ Healthcare providers would gain their income by delivering packages of care to specific patients. The sums of money involved are very considerable with a budget of approximately 1 billion British Pounds per year currently being devoted to the secure care of detained patients in England and Wales.

Dr. Ruth Mann of the National Offender Management Service then presented important research findings identifying the shortcomings and limitations of many of the offense-focused programs which are currently delivered both in prison and in secure

hospitals, and discussed the different philosophies of these programs. In a challenging economic climate it is important that programs which are delivered are evidence based and effective. Also from a financial perspective, Dr. Jackie Craissati of the Bracton Centre in London, discussed how the clinical work of secure services can be analyzed. Interestingly she explained how the HCR-20 risk assessment instrument has a role to play. This surely represents a significant development in the use of this structured clinical tool.

There followed a number of parallel sessions and the day finished with a discussion on the ethics of modern forensic psychiatry with formal presentations by two psychiatrists, a psychologist and a lawyer. Themes of confidentiality, balancing the rights of the patient with the responsibility to disclose information without consent when there was considered to be a risk to public safety, and the challenges and as yet uncertainties around sharing decisions on a patient's management, and in particular, his freedoms, with criminal justice and probation within a Multi-Agency Public Protection Panel (MAPPP), were discussed.

The second day of the conference continued these themes of service development and policy across mental health and criminal justice systems with presentations on proposals to fundamentally review the expensive and controversial DSPD (Dangerous and Severe Personality Disorder) services. It continued with discussion of treatment interventions in personality disorder, with emphasis on mentalization. This is a concept not easily summarized in a few words but which deals with the ways in which people reach conclusions about the emotions and motivations of others around them. This in turn led on to a lively and provocative presentation by Professor Jack Levin of North Eastern University, Boston, on spree, mass, and serial killers. The day concluded with a series of parallel workshops, predominantly “how to” sessions on various forensic topics, and

(continued on page 25)

Expert Testimony

continued from page 5

and acceptance of contingency fees. Reviewing situations where there is disagreement about the standard of care is more challenging. Whether testimony is “true” may be difficult as truth in a legal context means truth by a preponderance of the evidence, while in a medical context, it could mean sufficient to use in practice with patients, and may involve interpretations of published literature.

Licensure boards and professional organizations have begun to discipline members with suspensions and expulsions for “bad” expert testimony. The American Association of Neurological Surgeons (AANS) was one of the first professional associations to review expert witness testimony. It has reviewed expert testimony given by approximately fifty members and has disciplined about ten members. The disciplinary actions have generally been upheld in the courts with a few exceptions.³ The American College of Radiology (ACR) expelled a member who gave inaccurate expert testimony.⁴ Similarly, the Florida Medical Association (FMA) adopted a peer review system to evaluate expert witness testimony. These review programs give the relevant association authority to sanction physicians for improper testimony.

Sanctions by licensing boards and organizations have been appealed to courts for review and have had mixed results. For a licensing board to take action, the activity has to fall within the statutorily-defined scope of practice. The AMA found 29 states to have broad definitions whereby jurisdiction over expert witness testimony would not be a problem. In some states, other provisions which permit a board to discipline for unprofessional conduct, or for engaging in fraud or deception relating or pertaining to the practice of medicine, could also give jurisdiction.⁵

In a more difficult case, the appellate court reversed the licensing board’s suspension of a neurosurgeon for his testimony. This neurosurgery expert felt that there was evidence

of increased intracranial pressure and therefore did not believe the treating physician’s statements to the contrary. He was pressed on cross-examination; was he calling the treating physician a liar? He clearly did not want to use that terminology and tried to answer in a different fashion. The appellate court concluded: “the substantial evidence of record demonstrates that Dr. L had a good faith basis for making the statement for which the Medical Board seeks to impose discipline. Further, no other evidence in the record supports the Board’s decision. Therefore, the Board erred by finding that Dr. L levied a groundless accusation, and the superior court erroneously applied the whole record test to affirm the Board’s determination.” The decision was reversed with an order to dismiss the complaint.⁶

How to balance the competing values? On the one hand, we would not like to see too many deterrents to becoming an expert witness. That is why there is quasi-judicial immunity for experts as many deficiencies can be addressed through cross-examination. It is hard enough to find good experts willing to do this work in the first place. At the same time, bad testimony gives a bad name to the profession, harms practitioners, and raises medical costs. Licensure boards are probably the best positioned to do these evaluations as they have more resources and an ability to get the best data. Professional organizations are generally more knowledgeable about the area of practice but have not usually developed the machinery and procedural due process that is required. Ⓢ

References:

1. Report 18 of the Board of Trustees of the American Medical Association (I-98) Expert Witness Testimony
2. Policy H-265.993, AMA Policy Compendium 1998)
3. *Austin v. Amer. Assn. Of Neurological Surgeons*, 253 F. 3d 967 (2001)
4. C.P. Kaiser, Expert Witness Gets Booted from ACR, Diagnostic Imaging Online (July 8, 2004) <http://www.diagnosticimaging.com/dimag/legacy/dinews/2004070801.shtml>
5. *Missouri Board v. Levine, MD*, 808 S.W. 2d 440 (1991)
6. *In re Lustgarten*, 177 N.C. App. 663 (2006)

Annual Meeting

continued from page 2

restricts what physicians can discuss with their patients about gun ownership. There was broad sentiment that this is a serious intrusion into the practice of medicine. The House of Delegates also voted to support any litigation that may be necessary to block the implementation of such laws when they restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians. Expert Witness Certification: AMA voted to help interested state medical associations initiate legislation requiring physicians licensed in another state to obtain an expert witness certificate before being able to provide expert witness testimony in medical liability actions. AMA took this action in response to a new Florida law requiring obtaining an expert witness certificate before testifying as an expert witness in Florida. The House of Delegates also supports legislation that will empower state physician licensing boards to discipline any expert witness, either those licensed in that state or those with an expert witness certificate, who provide deceptive or fraudulent expert witness testimony. Maintenance of Certification: Delegates adopted five policies dealing with maintenance-of-licensure and maintenance-of-certification requirements including a call for the AMA to encourage medical boards to accept participation in maintenance of certification and Osteopathic Continuous Certification as meeting maintenance-of-licensure requirements. At the same time, active medical licenses should not be revoked on the basis of certification requirements, the policy says. The AMA also will study the effectiveness of proposed continued licensing requirements and recommend to the American Board of Medical Specialties that physicians be required to take only one specialty exam every 10 years. Finally, we wish to correct a report

(continued on page 26)

The Pharmacologic Treatment of Paraphilic Sexual Disorders

J. Paul Fedoroff MD, Chair, Sex Offender Committee

There are two reasons why all forensic psychiatrists should be aware of the treatment options for paraphilic sexual disorders. The first is because all forensic psychiatrists who provide clinical care to adolescents or adults will encounter patients with paraphilic sexual disorders. Not all patients will disclose their problematic sexual interests and not all will ever commit a sexual offense. However, the likelihood that they will disclose the symptoms of their paraphilic disorders increases if they believe their doctor not only understands their problem but can also help. Secondly, early and effective treatment does make a difference and may prevent the commission of a sex crime.

