

AAPL Newsletter

American Academy of Psychiatry and the Law



April 2011 • Vol. 36, No. 2

AAPL Semiannual Meeting Honolulu, Hawaii: May 14-15, 2011



Why Research Matters in Expert Testimony

Susan Hatters Friedman MD, Suzanne Yang MD, and Ryan C. W. Hall MD

Expert testimony is subject to scrutiny on scientific grounds that include an assessment of (i) the reliability and validity of empirical research utilized, as well as (ii) the expert's professional judgment and experience. Both types of scrutiny and argumentation are relevant in psychiatric testimony. The scientific evidence base regarding content areas directly pertinent to psychiatric expert practice is evolving, which should prompt us to read and critically assess available studies. In addition, the process by which we apply research information to the specific case, using our judgment and experience, itself forms the basis for a promising line of scientific investigation.

Bernet and Corwin¹ described use of evidence-based medicine to answer legal questions posed to a forensic psy-

chiatrist regarding child sexual abuse cases. The query into the literature may be somewhat different than that initially posed by the attorney to the expert. For example, instead of: *As a result of sexual abuse, is the plaintiff at increased risk of psychological problems later in life?*, the search of literature should seek an answer to the question: *Does an adolescent male who sustained sexual abuse have an increased risk of psychological/psychiatric disorder later in life, when compared with other adolescent males who were not abused?*

Empirical studies provide useful and sometimes surprising results that help to shape an opinion – on the condition that we remain vigilant, critical and analytical about their limitations and

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2011 Guttmacher Award Announced

AAPL member and APA Distinguished Fellow Liza H. Gold MD and Daniel W. Shuman JD will receive the prestigious Manfred S. Guttmacher Award at the Semiannual Meeting of the American Academy of Psychiatry and the Law in Honolulu, in May 2011.

The award, which was established in 1967 and first awarded in 1972, is co-presented by the American Psychiatric Association and AAPL. The Guttmacher Award honors outstanding contributions to the literature of forensic psychiatry.

Dr. Gold and Attorney Shuman are co-authors of *Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis*, published by Springer.

Dr. Gold is also the author of *Sexual Harassment: Psychiatric Assessment in Employment Litigation*, which won the 2006 Manfred S. Guttmacher Award.

The lecture "Psychiatric Disability: A Model for Assessment" will take place at 1:30 p.m. Sunday, May 15 in Room 311, Level 3 in the Hawaii Convention Center in Honolulu.



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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).

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COVER STORY

Expert Testimony

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attentive to caveats regarding their applicability to the question immediately at hand. Forensic psychiatrists practicing in the criminal arena are generally comfortable making determinations of competency to stand trial. However, when asked about restorability to competence, are we using evidence-based practices? Hubbard et al² found that examiners were relatively poor at pre-

“...forensic psychiatrists should also be aware of unsettled issues in the scientific literature, in order to prevent the misuse or mischaracterization of research in the courts.”

diction. They noted “few significant differences existed between defendants predicted restorable and those predicted not restorable by mental health examiners—the differences that did exist were related mainly to non-psychiatric variables.” Mossman³ found that diagnoses of mental retardation, schizophrenia or schizoaffective disorder, as well as older age, longer cumulative length of stay, and misdemeanor charges indicated lower likelihood of restoration. Morris and Parker⁴ similarly found a lower likelihood of restoration among those with psychotic disorder, mental retardation, or older age. In another sample of older adults, Morris and Parker⁵ found that defendants who were elderly, whether or not they were diagnosed with dementia, were significantly less likely to be restored than other defendants. However, a substantial percentage of both groups were successfully restored. If one has an awareness of these studies, one’s opinions regarding restorability may be better informed.

In addition to knowing what studies

to apply to the case, forensic psychiatrists should also be aware of unsettled issues in the scientific literature, in order to prevent the misuse or mischaracterization of research in the courts. The current Supreme Court case of *Schwarzenegger v. Entertainment Merchants Association* is an example of controversy in the literature that could have a profound impact on how forensic psychiatrists testify in the future. At issue in *Schwarzenegger* is whether states can have statutory restrictions on the sale of violent video games to minors. One of the issues which the Justices will examine in making their decision is whether violent video games have a causal relationship with negative behavior in minors. This is a contentiously debated topic in the scientific literature, with many studies being published in respected peer-reviewed journals supporting each side. *Schwarzenegger* may result in the Supreme Court issuing new guidance on how judges should use scientific research and testimony in the courtroom. However, unlike *Daubert* where the guidance addressed how to keep “junk science” out of the court, *Schwarzenegger* may elucidate how the judge should evaluate science to determine whether it is strong enough to potentially curtail constitutional rights. In the past, Justices have determined that certain forms of expression are not covered by the First Amendment, such as obscenity, but they have had difficulty defining it except to say they “know it when [they] see it” (*Jacobellis v. Ohio*; 378US184, 1964). In the future, Judges may be expected to know when to limit rights based on p-values and the validity of study design. In areas of scientific controversy, the forensic psychiatrist has to truly rely on both the art and science of medicine. It is only through our training, education, and professional (or individual?) experience that we will be able to provide intelligent and thoughtfully synthesized testimony based on scientific research and unique facts of the particular case.

Once we know statistical probabilities within a particular population, how do we situate one evaluate in relation to

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Economics of Prisons

Charles C. Dike MD, MPH, MRCPsych



"In no country is criminal justice administered with more mildness than in the United States." Yes, the same United States of America.

And, no, I am not dreaming, and, I do not need my head examined (Some may beg to differ, I know). This is a quote attributed to Alexis de Tocqueville, a French political thinker and historian who toured American penitentiaries in 1831. Oh, how have the mighty fallen! Today, the United States has the highest incarceration rate in the world, even more than China, Russia, or any other repressive regime; almost 1 million more prisoners than China, which has four times the population of the USA. Despite accounting for only 5% of the world's population, US prisoners account for 25% of all prisoners worldwide, and cost the nation \$70 billion annually, several folds higher than spending on education. There were more than 2.3 million prisoners in the USA and another 5 million on probation or parole in 2009. It is scandalous to observe that one out of 100 American adults is behind bars – Pew Center on the States and the Public Safety Performance Project (2008).

These alarming statistics have been the subject of much discussion on National Public Radio, in The New York Times, and on news outlets related to the DOC, especially Prison Legal News. The explosion in the US prison population began in earnest in the 1980s and 1990s, following the so-called tough on crime approach advocated by politicians, that emphasizes harsh measures after crimes have already occurred, and that disproportionately punishes poor and minority communities rather than addressing the root causes of crime and preventing it in the first place (NPR, April 7, 2011). By the 1990s, an average of 24 prisons was built per year. Texas has 112 state prisons, and about two-thirds of them

opened during the 1990s. As noted by the president of the NAACP in an NPR article on April 11, 2011, the massive expansion of the prison population was driven "largely as a result of the War on Drugs – which includes police stops, arrests, and mandatory minimum sentences – more than half of all prison and jail inmates – including 56% of state prisoners, 45% of federal prisoners, and 64% of local jail inmates – are now those with mental health or drug problems."

Across the country, rural areas that housed prisons flourished as the prisons provided employment for the citizens as well as supported and maintained local businesses. Incarceration had become profitable; one man's poison

"...it is understandable that little effort is expended to keep individuals out of prisons; job security trumps increased incarceration."

had become another man's gold. The pressure was on to build more prisons (and, of course, to fill them up) and to generate more jobs.

Then, suddenly, the economic recession struck like thunder, and things fell apart. The center could no longer hold. The scramble has begun.

State governments, scrambling to close deep budget shortfalls, now have no choice but to look at closure of prisons for salvation. Even the southern states with the harshest criminal justice policies and the most dependence on prison economy are not spared. Predictably, some politicians scrambling for votes in the affected "prison communities," are aligning themselves with employee unions scrambling to keep their jobs, and proprietors of local businesses scrambling to stay afloat. The

scramble is in full swing, indeed. What does it matter that states can no longer afford to keep some prisons open? What does it matter that a significant population of the prisoners is mentally ill and/or has substance abuse issues, and therefore, would be better served in treatment facilities supported by tight community follow up care? What does it matter...? Nothing. Who cares? Interestingly, upon learning of the state governor's plan to close a prison in her rural county in upstate NY, a local government official and activist rallied opposers of the plan with a cry for action; "We can't lose – this is more than just dollars! This is life. This is our heritage." Incredible! It is their heritage to keep the prisons in their backyard! Another individual, a businessman, opined, "If they (prisons) leave, its going to be devastation. I mean, there is nothing else around here." Message: fight to avoid devastation; fight for your lives.

In addition to closure of prisons, some states have responded with measures that appear inexplicable, if not downright illogical. For example, Massachusetts is discontinuing a jail diversion program that helps the mentally ill and diverts them from prison, while South Carolina is cutting a successful program that provides counseling and wilderness camps for at-risk youths. In Kansas, the corrections department is closing a sex offender treatment program and two residential supervision programs for parolees, while in Utah, the prison system is anticipating it will have to scale back sex offender, substance abuse and mental health programs. Florida lawmakers, on the other hand, have not only refused to cut prison spending, but have built more prison beds; they cut the state's education budget by \$300 million and spent \$310 million to expand the prison system. An author of the article wryly observed that Florida's reduced spending on education will create a self-fulfilling need for those new prison beds in the near future. Michigan, which also closed some prisons in line with the current climate, still spends \$2 billion a year on its correctional system, which is more than it

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Is it Opinion, Bias, or Conflict of Interest?

Peter Ash MD



The presenter was introduced, the lights went down, the title slide was clicked, and up came the DIS-CLOSURES

slide. As I sat watching the list of funding sources, mostly various arrangements with pharmaceutical companies, the message seemed to be that all professional consulting arrangements should be disclosed. In the dark, I began to wonder about whether the same principle would require forensic psychiatrists to disclose their financial arrangements with law firms when presenting.

Last December, the APA adopted a new policy regarding conflict of interest¹ and endorsed the Institute of Medicine (IOM) conflict of interest report². The APA policy does not address forensic issues, but the IOM report does list expert witness work as a candidate category to be considered under the following recommendation:

RECOMMENDATION 3.3

National organizations that represent academic medical centers, other health care providers, and physicians and researchers should convene a broad-based consensus development process to establish a standard content, a standard format, and standard procedures for the disclosure of financial relationships with industry.

Ref 2., p. 92

As a national organization of physicians, AAPL has a major role to play in contributing to a consensus on conflict of interest (COI) issues pertaining to forensic work.