Treatment interventions include individual, couples, family, and group psychotherapy; vocational and occupational therapy; social work interventions; addition therapy; treatment of concurrent psychiatric disorders; and pharmacotherapy. All are synergistically important and have been reviewed elsewhere¹. This article will focus on pharmacological interventions.

Pharmacologic guidelines for the treatment of paraphilic sexual disorders have recently been published and are available on-line². As in the case of any international consensus document, the recommendations may be subject to debate. However, the paper does provide a reasonable summary of the English language published literature on use of selective serotonin reuptake inhibitors (SSRI's), antiandrogens, and gonadotropin releasing hormone analogues (GnRHa's). The World Federation of Societies of Biological Psychiatry (WFSBP) review is an attempt to rate published studies according to the quality of the research methodology. A major weakness is a failure to consider treatment objectives beyond wanting

“to control paraphilic fantasies and behaviors... sexual urges...(and) distress of the paraphilic subject”.

The document includes reviews of many of the published studies, summarized in Table 1.

The WFSBP document does not provide a table summarizing studies of SSRIs but mentions 130 papers (mostly case reports). Fortunately summaries of SSRI studies are avail-

“Five year recidivism rates, even without modern pharmaceutical treatments are now below 15%.”

able elsewhere³. One important point is that SSRIs can inhibit orgasm, which can increase sexual frustration. In fact, inability to reach orgasm through conventional sexual scenarios has been proposed as a cause of paraphilic interest⁴. If SSRIs are prescribed to patients with paraphilic disorders, it is important to ask about inhibited orgasm. If the patient cannot reach orgasm, a lower dose may be more effective.

The WFSBP concludes with an algorithm of pharmacologic treatments for the paraphilias on the premise of varying pharmacologic interventions based on level of risk.

An abbreviated version of the algorithm is shown in Table 2.

A review of the algorithm reveals the following: a) the WFSBP recommends pharmacologic interventions designed to suppress both paraphilic and conventional sexual interests b) increasing levels of risk are dealt with more significant suppression of sex drive and use of intra-muscular injections. The use of anti-androgens during the first month of treatment with GnRHa's is due to the possibility of a “testosterone surge” resulting in the theoretical possibility of an increase in risk, unless countered by an anti-androgen.

The Sexual Behaviors Clinic (SBC) Experience

The WFSBP is an important document but is not intended to establish a standard of care. The SBC has assessed and treated adolescents and adults (men and women) with paraphilic sexual disorders for almost 30 years.

First, new patients receive a complete psychiatric and sexual behaviors assessment, which includes blood tests: a CBC, kidney and liver functions screen, and sex hormone profile. Their previous records, including previous pharmacologic treatments, are reviewed. They also are provided with the opportunity to have a base-line phallometry assessment and to complete a battery of self-rated questionnaires. Results are reviewed in detail with the patient before any medications are prescribed. There are four reasons for this approach. First, it provides the

(continued on page 22)

TABLE 1

Study design	MPA	CPA	Triptorelin	Leuprorelin
Double blind/Cross-over	3	5*	0	0
Open	9	5	2	4
Retrospective	1	0	1	2*
Comments		* 1 single blind		* 1 case report

CPA – Cyproterone Acetate (Not available in the USA)
MPA – Medroxyprogesterone Acetate

Sexual Disorders

continued from page 21

necessary base-line data and assists in diagnosis and treatment planning. Second, it establishes a treatment paradigm in which the patient's concerns and needs take priority. Occasionally, patients need to be reminded that their wish to not be re-arrested is the same as society's. Third, this approach emphasizes that the SBC is a University-affiliated clinical research program in which state of the art treatment is provided. Therefore it is necessary to consider each intervention an "experiment" from which we will learn what works and what doesn't. While there are guidelines, each person is unique. And fourth, this approach helps to make clear that sexual behaviors are not irresistible impulses. It is not uncommon to have "high risk" offenders delivered following release from jail with a systemic request for immediate "chemical castration" (or worse). Patients always respond favorably when they are informed that the treatment is something to be considered calmly and collaboratively.

A working diagnosis or diagnoses are established by the end of the first session, together with a differential diagnosis and plan for further investigations or additional information, as needed.

At the next meeting, the available treatment interventions (pharmacologic and nonpharmacologic) are reviewed with the patient. They are told about the risks and benefits of medications and the decision to decline medications. Medications are selected first to treat concurrent psychiatric conditions. For example, a man with pedophilia and major depression would be offered medication to treat his depression. It is not uncommon for patients to experience a significant diminution in problems related to paraphilic interests once their mood, anxiety, substance abuse, or schizophrenia, has been effectively treated.

In the SBC, problems are treated simultaneously and from multiple perspectives.

All patients with paraphilic disorders are told about SSRIs, anti-androgens, and GnRH analogues. They are informed the choice is theirs and that they are free to change their choice any time. Not only is this ethical, it also places responsibility for harm-avoidance on the patient. Patients who understand they are in charge are much more disclosing than those who think the treatment is punishment.

Increasingly, the most popular choice of SBC patients is GnRH analogues. This is a change from treatment patterns 15 years ago when SSRI medications, or no medication were easily the most popular choice of patients⁵. There are three possible reasons for the change. The first is that GnRH medications have few side effects aside from "hot flashes," osteoporosis, and expense. Patients

typically describe the effect of the medication as like "going on vacation." Second, most of the higher risk SBC patients attend group therapy where they notice that men on GnRH medications seem to be doing well. It is not uncommon to be asked, "What is he on? Can I get that too?" Third, current SBC policy is to fully respect consent to treatment. When treatment options are discussed, especially GnRH treatment options, they are always presented as reversible "experiments." Specifically, they are told about the medication and that only they will know if it is working. If it is not helping them, they are encouraged to say so. Men who are presented with a medication that can reliably reduce their sex drive until they are ready and interested in a respectful noncriminal relationship

(continued on page 30)

TABLE 2

RISK LEVEL	Paraphilic symptoms	Impact on conventional sex	Medication(s)	Evidence*
1	Lowest risk	None	None	C
2	"Hands-off"	Mild reduction	SSRI's	C
3	Non-sadistic/ No penetration	Moderate reduction	SSRI + low dose anti-androgen (e.g. CPA or MPA 50-100 mg/day p.o.)	D
4	Moderate to high risk sex violence	Substantial reduction	CPA or MPA 50 – 300/day	C
5	High risk/ sadism/Poor compliance	Almost complete reduction	GnRH agonist: triptorelin or leuprolide 11.25 mg i.m. every 3 months + CPA or MPA for first month	C
6	Catastrophic	Complete suppression	MPA 300-500 mg/week i.m. weekly + GnRH agonists as in level 5	D

SSRI = selective serotonergic reuptake inhibitor

CPA = cyproterone acetate (not available in the United States)

MPA = medroxyprogesterone acetate

GnRH – gonadotropin releasing hormone

i.m. = intramuscular

p.o. = oral

* = Rated according to Cochrane System

Cultural Factors in Competence to Stand Trial Evaluations: *Interpretation Beyond Translation*

Chinmoy Gulrajani MD, Cross-Cultural Committee

The borough of Brooklyn in New York City has an approximate population of 2.5 million¹ more than a third of whom were born outside of the United States¹. A staggering forty five percent of this population speak a language other than English at home¹, making this one of the most culturally diverse geographical areas in the country. About 25% of Brooklyn residents describe their ability to communicate in English as “less than very well.”¹ Needless to say, this cultural diversity is reflected in the criminal justice system and it is no surprise, then, that the New York City Court System provides interpreter services in over 100 languages². In my short tenure with the clinical team responsible for performing court ordered forensic psychiatric evaluations in Brooklyn, I have had the opportunity to evaluate numerous non-English speaking, migrant criminal defendants, with the assistance of the court interpreter services. From the very beginning, these cases have held my fascination, since I, like many of my evaluatees, am a foreign born migrant residing in Brooklyn. One such evaluation prompted me to write this piece:

Case: Mr. PK [not his real name] was a non-English speaking East Indian migrant who had allegedly assaulted his girlfriend in a fit of rage. He was scheduled to be evaluated by our team for assessment of his competence to stand trial, with the assistance of a bilingual court interpreter, fluent in Hindi, Mr. PK’s native tongue. Unbeknownst to all present, I am fluent in Hindi as well, a fact that I could not hold secret for any length of time into the interview. For, no sooner had we started the interview, I realized, to my horror, that the interpreter was making gross errors in translation. Frequently, instead of translating the defendant’s responses verbatim, he chose to provide us with his own inter-

pretation of these responses. Similarly, he chose to present the defendant with his interpretation of some of our questions. For other questions, he prompted the defendant without being asked to, so that the defendant’s true response was contaminated and it became impossible to assess the defendant’s actual level of awareness. This was especially true for legal terms for which there is no equivalent in the foreign language. As the interview segued into a discussion of the legal case, it was quite obvious to me that

“As the interview progressed, the interpreter’s irritation with the defendant rose to a point where he started berating the defendant.”

the defendant, albeit willing to plead guilty, could neither grasp the notion of bargaining with the prosecution over the penalty, nor the fact that he could choose to plead otherwise and present his case to the jury, since these were culturally alien concepts to him.

Of utmost concern however, were the interpreter’s maltreatment and his growing resentment of the defendant. As the interview progressed, the interpreter’s irritation with the defendant rose to a point where he started berating the defendant. When the defendant narrated the events that led to his arrest, the interpreter admonished him for his actions and hinted that the defendant deserved his present fate. At this point I could contain myself no further and stepped in to interrupt the interview. When I confronted the interpreter with his attitude, he told me

quite matter of factly that the defendant hailed from a lower social class than him and that he was ashamed of individuals like the defendant who tarnished the otherwise impeccable reputation of working class migrants hailing from India. It was only after I threatened not to utilize his services again that the interpreter agreed to control his temper and keep his contempt of the defendant in check for the remainder of the evaluation.

There is a small but growing body of literature focused on issues specific to communication barriers encountered with populations not proficient in English⁸ that can impact the quality of nonforensic psychiatric assessments. Existing literature suggests that psychiatric assessments may be compromised if conducted in a non-native language¹⁰ but that the use of professional interpreters is associated with increased disclosure of traumatic events and psychological symptoms¹². Use of ad-hoc interpreters (friends, family or bi-lingual staff) is problematic because it may lead to erroneous assessments since it may impede disclosure of sensitive material^{11,12} and contribute to distortions¹¹. Even when appropriate interpreter services are utilized, quality of psychiatric evaluation and care can be compromised. Several interpreter-specific sources of error have been identified. These include: interpreters’ inadequate language proficiency; their lack of psychiatric knowledge, leading to normalization of patients’ disordered thought process; interjection of interpreter’s attitudes; editorializing comments; and prompting by interpreters^{13,14}. Moreover, authors disagree on whether interpreters should provide literal translations only and avoid attempts to clarify the speaker’s intent or play an expanded role as cultural brokers¹⁵.

The importance of cultural influences is well recognized in forensic psychiatric evaluations conducted on foreign nationals seeking asylum⁷. In the criminal setting, psychiatrists have robustly investigated the role of cultural influences for the purpose of explaining motive, and by doing so,

(continued on page 24)

Cultural Factors

continued from page 23

looking toward the mitigation of the sentence⁸. Emphasizing the complexities of the evaluatees' cultural underpinnings, experts have promulgated the use of the Cultural Formulation that was first presented in the DSM-IV-TR⁹. And while literature is replete with anecdotal reports (like the case above) describing the influence of cultural factors in forensic psychiatric evaluations, the bulk of research tackling the issue of cultural diversity in the forensic psychiatric setting is centered not on culturally, but rather racially distinct sub groups³. Moreover, few studies have addressed this question in the context of competency evaluations³. Studies have noted that African Americans are over-represented in categories associated with incompetence and with the diagnosis of psychotic illness^{4,5}. Authors have speculated that members of ethnic minorities are also more likely to be perceived as irrational, and their opinions are more likely to be discounted by mental health workers, judges and attorneys^{5,6}.

The *Dusky* standard embodies a cultural notion of fundamental fairness and leaves open the possibility that cultural differences could justify a finding of incompetence¹⁶. Moreover, competence to stand trial is the most common of forensic psychiatric evaluations making it one of the most vital determinations in the course of justice. In sharp contrast to other criminal forensic evaluations, it hinges on the defendant's present mental state. The AAPL Practice Guidelines for the Forensic Psychiatric Evaluation of Competence to Stand Trial enumerate seven factors important to culturally competent evaluations that may come into play when evaluating adjudicative competence of individuals from non-dominant cultures¹⁶. These include nuanced discussions of issues such as cultural identity, transference-countertransference and communication styles. However, the guidelines acknowledge that psychiatrists will inevitably encounter novel situations

and emphasize that an increasingly multicultural America is generating new demands, challenges, and stresses for psychiatric assessments and the law¹⁶.

In the absence of systematic research that deals with the influence of cultural factors on competence to stand trial, an obvious dilemma is highlighted. Often times, as demonstrated by the case of Mr. PK above, psychiatrists are left to rely on their instincts and experience [or those of a lay interpreter] to form opinions about defendants whose cultural influences are poorly understood. Since Judges often give considerable deference to psychiatric experts, especially in competence determinations, this becomes the perfect breeding ground for erroneous interpretation and application of legal standards in the cultural context.