Forensic psychiatrists have long thought about COI issues in such contexts as double agent problems, biased testimony, and the ethics of the “hired gun.” The recent public attention to

COI in medicine has centered on the issue of pharmaceutical company money. The underlying concern is that corporate money is playing a hidden and negative effect on medical treatment, research, and education—that drug company payments to physicians affect physician’s judgments in those areas. For forensic evaluators, issues concerning Big Pharma seldom arise. But the increased attention on COI issues has brought increased focus to the underlying principles. The IOM report defines COI as “*circumstances that create a risk that*

“Even if the presenter changed the minds of most of the audience to support his approach in future cases (highly questionable at AAPL!), the retaining plaintiffs who paid the psychiatrists are unlikely to benefit.”

professional judgments or actions regarding a primary interest will be unduly influenced by a secondary interest [italics in original]” (Ref 2, p. 46), and goes on to explain that there is a conflict when the secondary interest (for example, money) outweighs the primary interest (making the appropriate clinical judgment). While disclosure is not the only approach to managing such conflicts, rules regarding disclosure for presentations and in other contexts have been expanding markedly.

Forensic psychiatrists are used to disclosures. In the courtroom, *voir*

dire and cross-examination routinely examine the testifying expert’s pay, prior relationships with the retaining law firm, types of cases the expert was previously involved in, and the frequency of how often the expert has been retained by one side or the other. To assist in discovery, the federal rules of evidence require experts in federal cases to keep a log of cases in which testimony was given in the previous 4 years. And the disclosures sought are much broader than most organizations’ COI rules: the inquiry stops when the cross-examining attorney decides he/she has heard enough. The potential for bias is well-recognized, and is fair game for exploration.

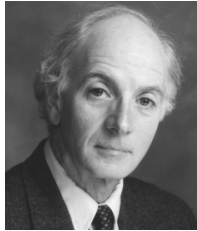
That is in the courtroom. What about on the speaker’s platform? Let’s assume that the speaker is a forensic psychiatrist who primarily testifies for one side, say for plaintiffs in personal injury cases, receives a significant portion of his income from doing so, and is talking about issues that frequently come up in those cases. Does that represent a COI such that relationships with payors (retaining law firms) should be disclosed in an educational presentation, such as at an AAPL meeting? Is this parallel to the situation of a speaker who consults to pharmaceutical companies and is discussing pharmaceutical treatment, a situation that would clearly require disclosure of those relationships? In both cases, the psychiatrist consults, is paid, and is presenting about content closely related to the issues involved in the consultation. If this model holds, disclosure would seem warranted.

Now consider another situation: a psychopharmacologist and a psychoanalyst are on a panel discussing the management of the same patient, and each, not surprisingly, emphasizes the type of treatment he/she typically utilizes – and gets paid for providing. Should each therefore be required to make financial disclosures about what percentage of their income is derived from each treatment modality they practice? Probably not. Psychiatrists come to views and approaches to

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Factitious Disorder by Proxy: Child Abuse or Mental Disorder

Howard Zonana MD



On January 5, 2011, a Missouri Court of Appeals issued an opinion in a tragic case where a woman, Judy Pickens, had been convicted of

second degree felony murder and first degree assault after being accused of killing her three year old son and poisoning her five year old daughter by giving them Clonidine, an antihypertensive drug.¹ The facts as they evolved left little doubt as to what happened.

The mother, a day care center worker herself, left her two children at separate day care centers before going to work in September 2004. They appeared sick to the staff but the mother said they had gotten sick from eating food bought from a street vendor over the weekend. A few hours later the day care centers insisted that they be picked up immediately. They developed vomiting, diarrhea, and fever and were lethargic and incoherent. The mother took them to the pediatrician that afternoon. They were diagnosed as having a viral gastroenteritis and fluids were suggested. Three days later the mother brought them back in a dehydrated state saying that other children in the day care center had also been ill. They were referred to an ER unit where they received i.v. fluids, improved and were sent home.

The pediatrician was again called three days later and was told they were not better. They returned to the ER and were admitted to the same room. One of the doctors did not recall seeing the mother ever leave the room. She was active in the children's care and even offered to clean the bathrooms. She continued to report other children at the day care center as being ill but did not report that she had told the day care center the children had eaten food from a street vendor over the weekend before they became ill. The hospital contacted the day

care center in an effort to identify a potential outbreak and learned that none of the children were ill.

On day seven, the mother reported that she had seen something brown in the IV tubing of her son and possibly also in her daughter's tubing during the night. The daughter gradually improved but the son's condition waxed and waned. His IV's continually became blocked and a larger catheter was inserted in a large leg vein. This catheter also became blocked. A nurse noted a white milky substance in it. When they attempted to flush the catheter it broke. The boy began to have trouble breathing and had decreased oxygen levels. X-rays were normal and he responded transiently to oxygen. Four hours later he was again struggling to breath, despite clear lung sounds. Within two minutes of the doctor's arrival he fell unconscious and stopped breathing. He could not be revived.

In response to the news of her son's death the mother was "visibly shaken" and eventually taken to the ER. When asked about medications she was taking, she mentioned only two; a calcium channel blocker and an ACE inhibitor. She did not mention the drug Clonidine, even though she had been taking it for the previous four years.

The same day the doctor went to check on the daughter whose symptoms had mirrored the brother's. Upon arriving in the room, the daughter's cousin gave the doctor some of the tubing that had been removed from the son's arm and thrown in a trash can. The cousin said that after the nurse left the room, the mother took the tubing out of the trash and put it in her bag. The tubing was sent for testing.

The next day the mother again presented to the emergency room with dizziness, weakness and an altered mental state. She was difficult to arouse. Her husband was asked about any drugs she was taking and he mentioned that she had missed her medica-

tions due to stress but had taken two Clonidine tablets that morning. At the mention of Clonidine, the mother immediately became alert and argumentative, saying she was not on Clonidine any longer. She demanded that any such notation be removed from the chart. Medical and pharmacy records showed that she had obtained over 800 doses of Clonidine in the prior six months. The most recent refill of Clonidine was two days earlier despite her having received a thirty-day supply only two weeks previously.

Later that afternoon the daughter's condition suddenly took a turn for the worse even though she had been improving. She was transferred to the ICU where the mother could have only limited access and a nurse was continually present. The mother was asked repeatedly about medications the family was taking but never mentioned the Clonidine. On day 15 the daughter was returned to a regular hospital room. That same day, an attorney sent the hospital a letter advising that he was representing the mother and her husband in a malpractice action.

At that point a patient care assistant was assigned to the daughter's room to sit with the girl. Later that evening the mother said she thought her daughter needed to drink more fluids, and subsequently tried to give her daughter something in a cup. The daughter said it tasted gross and refused to drink it. Another visitor offered her something else and she drank it. The mother later offered the same cup that she had given before, woke her daughter up and made her drink it. The daughter soon became lethargic but was arousable. The assistant at one point saw a syringe fall to the floor when the mother stood up, but she was distracted by the mother. When she looked again, the syringe was gone.

When the mother left the room, the patient care assistant examined the cup the mother had used and noted a cloudy white sediment at the bottom. A resident was called and the cup was sent for testing. When the mother returned, she asked where the cup was. She was told it had been cleared away

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Factitious Disorder

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with the tray. The mother said she had to find the tray as she had left keys on it. She also looked through the trash.

The next night another assistant noted that the mother commented on the i.v. lines being in disarray and she went over in an attempt to straighten them out. She remarked that she could not fix them. She was then noted to have thrown something in the trash. The daughter immediately began to deteriorate, having difficulty breathing, a fever and a change in her alertness. The assistant told the nurses that the mother was acting suspiciously and had thrown something in the trash. One of the nurses retrieved the trash bag and saw a syringe with a white residue.

By day eighteen the lab found that the cup the mother had forced the daughter to drink from contained Clonidine. Blood levels from the daughter also revealed the presence of Clonidine. The hospital pharmacy had not dispensed Clonidine in the amount necessary to have caused such a blood level. Based on this finding, the mother was barred from seeing her daughter and, within two days, her daughter significantly improved.

An autopsy on the defendant's son showed that he had pieces of a foreign substance throughout the blood vessels of his lungs consistent with the filler material in Clonidine pills. Tests on the tubing showed a binding agent that was typical for Clonidine manufacturer that made the mother's medication. Toxicology of the blood showed the presence of Clonidine in an amount 70 times greater than the amount considered toxic for a young child. The pill filler clogged the boy's pulmonary vessels, preventing proper oxygenation. The decreased oxygenation and decreased blood flow resulted in tissue and organ death, heart failure and ultimately death.

The defendant was consequently charged with first-degree murder. During the trial, the state called a forensic psychologist who testified in general about factitious disorder by proxy and answered hypothetical questions from the prosecutor regard-

ing whether a person with the disorder could be "very deliberate and reality oriented"; the prosecutor thought the defendant was acting in a manner which would indicate that she was "rational and in touch with reality." In responding to the questions, the psychologist opined that "those are rational and deliberate behaviors if they occurred in the absence of any other symptoms of a major mental illness." He added, "...the disorder was not a mental disease that would excuse responsibility for those actions."

The jury found her guilty of second-degree felony murder, first-degree assault, and child abuse. The trial court sentenced her to a total of two life sen-

“Sir Roy Meadow, one of the men who identified and popularized the disorder, ultimately resigned his medical license in 2009 in the wake of several controversial cases.”

tences plus 157 years. The appeal was predicated only on a three-pronged attack of the psychologist's opinion. The third attack was premised on the claim that the diagnosis was not generally accepted under the Frye test.

While the doctor opined that the diagnosis was controversial, it is listed in the DSM IV-TR under "factitious disorder, not otherwise specified," as well as in the appendix for further research and study. He also felt that the controversy was over the "soft signs" that could indicate the presence of the disorder, not whether the disorder actually existed. The court upheld the sentence.

It is typical for prosecutors to ask for expert witnesses in these cases so as to gain convictions for murder or to terminate parental rights. This disorder is not viewed as a true mental disorder

but one of severe child abuse regardless of the mother's motivation. The ICD 10 lists factitious disorder by proxy under child abuse, thereby furthering that interpretation. This seems a significant distinction between the DSM and the ICD listings.

Once the diagnosis is made it is difficult to refute, since denial is part of the criteria. This has led to unfounded accusations. Sir Roy Meadow, one of the men who identified and popularized the disorder, ultimately resigned his medical license in 2009 in the wake of several controversial cases.

In one review of 72 cases 25% involved simulation of illness only.² Fifty percent of cases involved production of illness only. In 25% of the cases both simulation and production of illness were involved, and in 84% of such cases, both the simulation and the production took place while the child was in the hospital.