In conclusion, by way of this article I highlight the dynamic nature and evolving concept of competence to stand trial in the cultural context and hope that readers will be motivated to share their own experience and add to the scant body of literature in this arena. ☪

References:

1. 2009 American Community Survey, <http://factfinder.census.gov>
2. <http://www.nycourts.gov/courtinterpreter>
3. Hicks JW: Ethnicity, race, and forensic psychiatry: are we colorblind? *J Am Acad Psychiatry Law* 32:21-33, 2004
4. Sundsmo, Alecia, "Examining the Role of Race and Ethnicity in Competency to Stand Trial Evaluations" (2007). *School of Professional Psychology*. Paper 45.
5. Stefan S: Race, competence testing, and disability law: a review of the MacArthur Competence Research. *Psychol Public Policy Law* 2:31-44, 1996.
6. EF Foulks, Commentary: racial bias in diagnosis and medication of mentally ill minorities in prisons and communities. *J Am Acad Psychiatry Law*, Mar 2004; 32: 34 - 35.
7. Susan M. Meffert, Karen Musalo, Dale E. McNeil, and Renée L. Binder, The Role of Mental Health Professionals in Political Asylum Processing. *J Am Acad Psychiatry Law*, Dec 2010; 38: 479 - 489.
8. James K. Boehnlein, Michele N. Schaefer, Joseph D. Bloom, Cultural Considerations in the Criminal Law: The Sentencing Process. *J Am Acad Psychiatry Law*, 2005;

33:335-41

9. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-TR (DSM-IV-TR). Washington, DC: American Psychiatric Press, 2000.

10. Haasen C, Yagdiran O, Mass R, et al: Potential for misdiagnosis among Turkish migrants with psychotic disorders: a clinical controlled study in Germany. *Acta Psychiatrica Scandinavica* 101:125-129, 2000.

11. Marcos LR: Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients. *American Journal of Psychiatry* 136:171-174, 1979.

12. Bischoff A, Bovier PA, Rrustemi I, et al: Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral. *Social Science and Medicine* 57:503-512, 2003.

13. Price J: Foreign language interpreting in psychiatric practice. *Australian and New Zealand Journal of Psychiatry* 9:263-267, 1975

14. Farooq S, Fear C, Oyebode F: An investigation of the adequacy of psychiatric interviews conducted through an interpreter. *Psychiatric Bulletin* 21:209-213, 1997.

15. Bauer AM, Alegría M. Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: a systematic review. *Psychiatric Services* 2010 Aug; 61(8):765-73.

16. Douglas Mossman, Stephen G. Noffsinger, Peter Ash, Richard L. Frierson, Joan Gerbasi, Maureen Hackett, Catherine F. Lewis, Debra A. Pinals, Charles L. Scott, Karl G. Sieg, Barry W. Wall, and Howard V. Zonana AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial *J Am Acad Psychiatry Law*, Dec 2007; 35: S3 - S72.

Moving Forward

continued from page 4

speakers, and I encourage you to do the same. This year's speakers will tell fascinating forensic stories which will provide a nice balance to the rest of the program. Dennis Maher will discuss his experience of being wrongfully convicted of a series of sexual assaults. The journalist Pete Earley will speak about his son with bipolar disorder who was caught up in the criminal justice system. And Gary Philips will talk of his experience as a federal agent investigating child exploitation in Southeast Asia. It promises to be a terrific meeting. See you there! ☪

Letter to the Editor

Dear Editor,

In the AAPL April 2011 Newsletter, there was an article by the Psychopharmacology Committee from the panel that presented on substance abuse. My question is; why did that end up with a 100% emphasis regarding marijuana? Why was marijuana chosen? I believe methamphetamine to be a far more serious national problem, and far more destructive to the CNS?

Best wishes,
Larry K. Richards MD

Response:

Point of clarification: the article regarding cannabis-related psychosis was submitted by the Addiction Psychiatry Committee, not the Psychopharmacology Committee.

The topic was chosen since cannabis-related psychosis is an area of increasing current research and interest, due in part to the widespread increase in “medical marijuana” dispensaries and higher-potency THC products. While methamphetamine-related psychosis has been better studied and well established, cannabis-related psychosis is more controversial and has variable presentation in individuals.

For this reason, the committee chose to present a brief review of cannabis-related psychosis and its potential forensic implications.

Methamphetamine-related psychosis, agreed, is a serious problem with many forensic implications, and may be a future topic for the Addiction Psychiatry Committee.

Sincerely,

Gregory Sokolov MD, Chair
Addiction Psychiatry Committee

Royal College

continued from page 19

before the conference dinner there was opportunity for those so inclined to participate in a fun run around the streets of Berlin.

On the last day Professor Marvin Swartz, Duke University School of Medicine, North Carolina and Professor Tom Burns, University of Oxford, gave an insight from both sides of the Atlantic on involuntary community treatment. The conference ended with a fascinating case presentation by Dr Tim Exworthy of the Institute of Psychiatry, London, on a “not guilty by reason of insanity” case with lively input from the audience.

Dr. James Reynolds from Missouri, AAPL-Midwest Treasurer, was honored to be chosen to present a poster on an interesting case from his facility, in concert with a medical student from London whom he had hosted for a clerkship. Dr. Reynolds valued the opportunity to socialize with

and learn from his British colleagues, who were friendly and patient in answering the many questions of an international guest, and he wishes to give a hearty endorsement for AAPL members to make a point of attending this meeting at least once, and maybe answering their “Call for Papers.” Although the systems of healthcare and justice in our two countries have many differences, the basic principles of good forensic psychiatric practice translate very well across the Atlantic. The session on “Avoiding Grief in Court” gave valuable pointers that any expert witness, British or American, should bear in mind when preparing for court.

Informal comment from delegates on all aspects of the event, the venue, the academic content and the social side were all very positive. Next year’s venue is still to be decided but will be worth putting in diaries when it is announced. As ever, colleagues from AAPL will be made most welcome. ☺

More than just medical malpractice insurance...

You need a medical professional liability insurance program that is more than just a policy. To safeguard your practice and reputation, you need a **real program** that includes proactive risk management resources and strategies, offers expert advice on call, and boasts a proven claims defense record.

Anything else is risky business.

That’s why you should trust
The Psychiatrists’ Program.

• We have handled more than 18,000 psychiatric claims. More than any other company in the world.

• In-house risk management helps you avoid risk; and includes free CME seminars, online resources and toll-free helpline.

• Occurrence and claims-made policies available.*

• Premium discounts - and much more!

The Psychiatrists’ Program®

www.PsychProgram.com
TheProgram@prms.com
Individual: +1 (800) 245 3333 ext. 389
Group: +1 (800) 245 3333 ext. 310

Managed and owned by:



Follow us on Twitter!

www.twitter.com/PsychProgram

PRMS

For over 25 years, providing medical professional liability insurance exclusively for psychiatrists

*may vary by state

Gutmacher Award

continued from page 1

performance, and employment history. A person's work capacity, therefore is the balance between supply and demand. The determination of permanent impairment requires an assessment of work capacity over time. For example, if Dr. Smith falls ill and makes the judgment to call in sick that day, it is because he has realized that on that day, his work demand is greater than his work supply. The work capacity must be below a minimal functional level for some period of time, before the person feels so impaired that they judge themselves to be disabled. The evaluator should review the longitudinal work history, including failure to progress at work, administrative

“The central opinion is then whether the symptoms lead to impairment in work functioning, and utilizing the proposed model is helpful in conceptualizing this.”

leaves, and poor performance evaluations, contrasted with good evaluations, steady promotions, and job stability.