The use of the illness by the defense has generally been attempts to negate the specific intent to murder, thus reducing the charge to second-degree murder or manslaughter. In some states where the diminished capacity defense is viable, that has also been used.³

Factitious Disorder by Proxy is a condition that continues to warrant further in-depth study, perhaps of individuals who have exhausted their appeals and, therefore, may be more willing to divulge some of their thinking. Since much of the data may be inferential, great care must be given to speculative conclusions drawn by experts;⁴ even videotaped cases can be misinterpreted. There certainly seem to be features of these cases that make Factitious Disorder by Proxy more complicated than mere child abuse. (F)

References:

1. State of Missouri v. Pickens, 2011 WL 208367 (Jan 25, 2011)
2. Rosenberg, D. Web of Deceit: A Literature Review of Munchausen by Proxy, Child Abuse and Neglect, v. 11, pp. 547-563, 1987
3. Steelman, E.S., Note: A Question of Revenge: Munchausen Syndrome by Proxy and a Proposed Diminished Capacity Defense for Homicidal Mothers 8 Cardozo Women's L. J. 261 (2002)
4. Pankratz, L. Persisten Problems With the Munchausen Syndrome by Proxy Label, v. 34:#1, pp90-95, (2006)

Program Committee Had Another Hard Task

Jacquelyn T. Coleman CAE, Executive Director



The Program Chairs have just finished their work choosing the presentations for the 2011 Annual Meeting in Boston.

It was a highly competitive year, with 203 abstracts submitted: the breakdown was 4 audiovisual sessions; 4 courses, 4 debates, 45 panel, 56 posters, 29 research in progress, 10 scientific papers and 50 workshops. Twenty-nine submissions were from committees.

Category breakdowns, recognizing that some presentations may overlap two or more categories were child, 8; civil, 18; correctional, 19; criminal, 51; legal, 15, other, which includes practice of forensic psychiatry, 49. Some presentations did not indicate a category and we are trying to fix our system to make sure we force that next year.

A strong message from the Program Committee is that a scientific paper means what it says. No Scientific Paper submissions will be accepted without the paper. Since this was the first year of enforcement of a requirement that has existed for many years, the Program Co-chairs were generous in transitioning “papers without papers” to research in progress if they were truly research, but this is the one time they will do this. As of 2012 “papers without papers” will be rejected.

Four courses were selected. “The Do’s and Don’ts of Depositions” was requested by the Education Committee as part of its plan to offer a course on basic content of forensic psychiatry every year. It will be taught by Drs. David Benjamin and Thomas Gutheil and Attorney David Gould

“Child Murder by Parents and Insanity” will be taught by Philip Resnick, M.D.

Drs. Michael Norko and Madelon Baranoski will present: Applying Risk Assessment in Psychiatry; and Sex

Offenders: Identification, Risk Assessment, Treatment and Legal Issues will be taught by several faculty.

The abstract review process starts when the deadline for receipt of abstracts closes. Immediately after that the AAPL staff assign abstracts to the members of the Program Committee. They have approximately three weeks to review the abstracts on line, assign a numerical rating, and add comments. In a new approach this year, the Program Committee expanded the rating that could be given numerically up to 7. Anyone who rated an abstract as a 1 or a 2 or a 6 or a 7 was asked to provide comments. The thought was that extremely good or extremely poor ratings should be elaborated upon. All members of the Program Committee are provided with an indexed copy of the last two year’s evaluation summaries so they can refer to a presenter’s past performance. Those sum-

maries of previous year’s meeting are used, so if you ever thought that no one read what you write in the evaluation form, you would be wrong.

With so many presentations, even some posters got the ax this year. And we are back to three poster sessions; in 2010 there were only two.

Another important point is that a workshop must involve audience participation. Successful submissions are those that show what exactly the audience will learn and how it will participate. I am sure you are aware of much of the published material that suggests that adults learn better in interactive ways. Of course some panels were selected because there is still material that doesn’t lend itself to a workshop format. Sometimes people really do want to hear experts presenting their opinions.

Looking over the Program as proposed however, the breadth of topics is remarkable. Anyone who comes to our meeting in Boston (October 27-30, 2011) will find a wide range of material to stimulate the brain as well as improve your competence or performance, which are AAPL’s goals for continuing medical education. (P)

MUSE & VIEWS

Lawyers should never ask a Mississippi grandma a question if they aren’t prepared for the answer.

In a trial, a Southern small-town prosecuting attorney called his first witness, a grandmotherly, elderly woman to the stand. He approached her and asked, “Mrs. Jones, do you know me?” She responded, “Why, yes, I do know you, Mr. Williams. I’ve known you since you were a boy, and frankly, you’ve been a big disappointment to me. You lie, you cheat on your wife, and you manipulate people and talk about them behind their backs. You think you’re a big shot when you haven’t the brains to realize you’ll never amount to anything more than a two-bit paper pusher. Yes, I know you.”

The lawyer was stunned. Not knowing what else to do, he pointed across the room and asked, “Mrs. Jones, do you know the defense attorney?” She again replied, “Why yes, I do. I’ve known Mr. Bradley since he was a youngster, too. He’s lazy, bigoted, and he has a drinking problem. He can’t build a normal relationship with anyone, and his law practice is one of the worst in the entire state. Not to mention he cheated on his wife with three different women. One of them was your wife. Yes, I know him.”

The defense attorney nearly died. The judge asked both counselors to approach the bench and, in a very quiet voice, said, “If either of you idiots asks her if she knows me, I’ll send you both to the electric chair.”

Submitted by James Knoll, MD

Source: <http://wwwnews.net/story.php?id=3029>

The Paranoid-Schizoid Position and Special Populations

Stephen Zerby MD

A former forensic fellow working at a secure juvenile placement recently texted me (this is 21st Century forensic psychiatry) asking how to handle dual agency issues. Dual agency, the state of “serving two masters,” can be the bane of working with such special populations. The conflict originates in the court-ordered nature of treatment. On the one hand, the treatment team has a duty to the court (i.e., society) that ordered treatment, while on the other, the team has a duty to deliver high-quality care to the patient. Such a treating clinician, from the patient’s point of view, on the one hand, is there to help (i.e., treat) while on the other hand, may report back to the court with regard to clinical progress or lack thereof. An ambiguous dynamic is created, as from the patient’s perspective, it is unclear whether the clinician’s purpose is to help or to hurt. It would seem prudent for the clinician to be straightforward about his or her role in the treatment process from the outset and delineate the limits of confidentiality early. In general, an atmosphere of frankness can engender more fruitful clinician-patient relationships; clinicians should state the limits of confidentiality in such settings despite the risk of patients subsequently becoming resistant to treatment. This is especially of concern in the treatment of sex offenders where the patient’s admission of offenses, both adjudicated and non-adjudicated, is a central component of the therapeutic process. It would not be surprising for patients in such special populations to develop powerful transference reactions to their treating clinicians. The question raised in the patient’s mind could very well be whether the clinician wished to help by providing service to the patient, or whether the clinician’s underlying motive was to gather evidence against the patient to be used later in court in building a case against the patient as untreatable and deserving of punishment.

This scenario hints at the Kleinian paranoid-schizoid position of object

relations theory in which infant development is viewed through the lens of the dynamic relationship between mother and infant. When the mother provides nourishment via the breast the infant is subjected to the paradoxical experience of being “attacked” by having an object being forced into the mouth, yet if able to surpass this initial anxiety will gain nourishment. Through the process of bonding, the infant gradually develops the positive expectation of nourishment while continuing his or her quiet vigilance for the mother’s other persona - the doppelganger

“Is the clinician’s stated purpose - to help - actually true, or only a mask for the unstated yet implied intent of inflicting punishment either in this facility or later, in a court of law?”

aggressor. Very early in life, we learn the maxim, “trust, but verify.” This powerful early life experience is likely recreated in the arts such as in the cinema. Consider for a moment the staple “big monster” genre of horror films in which a huge, loud, powerful creature (the infant’s experience of the parent?) capable of tremendous destruction, becomes tamed, or begins to expose the good side of its persona. Perhaps object relations plays a part in the cinematic magic at hand when Kong, the gigantic king of a land from long ago – in the forgotten past (perhaps our own psychic past) – picks up Fay Wray and proceeds to carry her through the jungle. The unspoken question in the mind of the audience is likely whether Kong is sim-

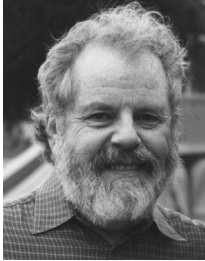
ply taking her somewhere to eat her or rather, is Kong capable of affection and wants to protect her? Leaping to her defense against an enormous Tyrannosaurus, is Kong saving her for his own dinner or does he have affection for her, even risking his own life to protect her? Similar questions may dwell in the minds of the very young who wonder suspiciously at the true intentions of their caregivers. Such is the paranoid-schizoid position. Part of the process of maturation is for the parent-child dyad to navigate their own personal primordial jungle to an eventual healthy equilibrium. It is little wonder that abusive and neglectful parents can inflict such damage on a young child.

We return to our primordial land of the present. A patient has been court-ordered to a secure facility for involuntary evaluation and treatment. The assigned clinician is not being paid by the patient but by the institution which, in turn, may very well be funded by the state. Misbehavior may lead to seclusion, physical restraints, or forced medication. From this starting point, the mental health clinician must initiate some form of positive treatment alliance - no small task indeed. Perhaps these universal experiences of long ago, in a place far away, are resurrected in the patient’s mind. Is the clinician’s stated purpose – to help – actually true, or only a mask for the unstated, yet, implied intent of inflicting punishment either in this facility or later, in a court of law? Are the medications being consumed for a therapeutic purpose (i.e., nourishment) or punitive one (i.e., attack)? Such may very well be the dynamic at hand in the treatment of special populations and it could prove quite fruitful to keep this in mind while working in such settings. The clinician may be prudent to understand that this may be the viewpoint of the patient – i.e., something akin to the paranoid-schizoid position. A more meaningful therapeutic relationship may begin to develop once the clinician recognizes this and addresses the problem in a straightforward manner. It would be helpful for clinicians to be frank with special populations’ patients, and clearly delineate his or her

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Cross-Cultural Issues in Child Custody Disputes

Stephen P. Herman MD



Several months ago, Amy Chua published a very controversial book, *Battle Hymn of the Tiger Mother*. In it she wrote of Chinese parenting being functional

and goal-oriented. She said this type of parenting is often thought by Americans to be especially harsh and even abusive. The book received a lot of negative criticism, although reports indicate that her children have grown into accomplished, well-adjusted, socially appropriate adults. They apparently have many friends who like them a great deal.

Author Chua is married to Jed Rubinfeld, a Jewish man raised in New York City. She describes her husband, with whom she appears to have a good marriage, as being more emotional and more permissive as a parent.

In an interview with me for the Huffington Post, on February 2, 2011, writer and attorney Liz Mandarano asked about the issue of inter-cultural differences when such parents split up and become involved in a custody dispute. (http://www.huffingtonpost.com/liz-mandarano/the-tiger-mom-dilemma-how_b_816589.html?ref=email_share). Ms. Mandarano noted in her article that a 2010 Pew Research Study found that in 2008, 1 in 7 new marriages in the United States were between inter-racial or inter-cultural couples.

We talked about some custody evaluations I have done over the years that have involved these kinds of families. The custody disputes are often more fraught than usual because of the cultural differences of the parents. Each may want custody to assure that their children are brought up in the “right” culture and not stifled by the other parent. In a difficult by fascinating custody dispute of several years ago, I evaluated a Roma (“gypsy”) family in which the father was demanding custody of his son. The Roma people do not abide by

civil marriage law, and couples are married in their own culture. When there is a “divorce,” the father is entitled to the children. In the case I evaluated in New York City, the mother decided to seek relief in the civil Family Court system. Because of this, she was declared “unclean” and ostracized from her Roma family. She prevailed in court but at great expense.

The issue of child abuse can also be complicated in custody cases. In American Samoa, for example, corporal punishment is the norm in child-rearing and it is often difficult for social services there to decide when a child is “just”

“Some judges ignore cultural differences. They may say families involved in divorce and child custody cases must be judged solely on American standards. Others take cultural differences into account when deciding on custody.”

being disciplined according to the culture and when abuse has occurred.

Some judges ignore cultural differences. They may say families involved in divorce and child custody cases must be judged solely on American standards. Others take cultural differences into account when deciding on custody.

In the Huffington Post interview, I listed steps which courts ought to follow in these difficult decisions:

1. Evaluators and judges need to recognize their own cultural biases and igno-

rance of certain cultures.

2. They need to examine how cultural differences affect child-rearing and law within a specific ethnic group. (For my Roma case, I consulting a book solely devoted to Roma law.)

3. Review available literature on the group in an attempt to ascertain whether you are dealing with a norm of that culture or abuse. (This might be the hardest thing to do.)

4. Assess the level of attachment between child and parent or significant other caretaker(s). There are certain cross-cultural universals to healthy parenting.

5. Assess the parental goals for the child and determine if these goals are connected to their behavior and developmental goals for the child.

6. Spend enough time with the child and educators to see how parenting is reflected in the everyday life of the child.

The American judicial system, using these guidelines, can assess what weight should be given to parenting styles, regardless of the culture differences between the parents. Even in situations where there is shared parenting and different cultural styles with each parent, children can and do thrive, if the parents are sensitive to and respectful toward the family’s inter-cultural differences. ☺

Special Populations

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role. Warning the patient beforehand and/or providing written consents which clearly indicate what information will be relayed to the court, may be key to establishing the ground rules for court-ordered treatment such that no surprises occur in the courtroom as a judge is apprised of the patient’s progress.

Although obviously not an analyst and possessing only a rudimentary knowledge of the field, this writer has found it helpful to keep object relations theory in mind while working with special populations. Keeping Kong in mind can be helpful as well. Please send comments, corrections of my psychoanalytic knowledge, and any potential submissions for this column to: zerbysa@upmc.edu. ☺

Healing Ourselves: Forensic Psychiatrists should not Limit Care to Patients

Helen M. Farrell MD



Every forensic psychiatrist has experienced professional highs and lows. Whether it is restoring a patient to competency, providing effective testimony to a fact-finder, or achieving board certification, forensic specialists like everyone else, thrive on success. These accomplishments and milestones motivate us to help others and advance our careers.

Throughout their professional careers, forensic psychiatrists are equally vulnerable to the ego insults associated with unavoidable negative, and sometimes, disastrous outcomes. Some forensic psychiatrists have authorized discharge of a patient who scored low on the HCR-20, but who upon discharge, immediately committed horrible criminal offenses such as rape or homicide. Others have undergone brutal cross-examination in court that left them feeling embarrassed or discredited. Most forensic psychiatrists have encountered cases that involve heinous charges or outcomes.

Psychiatrists spend so much time with their patients or on emotionally delicate and vigorous cases, that they often neglect their own health. Physician suicide rates have repeatedly been reported to be higher than those of the general population or other academics. We are therefore especially susceptible to the internalization of our work. Self-care is a topic that physicians rarely address. Barriers to self-preserving treatment include time and stigma.

The most formidable obstacle physicians face is time. More specifically, the lack of time. Most forensic psychiatrists work in multiple settings, some of which include billable hours, totaling close to eighty hours per week. Self-preservation does not become a priority for professionals

until the effects of stress interfere with their personal or professional life.

Another barrier to attention to a psychiatrist's needs is stigma. It can be really embarrassing and shameful for doctors to admit that they are human, that they may be vulnerable, and that they may have healthcare needs. Fear of scrutiny for having an illness, or even an emotional response to certain situations, is so severe that doctors may avoid seeking help.

Self-care is not a core competency for trainees, and many residency programs, fellowships, and hospital facilities ignore this important issue. Even when there is a bad outcome or psychologically difficult case, the impact of such difficult and painful issues on the clinician is often ignored. Negative

outcomes can have profound effects. Sub-specialty trained psychiatrists may fear reprisal from colleagues stemming from shame and embarrassment. The narcissistic blow can be so severe that doctors experience a crisis of faith in their education, training and value that leads to a sense of professional disillusionment. Once the shock subsides, forensic psychiatrists might experience a feeling of dissociation that leads to isolation.

Psychiatrists, who deal with sensitive emotional material on a daily basis, are especially susceptible to the internalization of their work. For those who work with the vulnerable and victimized, meeting our own needs is fundamental to our ability to thrive. Regular practices that promote reflection are crucial to a psychiatrist's compassion and self-preservation. Forensic psychiatrists, therefore, are advised to follow recommended guidelines for self-care, as described in Table 1.

Dr. Farrell is a forensic psychiatry fellow at University of Cincinnati School of Medicine.

Table 1 – Guidelines for self-preservation and health in an emotionally charged field

1. Define your professional role and know your level of competency	<ul style="list-style-type: none"> • Work within the confines of your skill set • Refer to more specialized physicians when cases are outside your scope of expertise • Consult colleagues for help with difficult cases
2. Respect your own boundaries	<ul style="list-style-type: none"> • Establish boundaries • Delineate professional and personal boundaries • Reflect on shades of gray or ambiguity • Seek reinforcement from a supervisor
3. Ask for help	<ul style="list-style-type: none"> • Clearly articulate your needs • Create a positive environment amongst colleagues
4. Be demanding of yourself and others	<ul style="list-style-type: none"> • Expect yourself and others to live with honesty, integrity, and compassion • Consider the source of any inability to maintain these standards • Correct your own behavior when your work is substandard
5. Prevent/Treat depression	<ul style="list-style-type: none"> • Find time • Seek out a physician skilled at and comfortable treating physicians
6. Keep balance in life	<ul style="list-style-type: none"> • Foster hobbies • Exercise on a routine and daily basis

Emanuel Tanay MD *Jack Ruby, Ted Bundy*

Philip J. Candilis MD

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



A founding father of AAPL, Emanuel Tanay recalls an early meeting with Jonas Rappoport, Robert Sadoff, and

Seymour Pollack that kicked off the organization. The discussion of whether to include “forensic” in the name of the organization exposed concerns with the perceived unseemliness of testimony, and led to the use of “Psychiatry and the Law” in the AAPL name. The perception that testifying was not dignified for medical professionals would color Dr. Tanay’s advocacy for the profession and for strict preparation for cross-examination throughout his career.

A teen-aged Holocaust survivor from Poland, Dr. Tanay criss-crossed Europe to evade capture. Dr. Tanay, or Emek to his friends, ultimately escaped the concentration camp at Topolya, Yugoslavia. By war’s end, he was responsible for saving family members and others, and found his story memorialized in the film *Courage to Care*. One scene in particular details how Dr. Tanay hid in a church organ to elude Gestapo officers. He himself wrote about his ordeals in *Passport to Life-Autobiographical Reflections of a Holocaust Survivor*. Dr. Tanay’s video narrative is captured in the final exhibit of the Holocaust Memorial Museum in Washington, DC.

A prolific author and lecturer, Dr. Tanay has testified in a broad range of cases and in 49 US states [Nebraska]: from “major airline disasters to zoning cases, from A-Z,” he says. Bringing psychiatric expertise to courtroom discussions of criminal responsibility, emotional distress, and even community welfare relies on the capacity to clarify and explain. “If I

had to choose between a Nobel Prize winner and a high school teacher for the courtroom,” Dr. Tanay relates, “I would choose the teacher.”

Dr. Tanay’s capacity to explain was critical to the examination of a number of historical criminal figures in modern forensic history. Renowned attorney Melvin Belli famously defended Jack Ruby with an unconvincing narrative of epileptic syndrome. Dr. Tanay was the defense expert in Ruby’s case after a new trial

““If you do well on direct but collapse on cross, your direct is wiped out,” he says.

“You have to be able to hold on and defend on cross, not just meekly accept criticism.””

was granted. He argued that the 55 seconds Ruby spent in the bowels of Dallas police headquarters was evidence of an impulsive homicide, not an unusual epileptic condition.

In the examination of serial killer Ted Bundy as well, Dr. Tanay described a close tie between Bundy’s personality disorder and his interest in being the center of attention. This was the elusive link to his self-defeating pleas and provocative courtroom behavior.

For Dr. Tanay, cross-examination remains the ultimate test of any forensic psychiatrist. “If you do well on direct but collapse on cross, your direct is wiped out,” he says. “You have to be able to hold on and defend on cross, not just meekly accept criti-

cism.” If a cross-examiner intimates the expert is untruthful or incompetent, more is required than a mild rejoinder. Dr. Tanay might point out that the attorney is permitted to make such inflammatory statements because he is not under oath. “I might get scolded by the judge, but the jury will understand better what has happened,” he says. Although this approach has been criticized as a failure to manage transference, Dr. Tanay holds a different view: he is well aware of his transference, his biases in a case, and addresses them throughout his analysis.

Dr. Tanay’s approach resonates with developments in professional ethics that recognize the challenges to maintaining objectivity and taking steps to expose and minimize them. “I am not biased before I evaluate a case,” he says, “but [I am] biased afterwards in favor of my opinion.” Indeed, in the introduction to his Golden Apple Award for contributions to AAPL, Dr. Tanay was recognized for an approach to advocacy for one’s opinion that was “once controversial but is now conventional.”

As Dr. Tanay battles a recent cancer diagnosis, he continues to write. His latest book, with an introduction by Robert Simon, is *American Legal Injustice*. It is an indictment of the forces undermining the US legal system, from disparities of power and influence to the specific influences of money and politics. Although the Ruby, Bundy, Sheppard and other prominent cases are described in the book and draw the most national attention, it is the personal touches from his work that make the most impact on Dr. Tanay. He recalls with great feeling the personal letter of thanks he received from a convicted naval officer who appreciated his work in a losing cause. Or the intricately carved belt the father of a crime victim took from his own outfit to present to him after testimony. For this long-time AAPL member, both the famous and anonymous cases combine to give meaning to his forensic practice. They enrich his readers and students as well. ☪

Michael Norko MD Connecticut v Ross (2005)

Charles C. Dike MD, MPH, MRCPsych

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



Dr. Norko was introduced to forensic psychiatry by Dr. Steve Billick during his residency at St. Vincent's in NYC in the

mid-1980s. After becoming a Rapport Fellow, Dr. Norko trained in forensic psychiatry at Yale with Dr. Howard Zonana, and has been part of the Yale teaching faculty since then, including 7 years as Deputy Training Director. Dr. Norko is the current AAPL Secretary and Deputy Editor of the Journal, and has been Councilor, Vice-President, Newsletter Editor and recipient of the 2006 "Red Apple" award for Outstanding Service to the organization.