The case formulation includes personal health, family health, finances, social support, marital and living circumstances, and criminal and civil litigation. Both the case formulation and model are used. The central opinion is then whether the symptoms lead to impairment in work functioning, and utilizing the proposed model is helpful in conceptualizing this. Multiple case examples were given to help apply these concepts. And there was no shortage of cartoons, Monty Python quotes, or pictures to keep the audience—who chose Dr. Gold's talk over the Hawaiian beaches—engaged. ☞

Annual Meeting

continued from page 20

in our last newsletter on AMA's position regarding marijuana. The newsletter stated that AMA would urge marijuana's status be re-scheduled to a status either equal to or less restrictive than the Schedule III status of synthetic THC, in part to increase availability of cannabinoid medications to patients in need. In fact, that was the wording of a resolution that failed to pass the AMA House of Delegates. Rather, AMA recognized that such rescheduling would not be reasonable at this time given the paucity of evidence to indicate benefits of marijuana use and the far more significant evidence indicating risks of such use. However, the AMA delegates also recognized that research on marijuana use would be appropriate. The passed resolution asks that the AMA work with appropriate parties to develop federal legislation that will allow research to more readily take place with marijuana, perhaps moving it from Schedule I into a special Schedule, as none of the other currently available Schedules are fitting for the plant. This vote was consistent with information and recommendations provided to the AMA House by the AMA Council on Science & Public Health one year earlier. ☞

Ask the Experts

continued from page 12

guidance. That usually solves the problem rather quickly.

Sadoff/Kaye: Take home point: Redacted records and legal stipulations place an additional burden on experts that requires even greater vigilance. However, we are invited guests in the courtroom and we must respect the legal agreements reached by the parties as conditions to the litigation. Consultation with the referring attorney is critical. An expert should always feel comfortable recusing herself/himself at any point, if the conditions change to the degree that the expert feels pressure to act unethically. ☞

Slate Announced

The slate of officers and councilors who will take office at the end of the Annual Meeting in October was announced at the Semiannual Business Meeting held May 15, 2011. No additional nominations were made and the nominations were closed as specified in the AAPL Bylaws. There will be a vote at the Annual Business Meeting Saturday, October 29, to elect the slate as presented.

Nominees are: President-elect: Debra Pinals MD, Vice Presidents: Liza Gold MD and Marilyn Price MD; Secretary: Stuart Anfang MD; Treasurer: Douglas Mossman MD; Councilors: Philip Candilis MD; Steven K. Hoge MD and Gregory Sokolov MD.

MUSE & VIEWS

Actual quotes from our nation's mayors about “Crime and Justice”!

The streets are safe in Philadelphia. It's only the people who make them unsafe.
Mayor Frank Rizzo

Life is indeed precious, and I believe the death penalty helps affirm this fact.
Mayor Ed Koch

I haven't committed a crime. What I did was fail to comply with the law.
Mayor David Dinkins

If you take out the killings, Washington actually has a very low crime rate.
Mayor Marion Barry

Source: <http://www.dumb-quotes.com/>

Submitted by Charles L. Scott MD

The American Academy of Forensic Sciences (AAFS) Meets in Chicago

John Young MD

The blustery Chicago winter provided a stimulating backdrop for thousands of forensic scientists attending the 63rd Annual Scientific Meeting of the American Academy of Forensic Sciences, February 21-26, 2011. Over the course of its history since the mid-twentieth century, the Academy has come to incorporate eleven sections representing the different varieties of forensic sciences. The Psychiatry and Behavioral Science Section currently has just over 150 psychiatrist and psychologist members. Most recently added was the Digital and Multimedia Sciences Section.

The conference theme was "Reliable, Relevant and Valid Forensic Science: Eleven Sections – One Academy." As a whole, the field of forensic science has come under active public questioning and scrutiny, including a proposal of legislation at the federal level to establish a national monitoring body. Most of the time national attention focuses on other issues, but the popularity of crime shows on television evidences a strong if latent interest in the field. Whenever a case excites national attention, the realities that come to light tend to stimulate calls for legislative reforms of the standards used in forensic investigations. In recognition of this, the meeting opened with a plenary debate entitled "Relevant, Reliable and Valid Forensic Science – From the Laboratory to the Courtroom." Two prominent attorneys, Rockne P. Harmon from Alameda, California and Peter Neufeld of the Innocence Project, debated the extent and implications of recent cases and developments. Questions from the large audience enlivened the discussion.

All section programs were available to everyone attending the meeting. The program for the Psychiatry and Behavioral Science Section included 36 presentations on a wide range of topics from eight countries (of the nearly sixty represented at the meeting).

Five papers focused directly on sexual offending. Dean De Crisce gave a

helpful organized review of the evolving differences of opinion regarding use of the diagnosis of paraphilia in the evaluation of sex offenders. Elizabeth Gilday presented the intriguing disturbing case of a necrophiliac morgue attendant. Nicholas Longpré skillfully dissected the associations of sexual sadism with other paraphilias and psychopathy. Felice Carabellese presented two informative cases of rape by elderly individuals. Roberto Catanesi utilized the case of a bipolar female stalker to distinguish critically the essential from the coincidental connections between stalking and mental disorder.

Five presenters covered broader evaluation issues. Qinting Zhang presented the results from a large and impressive study of a scale for the evaluation of civil capacities of disabled individuals. Steven Ciric described strenuous efforts to continue high quality evaluations despite the effects of fiscal restraint. Robert E. Remez with Kelly R. Damphousse and James D. Harnesberger gave an informative report on the relevance of current complex research in speech and voice analysis for detecting lies. Robert M. Tovar described the details of a sophis-

ticated protocol to enhance the quality and reliability of interviews conducted through interpreters. Felice Carabellese reported informatively on protective and risk-increasing factors for the development of PTSD among 18 survivors of a plane crash studied in detail by an 8-member interdisciplinary team.

Specific areas of forensic evaluation formed the focus of several papers. Weixiong Cai and Qinting Zhang offered the results of a meticulous study of event related (evoked) potentials in combination with other testing to meet the complex challenges of evaluating patients after brain trauma. Timothy Botello with Lakshmanan Sathyavagiswaran and Linda E. Weinberger and Bruce H. Gross gave a fascinating account of the 50-year evolution of psychological autopsies as originated and still carried out by the Los Angeles County Coroner Medical Examiner's office. Carla Carriera told the moving story of how forensic medical experts were helpful in addressing the complex needs of transsexuals. Sanford Finkel offered a rich and detailed update on how current secular changes affect the evaluation of testamentary capacity and undue influence. Finally two papers dealt with killings of relatives: Laura Volpini and Luciano Garofano explored psychological risk factors in hopes of improving prevention, and Eleanor B. Vo presented on some important differ-

(continued on page 28)



AAFS President Joseph P. Bono presenting the Academy's Distinguished Fellow Award to Richard Rosner, Past President of AAFS and AAPL.