Dr. Norko began his career in 1988 at the Whiting Forensic Institute in Middletown, CT, becoming Director of that facility in 1993 after serving in several other capacities. Dr. Norko served as President of the CT District Branch of the APA in 2002-2003. He has been the Director of Forensic Services for the state mental health authority since 2007, molding public policy on forensic matters, and overseeing Whiting's inpatient forensic services and a broad array of community forensic services, including those linked to a sequential intercept model of managing individuals with serious mental illness involved with the criminal justice system.

His interests have included public sector psychiatry, public policy, risk assessment, ethics, gun laws, the death penalty and religion/spirituality and psychiatry. While maintaining his teaching and administrative responsibilities, Dr. Norko completed a master's degree in religion at the Yale Divinity School in 2010. This past fall, he taught the first course on Religion, Spirituality and Worldview in Psychiatry to be offered in the Yale psychiatry residency.

Dr. Norko has worked on and testified about many amendments to Connecticut statutes related to competency to stand trial evaluations and treatment (including a post-Sell special conservator bill for involuntary medication) and management of insanity acquittees, most recently working on developing CT's relief from federal firearms disability bill being considered this legislative session. As part of his work on federal mental health firearms prohibitions, Dr. Norko was able to per-

"Mr. Ross' attorneys felt obligated to argue that he was not competent to make a decision to waive appeals, and that he was pursuing state-assisted suicide."

suaude the FBI to cease using the term "mental defectives" in its manuals and other documents to refer to those individuals prohibited from gun ownership under 18 USC § 922g(4) due to various mental health adjudications. With colleague Victoria Dreisbach DO, he co-authored an Action Paper that was passed, directing the APA to work with Congress to eliminate this terminology from federal law.

In 1995, when Dr. Norko was serving as Director of the Whiting Forensic Institute, the mental health department was ordered to evaluate the competence of Michael Ross to represent himself and waive further appeals to his death sentence imposed for capital felony murder in the rapes and murders of four Connecticut women (among 8 total victims) in 1987. (In 1994 his sentence had been overturned due to the state's failure to release

potentially mitigating evidence in his case.) As the senior psychiatrist in the state system, Dr. Norko was asked to conduct the evaluation. At the time, Mr. Ross had a history of depression treated with medication, and he was receiving anti-androgen therapy for sexual sadism. He had a superior knowledge of the proceedings, and maintained that he was not suicidal, but that he wanted to spare the victims' families the trauma of repeated appeal hearings, which he felt would not be helpful to him anyway. He was found competent and for the next three years, negotiated with the prosecutor a set of stipulations regarding the absence of mitigating factors and the presence of aggravating factors. The CT Supreme Court ultimately rejected that agreement and ordered a new penalty phase hearing – which again resulted in the imposition of a death sentence in 2000, with the final CT Supreme Court affirmation of that sentence in 2004.

One month later, Mr. Ross petitioned the court to waive further appeals and set an execution date, with the same reasoning as a decade earlier. Dr. Norko was once again asked by the court to evaluate Mr. Ross' competence to waive his appeal rights. Despite more than one suicide attempt in the intervening decade, Mr. Ross continued to maintain his desire to live were it possible to do so and not subject his victims' families to further trauma in court proceedings. Absent that possibility, he felt compelled not to inflict further injuries upon those he had hurt so grievously. Dr. Norko interviewed multiple collateral sources in evaluating Mr. Ross' motivation, including mental health staff and a Catholic bishop who had counseled him that the Church would not consider his decision to accept the death penalty as sinful.

Mr. Ross' attorneys felt obligated to argue that he was not competent to make a decision to waive appeals, and that he was pursuing state-assisted suicide. Therefore, they argued for "best-friend" status in order to continue further appeals on his behalf, in opposition to his wishes. In his testimony, Dr. Norko was examined by the prosecu-

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Malingering Wellness

Lawrence A. Siegel MD, Abraham L. Halpern MD, John H. Halpern MD

As is well-known to many mental health professionals, and certainly to all forensic psychiatrists, the use of civil commitment to supplement criminal sentences in order to incapacitate the most dangerous sex offenders has been declared to be constitutional by the United States Supreme Court.¹ Also, an increasing number of states have enacted laws authorizing involuntary psychiatric hospitalization of convicted sex offenders identified as “sexually violent predators (SVPs) on completion of their prison sentences. These developments have confronted forensic psychiatrists who are involved in the evaluation of hospitalized SVPs under consideration for release from confinement. Up to now, forensic psychiatrists have had to be on guard against malingering of illness mainly in their examinations of defendants for competence to stand trial. According to the AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial,² many such defendants have been found to be malingering. Two reports are cited that indicate that at least ten percent of defendants referred for triability determination attempt to feign mental illness that would render them incompetent.^{3,4} Given the lengthy periods of hospitalization and the regular reviews mandated by the new SVP laws,⁵ malingering “wellness” (or feigning recovery) is likely to be encountered much more frequently than has been the case in court or review board hearings for persons seeking release from other involuntary retention settings.

Quite by happenstance, we acquired a document⁶ that we felt would be of interest to Newsletter readers. It consists of advice, especially for SVPs, on how to deceive authorities empowered to decide on the patient’s release or parole. We hope it will assist those who are charged with the responsibility of assessing an SVP’s suitability for less restrictive confinement or release. It reads as follows:

How to Survive a Multidisciplinary Meeting (Particularly if you’re an aggressive sexual offender)

1. Give an account of your offense which correlates closely, if not exactly, with the Probation Officer’s report; particularly with respect to: (a) Whether a weapon was involved; (b) Whether physical violence was involved.
2. Show remorse: e.g., “I’m sorry” “What I did was wrong,” plus 25-50 additional words appropriately chosen. Include a reference to the victim, and particularly make a “guess” about

“Even though you believe you have made some positive changes, be sure to express doubt as to whether or not you are really “cured.””

how badly they must have felt about your actions towards them.

3. Be able to explain, very clearly and convincingly, any discrepancies between your description of your offense and that contained in the Probation Officer’s report.
4. Be able to give a nice “insightful” explanation as to why you committed your offense.
5. Be prepared to discuss any personal “beefs” which have accumulated with members of the hospital staff. These disagreements may or may not have anything to do with your presenting problem. You can recognize the beginning of such a discussion by hearing the staff members’ voice become high pitched and louder than usual as they ask, e.g., “Do you remember what you said to me when ...?” or “is it not true that on the occasion of ... you said to me that ...?” At these times, the best guideline would be to quietly agree with the staff

member, without offering any alternative view of the situation being described.

6. “Accept” and agree with any semi-punitive homespun observation about your offense, such as “what you did was pretty sick, don’t you think?” Head-nodding and a quiet “yes” as the statement is being made would be most helpful.
 7. Be prepared for irrelevant questions such as, “can you really have children?” or, “didn’t your parents really break up your marriage?”
 8. Be able to explain how “the program” has helped you, and how it could be improved. (A brief suggestion or two would be sufficient.) Do not suggest in any way that “the program” is at all unclear to you, or that there may not, in fact, be a program.
 9. Never deny any statement contained in the Probation Officer’s report, which is unfavorable to you (e.g., a weapon being involved; physical force being involved), and then later admit it. Particularly undesirable would be to claim that the original denial on your part was due to “nervousness” or “being scared” or some other reasonable explanation.
 10. Be able to give a convincing description of what you will do if the same set of circumstances recurs which led to the offense for which you are now confined. This description should obviously include the comment that you would not repeat the same offense again. Also, refer to having gained better inner “controls” through treatment in the hospital, getting more “help” by going to a psychiatrist immediately.
 11. Be a patient here for three years.
 12. Make no statements which suggest that you, or others like you, are “entitled to” or “were justified in doing” any of the things which led to your hospitalization.
 13. Even though you believe you have made some positive changes, be sure to express doubt as to whether or not you are really “cured.” Show concern about recidivating and the need to stay on guard.
 14. Be able to explain how you have made constructive use of the hospital
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Ask The Experts

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

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

Q. How do I tell a lawyer that she/he is asking the wrong question?

A. Kaye: It is not uncommon for a forensic psychiatrist to have more knowledge and experience in a particular area than does the referring attorney. Hopefully, that is part of why our expertise is being sought, and the lawyer is prepared to hear our input. The “wrong question scenario” can arise from a misunderstanding of the issue at hand, a common problem in criminal law where criminal responsibility and competency to stand trial are often confused. In civil cases, it is not uncommon for a lawyer to appear to be targeting the wrong party or issue completely.

It is time for a phone call to the lawyer to discuss the case and your thoughts. These conversations are usually considered “work-product” and are not usually subject to discovery. Before telling the attorney that she/he is wrong, try to get her/him to better explain her/his thinking and present strategy on the case. Because lawyers plan the legal strategy, there might be a good reason she/he has framed things in a certain manner (who has the deep pocket, liability issues, settlement by other parties, stipulations, etc.)

You will need to be prepared to state whether not your analysis of the data allows you to support the position articulated. If you cannot, be honest and say so, but if you have an

alternative theory or approach based on your knowledge and experience, it is appropriate to share your ideas. Be polite, firm, honest, and know the facts of the case that support your opinion and tell the attorney succinctly. If nothing else, it will demonstrate how good you can be when you get to court.

A. Sadoff: I agree with everything Dr. Kaye has said. Let me add the following by expanding the question: Sometimes the lawyer asks the “wrong” question because he/she does not know the extent of the psychiatrist’s expertise. Sometimes the expert may not wish to go to the extent the attorney requires in order to succeed in a particular case. Sometimes the question is only partially within the expertise of the psychiatrist who needs consultation from a colleague in a related field (psychology, toxicology, pathology, child psychiatry, psychopharmacology, neuropsychiatry, neurology, or other specialty of medicine)

Thus, the question may not be “wrong” but there will need to be a clarification in the communication between expert and attorney. In the case of a clear incorrect question for the expert, the psychiatrist needs to alert the lawyer about his/her expertise and why he/she cannot help in this case. It is always helpful to the lawyer to recommend the proper expert in that particular case.

Occasionally, the attorney will request the psychiatrist to go beyond his/her expertise or to “see things my way.” My response to these requests is to refuse and never work with that attorney in the future. Fortunately, these requests are rare, but do occur.

Finally, if after reviewing the records one believes he/she cannot help the attorney or does not have the required expertise for the issues at hand, it is prudent and appropriate to refer the lawyer to the appropriate expert or to let the attorney know that he/she is focusing on areas not amenable to our professional expertise. ☞

Malingering Wellness

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tal’s resources.

15. Tell how you have improved relationships with others to tolerate stress and frustration.

16. Tell how you never strike out at others physically or verbally.

17. If you had a headache, ulcers of stomach or depressions, tell how you cried in therapy and confessed your wickedness and these physical pains and discomforts healed themselves without medications.

18. Tell about disturbing dreams, especially nightmares or any recurring dreams.

19. Have a choice of realistic plans for the future and be willing to conform. Prospects for further training and constructive employment are great.

20. Avoid reliance on religion and other “good” things but don’t knock them. Plan to attend church to associate with the right kind of people.

21. Be fearful of the use of alcohol in any form and strive to attend AA if alcohol was ever a problem. The same for drugs.

22. Tell how you used to use “words” in group therapy, but then experienced deep feelings of regret for what you have done and a quiet desire to stop using words as a cover-up for real feelings. Give examples similar to those you read in biographies of great men. ☞

References

1. Kansas v. Hendricks, 521 U.S. 346 (1997)
2. Mossman D, Noffsinger SG, Ash P, et al.: AAPL practice guideline for the forensic psychiatric evaluation of competence to stand trial. *J Am Acad Psychiatry Law*. 2007;35:Supplement_4S3-S72
3. Rogers R, Sewell KW, Goldstein AM: Explanatory models of malingering: a prototypical analysis. *Law Hum Behav*. 1994; 18:543-52
4. Gothard S, Rogers R, Sewell KW: Feigning incompetency to stand trial: an investigation of the Georgia Court Competency Test. *Law Hum Behav*. 1995;19:363-73
5. See, for example, New York State’s Sex Offender and Management Treatment Act, 2007
6. Colleagues interested in learning about the provenance of the document are invited to contact Dr. A. Halpern at email ahalpern1@verizon.net or 914-698-2136

Across the Andes: Forensic Psychiatry Training in Chile

Carolina A. Klein MD



Little did I know when I spoke of what I was going to be when I grew up that I would be following this journey to get there. Almost

fifteen years after my high school graduation, and with 31 candles on my last birthday cake, here I am— an early career forensic psychiatrist. I completed my medical education in Chile, where medical school is a seven-year long program that starts immediately after high school and culminates with two internship years. I then completed my psychiatry residency in New York, followed by my forensic fellowship in Washington, D.C. Now I look back and wonder how my training would compare if I had stayed in Chile.

In Chile, specialty training after completion of medical school is not required, and medical doctors can work as general practitioners. Training in psychiatry is a three year-long program, provided through State hospitals or through academic institutions. Those provided by academic institutions charge tuition, whereas State funded programs may provide a stipend which then is repaid through service in underserved areas. There are no standardized training or subspecialty qualifications in forensic psychiatry; rather, forensic psychiatrists become such subspecialists through brief courses in areas of the field or through clinical experience in forensic settings. Training seminars may range from hours-long conferences to a year-long program of twice per week classes; and they may be provided in areas of criminology or social pathology, among others. Clinical experience in forensic settings may include work with incompetent to stand trial patients, victims of sexual offenses, or minors in family disputes.

The forensic psychiatrists' role in Chile, within the criminal arena, is

mostly contracted for the purposes of criminal responsibility evaluations, competency, and assessment of dangerousness. Civil forensics is mostly concerned with matters of testamentary capacity, and family law, including child abuse and custody matters. Forensic psychiatry consultations may be petitioned directly by the judge, through law enforcement agencies in charge of investigations (Policía de Investigaciones), or through a national institute for forensic investigations. This institute, Medico-Legal Service (Servicio Médico Legal), provides assessments in the areas of thanatology, injury evaluations, forensic sexology, and forensic psychiatry. It also

“...forensic psychiatrists become such subspecialists through brief courses in areas of the field or through clinical experience in forensic settings.”

comprises a comprehensive forensic laboratory, and offers educational programs in forensics.

When comparing the training system in Chile to ours in the United States, several things become relevant. The Chilean system allows for younger practitioners to enter the field, which is of benefit when one considers that most of them have been able to accrue no income throughout their medical training up until that point. It also allows for immediate subspecialization according to their line of work, as practitioners may choose to attend post-doctoral trainings that pertain exclusively to their area of expertise or practice. It may also allow for a closer maintenance of clinical skills, as most

work opportunities are grounded in settings where treatment is also required.

On the other hand, the lack of a formal or standardized forensic psychiatry training program may impede the development of a basic terminology within forensic psychiatry, the establishment of a standard of care in forensic psychiatry, and the ongoing assessment of forensic psychiatry needs in different areas. Educational exchanges and international academic collaborations may prove difficult given the disparity in training curricula.

In terms of practice, outpatient forensic services in Chile are scarce, and most are based within governmental institutions that may or may not have academic affiliations. Research could thus be compromised. Furthermore, the potential for a more lucrative private practice in forensic psychiatry may be difficult to achieve, deterring potential candidates away from this field, where services are in high demand. Overall, services are centralized in the capital city.

Differences in forensic psychiatry training are marked all over the world. In Europe, only England, Ireland, Sweden, and Germany have formally recognized training (Denmark has forensic training but no subspecialty qualification). In Bulgaria, forensic psychiatry training is a two year-long training. Efforts to reach a consensus in training within the European Union are underway. In the United States, formal forensic psychiatry training was required as of 1997, but a general psychiatrist may be asked to perform certain forensic duties in areas where the subspecialist may not be available. It appears as though developed countries are moving towards a system of standardized training and qualification by a nationally recognized entity (such as the American Board of Psychiatry and Neurology in our case). I have certainly benefited from a curriculum that provided me theoretical and supervised clinical exposure to many areas of forensic psychiatry, and I can see how a program like this would flourish in a country like Chile.

Dr. Klein is a forensic psychiatrist at Saint Elizabeths Hospital and Georgetown University Hospital, Washington D.C. ☎

Photo Gallery



Grand Annual Meeting hotel surrounded by beautiful hills and cacti plants.



AACL registration desk – busy throughout!



Lecture time with Debra Pinals.



Tom Gutheil worries with fellow AACL members.



Lunch Head Table: L-R: Annette Hanson, Wade Myers, Richard Frierson, and Alec Buchanan



Meeting attendees arrive.

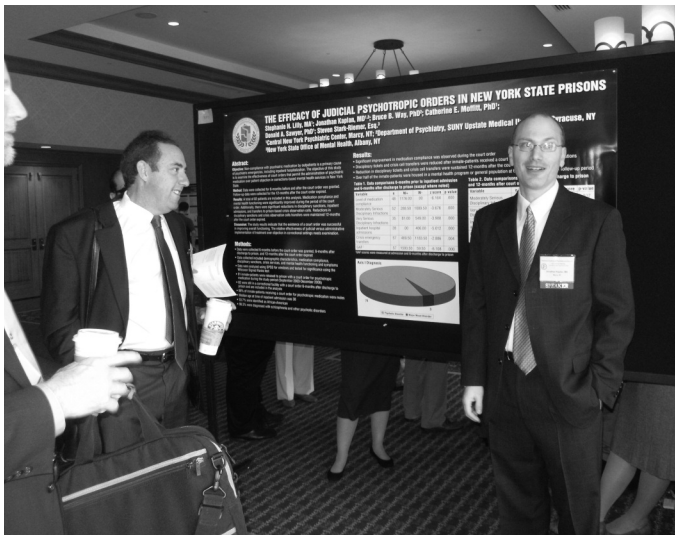
Photo Gallery



View from inside the hotel.



Questions/comments – a reflection of AAPL's vibrancy.



Colorful and impressive poster presentations.



Michael Norko and Donna Norris strike a pose as they wait for the Opening Ceremony.



Lunch Head Table: L-R: Howard Zonana, Barry Wall, and Ezra Griffith



Elegant reception under "moonlight."

Serotonin Syndrome in Children: A Potentially Toxic Clinical and Legal Entity

Ryan Hall MD, Christopher Davidson MD, Hank Levine MD,
Psychopharmacology Committee

Major regulatory and legislative changes are occurring in medicine due to serotonin syndrome. The 1984 serotonin syndrome case of Libby Zion was one of the major reasons for the enforced reduction of the medical house staff work week to 80 hours.^{1,2} Although there is some debate on her exact diagnosis, 18-year-old Libby Zion's death was attributed to a medication interaction between the MAO-I phenelzine and the narcotic meperidine, which has serotonergic effects.^{1,3} Libby's father, who was a journalist for the *New York Times*, made her death the face of his contention that medical errors were occurring due to house staff being fatigued.¹ His campaign led to changes in New York state laws, which later became part of a national reform.² Since then, there have been other highly-publicized deaths attributed to serotonin syndrome, such as the death of 12-year-old Denis Maltez in Florida.⁴ The Maltez case and others like it in Florida in part have resulted in legislation being proposed which uses wording similar to the Sell criteria, for the prescription of any psychotropic medication for children in the Florida foster care system whose parents or legal guardian are unable or unwilling to provide consent to medication.⁵ The legislation calls attention to the lack of published studies regarding polypharmacy in children, a common feature in adult serotonin syndrome cases, as a justification for the Sell type requirements.

The study of serotonin syndrome is extremely difficult in adults, let alone in children. It is unethical to give humans multiple medications with the intention of inducing a potentially lethal disease state. Although animal studies have provided insights into the condition, such as probable symptoms and treatments, the findings may not be applicable to

humans.^{6,7}

Most of the literature on humans with serotonin syndrome is derived from retrospective case studies or series. The initial diagnostic criteria for the condition were suggested by Steinbeck after reviewing 38 adult cases in 1991.⁸ His recommended criterion set calls for the presence of only 3 of the following 10 symptoms with no other identifiable cause, occurring after the initiation of a new

“The legislation calls attention to the lack of published studies regarding polypharmacy in children, a common feature in adult serotonin syndrome cases.”

serotonergic compound: agitation, diaphoresis, diarrhea, fever, hyperreflexia, incoordination, mental status changes such as confusion or mania, myoclonus, shivering, and tremor. Since Steinbeck's initial work, there have been multiple criteria proposed, with the Hunter criteria having the best reported sensitivity (84%) and specificity (97%).⁹ The Hunter criterion set calls for there to have been the recent start of an agent which affects serotonin, followed by one of the following set of symptom clusters: spontaneous clonus; inducible clonus and agitation or diaphoresis; ocular clonus and agitation or diaphoresis; tremor and hyperreflexia; or hypertonia and temperature increase to 38°C or higher with ocular or inducible clonus. As with the Steinbeck criterion set, the Hunter criteria also make the diagnosis after other potential causes such as meningoencephalitis, delirium

tremens, heat stroke, neuroleptic malignant syndrome, malignant hyperthermia, and anticholinergic toxicity have been excluded. Even with relatively sensitive and specific screening criteria, it is hard to accurately estimate the prevalence of serotonin syndrome due to the multitude of drug combinations that can cause it, the varying degree of symptom severity, and because it is a diagnosis of exclusion.