Scientific Meeting

continued from page 27

ences found between psychotic and non-psychotic parricides.

Five presenters talked about work with juveniles. Zachary D. Torry gave a practical account of how to sort out and respond to the effects and impact of antisocial parents on the developing child. Christopher R. Thompson gave a useful concise update on the continuing efforts to either validate or rule out the construct of juvenile psychopathy. Abigail M. Judge neatly summarized the current literature on the identification, risk assessment and treatment of problematic sexual behavior among juveniles. Eugene Lee and Stephen B. Billick provided a usefully detailed and thoughtful analysis of forensic implications that arise from key differences between adolescents and adults. Valeria Santoro and Antonella Scorca drew interesting preliminary correlations between early childhood dental caries and child neglect, again illustrating the value of promoting collaboration across forensic sciences.

Advancing technology was another theme, especially obvious in five of the sessions. Karen B. Rosenbaum, Katherine M. Brown, Amanda L. Farrell and Leila Dutton teamed up for a detailed and compelling account of how various Internet sites are beginning to figure in such crimes as bullying and stalking, and how collaboration across forensic sciences can best address the many issues they raise. Muhammad Saleem presented a substantial literature review of the growing impact of fMRI and the need for scientific foundation before it can be validly applied to forensic psychiatric issues. Lorente Miguel discussed recent use of GPS devices to substantially reduce the risk of violence against women in Spain. James S. Walker, Stephen A. Montgomery and William Bernet presented interesting preliminary data regarding a gene variant called MAOA that could figure in part in accounting for some aggressive behavior, illustrating a need for wide knowledge of behavioral genetics in the forensic arena.

A few presentations touched on substance abuse matters. Manuel Lopez-Leon reflected adolescent trends,

including their increasing drug arrest rates and the potential contribution of drug courts. Niamh NicDaeid correlated fire fatalities and the use of drugs and alcohol. Liqun Wong compared indicators of substances from various national and local sources of data.

Some interesting cultural aspects also added value and variety to the program. Giuseppe Troccoli described a case of Italian criminal-style ligature strangulation. Richard Rosner shared his personal observations on an interesting variety of issues from his experiences on an invited speaking trip to Japan. Maurizio Chiesi provided an Italian perspective on homicide-suicide based on 578 cases. Rupali Chadha did some consciousness-raising on the reality of honor killing in the U.S.

Ethical issues also received significant attention. In particular there was a discussion by Vivian Shnaidman of women who had affairs with their inmate patients. Robert Weinstock provided a detailed account of the handling of assessments of competency to be executed. This author described the differing contributions of distinct causal elements in assessing the moral and legal aspects of behavior. Susan M. Gray organized some well-considered instructions for balancing the right to a speedy arraignment and the right to psychiatric care.

Emanuel Tanay gave a colorful and informative breakfast seminar presentation classifying a long list of forensically notorious killers. Other breakfast offers included "Coping With the CSI Effect," "Lightning Strikes Twice: The Case of a Femme Fatale," discussions of criminal profiling, and a friendly debate between a British forensic pathologist and his American counterpart. There were also multidisciplinary workshops and luncheon seminars. Two evening sessions were on offer; one, providing a challenging assessment of the state of forensic analysis and trial testimony by Cyril H. Wecht, Michael Welner and Henry C. Lee; and at the other session, nine speakers focused on the details from several forensic angles, including the 2005 exhumation of the body of Emmett Till.

AAFS will hold its next meeting in Atlanta February 20-25, 2012. Further information is available at www.aafs.org. ☯

RFPs for AAPL Institute

The AAPL Institute for Education and Research (AIER) accepts submissions for educational and research grants on March 1 and August 1.

AIER was developed as a 501 (c) (3) corporation to stimulate educational and research activities, provide educational resources and activities, and aid education and research by encouraging tax-exempt donations to forensic education and research programs.

AAPL members are encouraged to apply for educational grants to develop an innovative educational product or for research grants to conduct research in forensic psychiatry. AAPL members can collaborate with non-AAPL members but the lead developer of the educational projects or the principal investigator of research submissions must be an AAPL member.

The Education Committee will consider proposals for educational projects that will benefit forensic psychiatry, forensic psychiatry trainees, and other professionals.

The Research Committee will consider proposals for research that advances the field of forensic psychiatry.

Awards can be used for production of materials, data analysis and collection, and salary support to free up time to work on this project.

Funds may be used to purchase technology needed for the project that is not otherwise available. The reviewers reserve the opportunity to request further information about proposed purchases or uses of specific technology.

Indirect costs are not covered, and funds cannot be used for travel and lodging to the AAPL meeting where members generally pay for themselves.

Proposals should be submitted for no more than \$15,000. Proposals for smaller amounts are encouraged.

Requirements for submissions are available from the AAPL office. ☯

DSM-5 PTSD

continued from page 18

to satisfy it. Threats vary in the likelihood of their being realized and the severity of physical harm they are likely to produce. Moreover, the perceived and objective magnitude of a threat may significantly differ.

Noting that an event's objective characteristics are central to whether it fulfills the stressor component, and specifying the physical and temporal proximity required of a threat, would facilitate uniform application of the stressor criterion. If PTSD is to fundamentally denote a psychiatric condition which arises from exposure to a significant (objective) environmental threat of serious (physical) harm, the stressor criterion must be as clearly and precisely defined as language and scientific knowledge permit.

In conclusion, the proposed DSM-5 PTSD stressor criterion constructively addresses several forensic psychiatric difficulties created by the DSM-IV-TR PTSD stressor criterion. However, the addition of "actual or threatened sexual violation" to the stressor criterion would produce profound definitional ambiguity and generate further controversial forensic psychiatric use of this diagnosis. The new stressor criterion should be modified so that it does not create more psychiatric-legal difficulties than it resolves. ☎

References:

1. Slovenko, R., (2011). The DSM in Litigation and Legislation. *The Journal of the American Academy of Psychiatry and the Law*, 39, 6-11.
2. Luz, M. P., et. al., (2011). PTSD Criterion A1 Events: A Literature-Based Categorization. *Journal of Traumatic Stress*, 24 (3), 243-251.
3. Breslau, N., et. al. (1998) Trauma and Posttraumatic Stress Disorder in the Community – The Detroit Area Survey of Trauma. *Archives of General Psychiatry*, 55, 626-632.
4. Mancini, A.D., Prati, G., Black, S., (2011). Self-Worth Mediates the Effects of Violent Loss on PTSD Symptoms. *Journal of Traumatic Stress*, 24 (1), 116-120.

Forensic Psychiatry

continued from page 13

Training (CCT) can apply to continue in their post for a maximum of six months while they seek consultant level employment.