The authors are aware of only one published case series or study that looked at just children. A 2006 review of the literature by Buck from 1994-2004 contained six cases of hospitalized children suspected of having serotonin syndrome.¹⁰ Ages were from 24 months to 12 years, and length of hospital stay ranged from 2 to 7 days. All cases included an SSRI; one case with fluvoxamine, one case with fluoxetine, and four cases with sertraline. Only two cases contained combinations of medications. One patient took sertraline and erythromycin (thought to increase sertraline concentration through P450 system interaction), and another was prescribed fluoxetine, linezolid (a weak MAO-I), and fentanyl (similar to meperidine).^{3,10} Two were accidental ingestions (sertraline only). Symptom onset varied from an hour to four days. No deaths or permanent sequelae were reported in the children. The pattern in pediatric cases appears to vary some from the “classic” adult presentation, where the onset of symptoms is usually less than 24 hours, usually results from a combination of medicines, and if associated with a single agent, is usually the result of a significant super-therapeutic ingestion.³ As has been known in pediatrics for a long time, children are not just little adults, and more information is needed to fully understand the similarities and differences in serotonin syndrome in adults and children.

In summary, serotonin syndrome is a condition having both significant historical impact and potential future influence on the practice of psychia-

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Technology and Forensic Psychiatry: Recommendations for Practice

Delaney Smith MD, Cathleen Cerny MD, Sherif Soliman MD, Susan Hatters Friedman MD

Before discharging a suicidal patient from the emergency department, Dr. Jones uses her Smartphone to enter the patient's name into a popular search engine and finds a social networking profile picture of the patient holding a gun to his head. Though he claims the picture was a prank, Dr. Jones decides to hospitalize the patient involuntarily. Did she violate the patient's privacy? Would she be liable for an untoward outcome had she failed to obtain this information?

The role of technology in psychiatry has expanded rapidly. Tablet PCs and smart phones have brought technology into the examination room. New technologies have the potential to improve communication, accelerate the adoption of new treatments and guidelines, and preserve medical information. Email, websites, and social networking have the potential to significantly change the doctor-patient relationship. The standard of care will evolve to incorporate these technologies, requiring the use of some, while curtailing the use of others.

Currently, the federal government is making a strong push for the adoption of electronic health records (EHRs), and the goal is to have all medical records computerized by 2014. The American Reinvestment and Recovery Act of 2009, includes billions for the promotion of Health Information Technology. EHRs offer many benefits such as improved patient safety, health savings, better preventive care, and the facilitation of research. As with any technology, there also exists the potential for liability. Input errors, lost data, system defects and HIPAA violations are just a few of the areas that could lead to EHR legal battles. The information available through EHRs will be vast and immediately available. How much material will courts hold psychiatrists responsible for knowing? Will key information get overlooked? Forensic psychiatrists will face the

daunting task of first locating all relevant electronic records for a particular evaluation and then sifting through the voluminous material for key data.

Forensic experts will need to be careful, about how their reports are saved not only within EHR systems, but also within their own personal computers. EHRs and many computer programs, including Microsoft Word, create voluminous amounts of meta-data (data about data) including timing

“In the forensic setting, the internet potentially provides a wealth of data about evaluatees but we may not all have the necessary training or experience to adequately and accurately evaluate someone's digital footprint.”

of entries, edits and even templates used to create a document that may then become discoverable. Email also creates meta-data which can be discoverable in certain circumstances. Electronic discovery was addressed by the new Federal Rules of Civil Procedures in 2006, which acknowledged meta-data as its own distinct form of information and encouraged its pursuit early in litigation. Many states are adopting similar rules increasing the likelihood that forensic experts will be seeing more of this sort of information in the courtroom.

As medical records have become electronic, so have many aspects of prescribing and dispensing medica-

tions, and the courts will likely be looking to forensic experts to weigh in on whether use of these advances is considered standard of care. Care provider order entry (CPOE), also referred to as computer order entry, allows physicians to input medication orders directly into a computer program. While there are numerous benefits of CPOE, there are also areas of potential liability concerns, including “point and click errors,” where an incorrect medication or dosage is selected from a list, and “alert-fatigue,” in which the user becomes desensitized by the volume and frequency of alert messages and begins to ignore even significant warnings. Many CPOE systems also have a built in mechanism for generating electronic prescriptions which carry many of the same potential legal pitfalls. However, unlike CPOE which is primarily utilized in inpatient settings and generally unavailable to independent practitioners, electronic prescribing software can be easily purchased and fit into most patient care settings.

Medication interaction tools, either built into CPOEs or electronic prescribing software or available for free through services such as Epocrates and Drugs.com, allow providers to input a patient's medications, and in some cases medical problems, in order to quickly search for potentially dangerous interactions. Areas of concern with the use of this advancement include over-reliance on the system, and the ability of the software to keep up with all new medications on the market and newly discovered interactions. Among the newest medical technological advances to impact prescribing are automatic prescription reporting systems which provide access to electronic listings of all prescriptions that an individual has filled, allowing monitoring for medication interactions, duplications, and drug-seeking, with little foreseeable liability risk associated with its use.

Courts have consistently held that physicians have a duty to keep up-to-date with medical literature and to make sure that their practice follows the latest research-supported recom-

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Emphasizing Electronic Medical Records

Lawrence K. Richards MD, Committee on Computers

Among the topics discussed by the AAPL Committee on Computers were ideas for computerized internal communications for intra-committee discussion, and the impact of electronic medical records. The latter will be expanded to EHR (electronic health records) by the Office of National Coordinator (ONC) appointed by President Barack Obama, and the Centers for Medicare and Medicaid Services (CMS or CMMS). General agreement has unfolded for using CMS, and googling either CMS or CMMS gets you the same 2nd choice showing this government entity. Related to this, Dr. Richards also reported on the immediately preceding Boston IPS meeting where he and Drs. Gutheil, Plovnick (of APA HQ) and Pulier gave a Workshop on H.I.T. (Health Information Technology). The remainder of this report utilizes that content (Syllabus CD of 62nd IPS).

Just to get readers' attention, it is noted that CMS plans to reduce payments to doctors a few years from now if EHR are not used. Contrariwise, \$44K are available for "meaningful use" of EHR, and the ONC is currently saying this will be paid in 3 divided sums over 3 years based on doctors' meaningful use (And to all "health care" providers?). The definition of "meaningful use" is being defined as we speak, with considerable progress made in the last year, refining and somewhat simplifying 25 criteria. While these can still be altered, a new summary of these appears in the Aug.5, 2010 issue of the N.E.J.Med., (vol.363,#6,p501) written by none other than David Blumenthal, M.D., the Boston internist appointed as Director of ONC.

Most likely, some of this money will be spent on hardware and the rest on software, this latter being in the form of programs certified by the ONC as secure systems that meet providers' needs (Hopefully designed for effective office use by doctors). Of

course, it is EHR rather than EMR because it is expected to contain everything related to a patient's health. If certain folks get their way, you will also have to hire some person to input all this data. If done well, the programs should be so direct, so clever, and so clear that the doctor can do this in real time while seeing patients, push a few more keys, and have it all done easily by him/herself. Most likely, unless the doctor is thinking and making the entries, there will be no improved care. If the doctor cannot do it in real time, it just means longer hours, poorer coordination, failed

"If the doctor cannot do it in real time, it just means longer hours, poorer coordination, failed entries and a greater energy drain on the doctor."

entries and a greater energy drain on the doctor.

Some think patients will object, not feel attended to, etc., but more likely, if these programs are well written, once the patient senses the value, cooperation will result. If the software programs "meet providers' needs," this will not interfere with rapport and can be seen as "teamwork" between patient and physician. Then the patients take their copy home!

Confidentiality is also a major problem—not an issue, but a problem. (Check out www.PatientPrivacyRights.org)

There are fairly frequent call-in or in-person sessions associated with all the above, (check out <http://healthit.hhs.gov>)

It should be noted the value of EHR

is to achieve coordinated care and decrease mistakes, as well as avoid redundancies and wastefulness. It is also hoped that there will be savings through "everyone" being party to these records, such as tests already ordered, better evaluation planning, and patients' awareness of their record. Giving copies to the patient is a big deal, and part of the "meaningful use." Then there is the possibility of enhanced treatment planning and coordinated multi-disciplinary inputs, all hopefully for the benefit of the patient. (P)

Economics of Prisons

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devotes to higher education – Prison Legal News, April 7, 2011.

In conclusion, the current economic crisis has forced desperate state governments to shine a bright light on the economics of incarceration, and the outcome is troubling. With most of the money related to incarcerations going toward the cost of imprisonment, little is left for prevention, treatment, education, and services to help more than half of the population of prisoners who struggle with mental illness and drug problems that led them to crimes and imprisonment in the first place. More troubling, however, is the fight to keep prisons open even when they are no longer needed, mostly to maintain jobs in the locality and support businesses dependent on the prisons. With such ulterior and selfish motives, it is understandable that little effort is expended to keep individuals out of prisons; job security trumps increased incarceration. It would also be understandable if laws were crafted for maximal impact, to snare as many people as possible into prisons to support local economies. Sad, but true.

In recognition of this absurdity and in response to those clamoring for more prisons, Gov. Cuomo of New York State appropriately retorted, "An incarceration program is not an employment program. If people need jobs, let's get people jobs. Don't put other people in prison to give some people jobs." Wise words, but unfortunately, they have fallen on deaf ears till date. (P)

Computer Crimes and the Use of Digital Evidence are on the Rise

Alan R. Felthous MD, Liaison with Forensic Science

Today “90 percent of every FBI investigation involves digital evidence,” said Marcus K. Rogers, Ph.D., representing the Digital and Multi-media section of the American Academy of Forensic Sciences. Professor Rogers is Director of the Cyber-Forensics Program, Department of Computer and Information Technology at Purdue University: Purdue University has a master’s program in forensic cybernetics. The FBI now has 16 Regional Cybernetics Forensic Laboratories in the United States. Although computer crime existed in the 1970s, the Digital and Multimedia Section of AAFS was not established until 2008. The Council of Europe has enacted laws through which internet crimes are recognized by all signatory countries. Violators can be extradited to the appropriate jurisdiction. Forensic cybernetics is a forensic science with specific rules of practice and ethical guidelines. The field encompasses both digital evidence and visual imaging technology. It is applied within the realms of law enforcement, the military, business, academia, intelligence gathering agencies and by private practitioners. Forensic cybernetics is relevant to homeland security. Digital forensic research pertains to iPads, iPods, and cell phones.