Trainees are supervised in each post by Clinical Supervisors, (Consultant Forensic Psychiatrists), who are approved as suitable trainers by the GMC on advice from Deaneries and the Royal College of Psychiatrists. The Clinical Supervisor in each placement is required to spend one hour per week in personal face to face supervision with each trainee, not including the periods required to complete workplace based and other assessments. Clinical supervisors are assisted by Educational Supervisors, i.e. Consultant Forensic Psychiatrists, appointed to provide individual mentoring and monitoring to a number of trainees throughout their three year training pathway. Educational Supervisors ensure that each trainee is provided with a variety of training experiences and challenges at increasing levels of complexity as their training progresses.

Training programs are organized by Training Program Directors, (TPD), who are responsible to the Deanery and to the Directors of Medical Education in Trusts. TPDs organize the academic programs, support trainees and trainers, manage placements and ensure the scheme provides the widest possible variety of opportunities so that, in addition to training in clinical and legal matters, trainees reach the required standards of competence in audit, research, teaching, management and leadership. TPDs facilitate information flow between the Deanery, trainees, and supervisors and sit on appointments panels. They are members of the Deanery Specialty Trainee Committee in Forensic Psychiatry, which also has a trainee representative. This body manages the Annual Review of Competence Progress (ARCP) by which trainees move through the training period. If a trainee needs extra training to

achieve competence, targeted training can be directed at the yearly reviews and the training period can also be extended.

Training schemes are subject to yearly quality assurance reviews by the Deaneries, who audit the Trusts, hospitals, and institutions which provide training. Training in all branches of psychiatry is reviewed by a team which includes independent doctors and Deanery personnel.

It is an exciting time to be a trainee or an educator in the specialty.

Dr. Mary Whittle is Consultant Forensic Psychiatrist and Training Program Director, North East London Specialty Training Scheme in Forensic Psychiatry and Chair of Specialty Training Committee in Forensic Psychiatry, London Deanery, London, UK. ☎

References:

1. In conversation with John Gunn. Grounds A, Gordon H. *Psychiatric Bulletin* (2007) 31: 25-28
2. Seminars in Practical Forensic Psychiatry. Eds. Chiswick D & Cope R. Royal College of Psychiatrists: Gaskell (1995)
3. Royal College of Psychiatrists and London Deanery: personal communications
4. <http://www.gmc-uk.org/education/post-graduate>
5. A competency based curriculum for Specialist Training in Psychiatry: Specialists in Forensic Psychiatry, Royal College of Psychiatrists (February 2010); www.rcpsych.ac.uk/training/curriculum2010.aspx
6. A Reference Guide for Postgraduate Specialty Training in the UK: *The Gold Guide; Fourth Edition* (June 2010). <http://www.mmc.nhs.uk/pdf/gold>

AAPL Committees

AAPL members who are interested in serving on committees for a three-year term beginning on October 31, 2011 are invited to send a letter to the Executive Office by October 31, 2011. Committee members must be full voting members of AAPL. The President-Elect, Charles Scott MD will be making appointments after the Annual Meeting. Letters should indicate particular interests or qualifications for the committee appointment desired.

Sexual Disorders

continued from page 22

are much more compliant than men who are informed they are about to be chemically castrated “in perpetuity.” whether they like it or not.

Summary

Judging from the year after year reduction in sex crimes, it is hard to dispute that treatment of sex offenders has improved⁶. Five year recidivism rates, even without modern pharmaceutical treatments are now below 15%⁷. The SBC experience is that patients with paraphilic disorders are willing and eager to get better. Compliance is rarely an issue when treatment options are presented in a therapeutic context. While double blind studies in this field are rare, the consistent drop in sex crimes and numbers of victims suggest the field is on the right track. ☺

References

1. Fedoroff, J.P., Paraphilic Worlds, in Handbook of Clinical Sexuality for Mental Health Professionals S.B. Levine, Editor 2010, Routledge New York, Chapter: New York. p. 401-424.
2. Thibaut, F., et al., The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for biological treatment of paraphilias. World Journal of Biological Psychiatry, 2010. 11: p. 604-655.
3. Fedoroff, J.P., Serotonergic drug treatment of deviant sexual interests. Annals of Sex Research, 1994. 6: p. 105-107.
4. Fedoroff, J.P., et al., Sexual disorders in Huntington's disease. The Journal of Neuropsychiatry and Clinical Neurosciences, 1994. 6: p. 147-153.
5. Fedoroff, J.P., Antiandrogens vs. Serotonergic Medications in the Treatment of Sex Offenders: A Preliminary Compliance Study. The Canadian Journal of Human Sexuality, 1995. 4: p. 111-122.
6. Fedoroff, J.P., The Paraphilias In: Michael G. Gelder, Nancy C. Andereasen, Juan J. Lopez-Iber, Jr., John R. Beddes (Eds). *The New Oxford Textbook of Psychiatry*, 2nd Edition, M.G. Gelder, et al., Editors. 2009, Oxford University Press: Oxford p. 832-842.
7. Hanson, R.K. and K.E. Morton-Bourgon, Predictors of Sexual Recidivism: An updated meta-analysis. Research Rep. No. 2004-02 Ottawa, Canada: Public Safety and Emergency Preparedness Canada., 2004.

Program Committee

continued from page 32

drug task forces and as the case agent of hundreds of criminal investigations. In May 2002, Agent Phillips was transferred to the U.S. Embassy in Bangkok, Thailand where he was the Assistant Attaché. While overseas, Agent Phillips was the first U.S. agent to investigate and utilize a new law called the U.S. PROTECT ACT of 2003. The PROTECT ACT criminalizes illicit sexual conduct with persons under eighteen while traveling abroad, and establishes extraterritorial jurisdiction over the crimes. Special Agent Phillips presents a riveting description of how he personally pursued US citizens through the dark Far East underworld of child sex tourism and subsequently assisted in the first prosecution of these overseas sexual offenders.

The AAPL Program Committee is also appreciative of the efforts of the Education Committee that has generously offered to provide updates to our members regarding the Maintenance of Certification (MOC) requirements from the American Board of Psychiatry and the Neurology (ABPN). On Friday, October 29, 2011, from 7:00 a.m. to 8:00 a.m. Dr. Larry Faulkner, along with other AAPL members, will be personally available to review the requirements for self-assessment and performance in practice: what you need to do to keep current and to maintain your certification.

Dr. Thompson and I wish to thank the members of the Program Committee as well as members from other committees who worked very hard to pull this program together. We also wish to extend our incredible appreciation to Jackie Coleman and the entire AAPL office for their amazing dedication to our organization. Jackie Coleman and her team really make this happen! Finally, I am pleased to announce that the Program Chair for the 2012 conference is James Knoll, MD. I know he will do a fantastic job in planning the program for the 2012 conference in Montreal. ☺

BC/BE Psychiatrists
Oregon State Hospital (OSH)
Salem, Oregon

Oregon State Hospital is looking for BC/BE psychiatrists. You will work in a brand new hospital that incorporates modern architecture, treatment spaces, and technologies. Salary is very competitive and includes psychiatric differential, board certification pay, and opportunities for additional on-call work. OSH offers opportunities in our general adult, geriatric, and forensic programs. A generous and comprehensive benefit and PERS retirement package is included as well as opportunities to have an academic appointment with the Oregon Health Sciences University. Phone: (503) 945-2887; email: lila.m.lokey@state.or.us; fax: (503) 945-9910; www.oregon.gov/DHS/mental-health/osh. The State of Oregon is an Equal Opportunity Employer.

MUSE & VIEWS

“The ideal psychiatric expert witness is generally conceived of as objective, unbiased and uninformed in the outcome of the trial in which he is testifying. Nevertheless, the expert witness must inevitably act as advocate, either willingly or unwillingly, either with or without awareness. To accept the advocate role and to pursue it intentionally from the witness stand is honest and ethical if done without deceit. Such advocacy may result in important legal reforms, in benefits to the participants in the trial process and in improvements in the relations between psychiatry and the law.”

Bernard L. Diamond, M.D., Journal of Psychiatry and Law, 1973

Submitted by Ken Weiss

FORENSIC PSYCHIATRISTS

The Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine is recruiting forensic psychiatrists for full-time faculty positions. The candidates selected for these positions will be part of a forensic team responsible for supervision of residents, forensic fellows, and medical students during their rotations at Feliciana Forensic Facility and in various state mental health facilities where they will provide clinical services. You must be professionally competent and be board certified in general psychiatry and in forensic psychiatry. You must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Salary will be competitive and commensurate with the level of the candidates' academic appointments. We will continue to accept applications for these positions until suitable qualified candidates are identified. Qualified applicants should send email of interest, updated CV and list of references to John W. Thompson, Jr, MD, Professor and Vice Chair for Adult Psychiatry, Director of the Division of Forensic Neuropsychiatry at jthomps3@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.

**2011-2012
Rappeport Fellows**

- Sandra Antoniak MD
- Abilash Gopal MD
- John Jimenez MD
- Kevin Marra MD
- Monifa Seawell MD
- Melissa Spanggaard DO

FORENSIC PSYCHIATRY FELLOWSHIP DIRECTOR

The Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine is recruiting a forensic psychiatry fellowship training director for a full-time faculty position. The candidate selected for this position will assume the responsibilities for the Directorship of the fully accredited Forensic Fellowship Program. He/she will lead the forensic team responsible for supervision of residents, forensic fellows, and medical students during their rotations at Feliciana Forensic Facility and in various state mental health facilities where they will provide clinical services. He/she must be professionally competent and be board certified in general psychiatry and in forensic psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Salary will be competitive and commensurate with the level of the candidate's academic appointment. We will continue to accept applications for this position until a suitable qualified candidate is identified. Qualified applicants should send email of interest, updated CV and list of references to John W. Thompson, Jr, MD, Professor and Vice Chair for Adult Psychiatry, Director of the Division of Forensic Neuropsychiatry at jthomps3@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.



Fall 2010 Admissions:

Priority consideration is given to applications received by May 14, 2010. Applications received after this date will be considered if space is available.

**NEW YORK
LAW SCHOOL**

**ONLINE MENTAL DISABILITY
LAW PROGRAM WELCOMES
FORENSIC PSYCHIATRISTS**

The Online Mental Disability Law Program offers you the opportunity to enhance your knowledge base and credibility in your report preparation, evaluations, and testimony; to gain significant insight about the legal system necessary for your daily practice; and to learn valuable information that will prepare you for your board certification examinations.

New York Law School is on the cutting edge of education by presenting you innovative training as you work with, or on behalf of, persons with mental disabilities. All courses are delivered primarily through the convenience of distance learning. You can now apply for admission to the Master of Arts in Mental Disability Law Studies and the Certificate in Advanced Mental Disability Law Studies on a full- or part-time basis. You may also take any of the program's 12 courses on an individual basis.

For more information about the M.A., the Certificate, and all the individual courses, visit www.nyls.edu/mdl.



Report from the Program Committee

Charles Scott MD

The 2011 AAPL Program Committee enthusiastically welcomes our fellow AAPL members to the upcoming AAPL Annual Meeting in Boston from October 27 through October 30, 2011. The meeting will be held The Boston Park Plaza and Hotel. The Program Committee worked hard to achieve a balance of relevant civil and criminal topics combined with cutting edge new research presentations.

The Program Committee has continued the tradition of the mock trial which will be held on Thursday October 27, 2011 from 7:00 to 9:00 p.m. The purpose of the mock trial is to recreate opposing views on a forensic psychiatric topic through the presentation of the exact direct and cross-examination testimony presented at trial. This year the Program Committee selected the 2010 case of *Commonwealth of Massachusetts v. Paul Shanley*. This case involved an appellate review by the Supreme Judicial Court of Massachusetts on the issue of the admissibility of recovered memories in the criminal prosecution of Boston priest Father Paul Shanley. We are excited to have one of the original experts, Dr. James Chu, present the case, along with assistant district attorney,

Katharine Folger, as to why testimony regarding recovered memories should be allowed in court for purposes of criminal prosecution of alleged child molestation. In the appellate review, Dr. Loftus provided testimony based on her research indicating that recovered memories often included false memories.

This year, we also have three incredibly interesting luncheon speakers. On Thursday, October 27, 2011, Mr. Pete Earley, New York Times bestselling author, will provide a moving account of his attempts to navigate the mental health system to try to help his son after his son is diagnosed with bipolar disorder. His speech is based on his book, *CRAZY: A Father's Search Through America's Mental Health Madness*. This amazing book was one of two finalists for the 2007 Pulitzer Prize and has won awards from the American Psychiatric Association, Mental Health America, and the National Alliance on Mental Illness. Mr. Earley is a dynamic and passionate speaker who spent a full year as a reporter inside Leavenworth prison, a maximum-security prison.

On Friday, October 28, 2011, our luncheon speaker is Dennis Maher. Mr. Maher was a sergeant in the army when he was misidentified as the perpetrator of a series of sexual assaults in Lowell, Massachusetts, and wrongfully convicted of the crimes. Mr. Maher spent 19 years behind bars, from 1984 to 2003, before post-conviction DNA testing proved his innocence. Mr. Maher advocates for criminal justice reform in New England, speaking to criminal justice professionals and legislators about his experience of wrongful conviction. Mr. Maher speaks to the experience of being wrongly convicted and imprisoned for a crime he didn't commit. His presentation titled "*Counseling Innocent Prisoners: An Exoneree's Perspective*" promises to provide a perspective rarely presented though important for our field.

Our Saturday luncheon speaker is Special Agent Gary Phillips. Special Agent Phillips has served on many federal

(continued on page 30)



AAPL Newsletter

American Academy of Psychiatry and the Law
One Regency Drive
PO Box 30
Bloomfield, Connecticut 06002

Charles Dike, MD, MPH, MRCPsych, Editor

PRSR STD
U.S. POSTAGE

PAID

BLOOMFIELD, CT
PERMIT NO. 15

HIGHLIGHTS

DSM-5 and PTSD

Miranda for Minors

Culture and Competency