Presentations by Marcus Rogers and Edward Fischer, Ph.D., contributed to “Forensic Sampler: Computer Crime,” a panel moderated by Robert Weinstock, M.D. About “80 percent of law enforcement time” in computer crime is investigating internet use of child pornography, said Rogers. Digital evidence includes networks, code analysis to investigate viruses, storage media (i.e., computer forensics), and small scale digital devices such as cell phones, iPads, iPhones and even the computer chips in automobiles. The primary activity is investigation, which involves identification, preservation, examination, analysis, presentation of the evidence and a decision. Digital evidence can be hidden in cars, toilets, the inter-

net or a refrigerator.

“Cyber crime deals with deviant use of technology by people,” noted Rogers. Technology itself can serve as the target, the victim or a weapon of illegal misuse. Using the Audience Response System, 45 percent of those in attendance had worked with a defendant who was charged or convicted of a computer crime.

Psychologists and psychiatrists can become involved by participating in offender treatment programs, conduct-

Expert Testimony

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this aggregate information? The depth of detail obtained in forensic evaluation allows for case-specific factors to emerge and for the construction of a narrative form of knowledge that may sometimes be difficult to situate within research findings. How should we argue that an empirical study’s results apply to our case? What do we do if the case does not fall squarely within the scope of existing studies, but resembles certain populations, broadly defined? The process of inference and theory development that experts employ as they formulate knowledge in the particular case requires clarification as well as focused debate regarding the ways that explanatory or predictive theories are confirmed, generalized, and either do — or don’t — reach consensus within the community of forensic practitioners.

Precise application of scientific information to the particular case would thus appear to require the expansion of three main areas in forensic psychiatry research: (i) comprehensive studies, with large samples, regarding outcomes in both forensic treatment settings and in legal proceedings; (ii) a nuanced and empirically based understanding of the effectiveness of testimony and scientific argument in the context of legal proceedings; and (iii) the development of con-

ing forensic evaluation of computer crime defendants, or conducting offender release risk assessments. Although only 16 percent of attendees had provided expert testimony related to a defendant having been charged with computer crime or child pornography, Rogers expected this percentage to increase over time. Most offenders and victims are willingly participating adolescents. Rogers and colleagues have studied Aspergers Syndrome and found no association with computer crime.

In conclusion, Rogers stated that “computer crime will not go away.” Rather it will increase.

In answer to a follow-up question, Rogers stated that research in Europe
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sensus regarding clinical methods for the analysis of the particular case and the ways that information from large studies are applied to the individual. Increased collaboration with psychologists in existing research programs regarding the first two points would help to ensure the applicability of findings obtained from such studies to forensic psychiatric practice. The third issue may appear to be more theoretical and clinical – after all, “experience” refers to the individual expert and his/her judgment – but this too can be an object of research, one with a forensic specificity that remains to be explored. 

References:

1. Bernet W & Corwin D. An evidence-based approach to estimating present and future damages from child sexual abuse. *Journal of the American Academy of Psychiatry and the Law*, 34:224-230;2006
2. Hubbard KL, Zapf PA, Ronan KA. Competency restoration: an examination of the difference between defendants predicted restorable and not restorable to competency. *Law Hum Behav*, 27:127-139;2003
3. Mossman D. Predicting restorability of incompetent criminal defendants. *Journal of the American Academy of Psychiatry and the Law*,35:34-43;2007
4. Morris DR & Parker GF. Jackson’s Indiana: State hospital competence restoration in Indiana. *Journal of the American Academy of Psychiatry and the Law*, 36:522-534;2008
5. Morris DR & Parker GF. Effects of advanced age and dementia on restoration of competence to stand trial. *Int J Law Psychiatry*, 32:156-60; 2009

Cannabis Psychosis: Reefer Madness Redux

Gregory Sokolov MD, Douglas Tucker MD

(Part of panel presentation by AAPL Addiction Psychiatric Committee: "Substance-Induced Psychoses: Intoxication, Insanity and Interventions" at 41st Annual AAPL Meeting, Tucson AZ.)

Cannabis, or marijuana, is the most commonly used illicit substance in US, Europe, and Australia (40-60% of individuals from ages 18-25 have used it at least once). The average potency in seized samples has increased from 1.2% THC (tetrahydrocannabinol, the main psychoactive substance found in the cannabis plant) in 1980 to 4.2% in 2007, with up to 15-20% in cultivated "medical marijuana."

Cannabis use has been associated with acute toxic psychosis, as well as causation and exacerbation of chronic psychotic disorders. A recent large-scale study has provided the first conclusive evidence that cannabis use significantly hastens the onset of psychotic illnesses – often with life-long consequences. A first ever meta-analysis of more than 20,000 patients has shown that smoking cannabis is associated with an earlier onset of psychot-

ic illness by up to 2.7 years¹.

Cannabinoid receptors are central and pre-synaptic, and modulate the release of neurotransmitters including dopamine and glutamate. They are localized in brain areas implicated in psychosis (e.g., frontal and cingulate cortex, basal ganglia, cerebellum, hypothalamus, hippocampus). Studies have shown that THC can induce the full range of transient schizophrenia-like positive, negative, cognitive and behavioral symptoms in healthy individuals. Compared with schizophrenia, cannabis-induced acute psychosis more often demonstrates visual hallucinations, sudden delusional ideas, thought insertion/withdrawal, irritability, agitation, retained insight, and "organicity," with less thought disorder and affective flattening, but there is a large overlap.

Case examples of cannabis psychosis have been portrayed in popular culture, e.g. the character of Ralph Wiley from the 1936 American cult movie "Reefer Madness," who pleads not guilty by reason of insanity for homicide committed during a

cannabis-induced paranoid psychosis. Cases of cannabis psychosis are also described in case law, e.g. State v. Hornsby in North Carolina, in which the not guilty by reason of insanity defense was rejected by jury for homicide committed during an episode of cannabis psychosis².

Evaluation of the criminal responsibility of an offender who has consumed cannabis necessitates knowledge of the effect of the substance on the offender's mental state at the time of the alleged offense. However, as the effects induced by cannabis are numerous and vary among individuals, the forensic psychiatrist should base the evaluation and diagnosis on facts which are as objective as possible. Published guidelines have been proposed for the evaluation of criminal responsibility with relation to cannabis psychosis³. (P)

References:

1. McGrath J, Welham J, Scott, J, et al., Association Between Cannabis Use and Psychosis-Related Outcomes Using Sibling Pair Analysis in a Cohort of Young Adults. Arch Gen Psychiatry 67:440-7, 2010.
2. State v. Hornsby, North Carolina Court of Appeals (2002).
3. Niveau, G., Criminal responsibility and cannabis use: psychiatric review and proposed guidelines. J Forensic Sci 47: 451-458, 2002.



Midwest Chapter Elects New Officers

Steve Berger MD

The Midwest Chapter of AAPL held its annual meeting in March in Cleveland. The excellent program featured new presenters and older familiar presenters, with more civil than criminal topics. The newly elected officers are pictured here: Seated from left are Secretary Cathleen Cerny, Outgoing Past President Maureen Hackett, President-Elect Susan Hatters-Friedman, Councilor Christine Martone. Standing from left are New Immediate Past President Joy Stankowski, President Phil Pan, Treasurer Larry Jeckel, Councilor Sherif Soliman. Not pictured is Councilor Michael Harlow. (P)

Tri-State AAPL Meets in New York City *Civil Liability and Forensic Psychiatry: Selected Topics*

John Young MD

On Saturday January 22, some 50 stalwart AAPL members braved the cold to attend the Tri-State Chapter's 36th annual conference, held in cooperation with the New York State Office of Mental Health and the Forensic Psychiatry Clinic for the Criminal and Supreme Courts of New York State. The program offered five hours of Category 1 CME credits. We heard four 1-hour presentations, followed by questions and discussion.

The first presenter was Charles R. Marmar, Professor and Chair of Psychiatry at N.Y.U. He spoke on "Assessing PTSD in Forensic Settings." He pointed out the importance of being able to detect both malingering of the disorder and dissimulation of its absence. It is not only costly to treat based on an incorrect diagnosis but also arguably more expensive to miss the diagnosis when evaluating, for example, applicants to a city police force.

By way of history Dr. Marmar pointed out that Homer made reference to the "moral injury" experienced by some soldiers after they had taken lives in battle. The first peer-reviewed report of the disorder was in the initial volume of *The Lancet* in 1884. During the U.S. Civil War, it was known as "soldier's heart," and in 19th century Europe, the term "railway spine" probably covered at least some PTSD cases. On the other hand, the First World War term "shell shock" was likely applied to both traumatic brain injury (TBI) and PTSD. This inference is partly based on the regular documentation of TBI in troops exposed at some distance to explosive devices in Iraq and Afghanistan. This discovery, along with the rapidly developing understanding of what the so-called "Vietnam syndrome" could entail, add to the pressure for biological markers for PTSD.

Dr. Marmar then reviewed the longitudinal course of PTSD, pointing out that 70% of affected individuals recover, 58% within 9 months. About 20%

become chronic and half of these are depressed. There is a significantly increased violence risk. There are several likely predisposing factors, including economic and cultural, as well as education, intelligence, and family history of mental illnesses.

The speaker's main point was his expectation for biological diagnosis of PTSD in the near future. He began by describing his working model for PTSD as an adrenaline-driven disorder of unmanageable anxious arousal. In the susceptible individual, the experience of peri-traumatic panic and terror results in prolonged activation of the

"The speaker's main point was his expectation for biological diagnosis of PTSD in the near future."

sympathetic nervous system, setting up a massive fear conditioning associated with lower levels of cortisol and other stress hormones including Neuropeptide Y. At the same time adrenaline becomes chronically elevated. There are associated brain circuit changes involving the ventrolateral prefrontal cortex, the lateral nucleus of the amygdala and the locus coeruleus. Simultaneous changes occur in the function of the hippocampal-hypothalamic-pituitary-adrenal axis.

Several potentially diagnostic "biomarkers" arise from the model. These include heart rate, skin conductance, and certain nerve conductance measures. Imaging studies are becoming increasingly refined, beginning to demonstrate such changes as decreased hippocampal volume on MRI (reversible with SSRI administration) and decreased anterior cingulate and orbitofrontal reactivity to traumatic stimuli on PET. Genetic studies of

PTSD are also beginning to demonstrate additional markers, including polymorphisms and variations in gene expression.

In the question period Dr. Marmar opined that a combination of the measures he had described could be mature enough for forensic psychiatric applications in two or three years.

The second presenter was Marsha Garrison JD, a Professor at the Brooklyn Law School. Her talk was entitled "Child Custody and Visitation: Legal Principles and Psychiatric Evidence." She opened with the proposition that custody law is vague and subject to changes as it follows social and cultural values. For example over the past 50 years the advantage passed from the child's father to the mother and now is erratically swinging to a set of varied models of shared custody. The pace of change has picked up as families adopt differing structures and the influence of gender decreases. Foster parent status has little weight, and grandparents are gaining recognition.

The principle of the child's best interest has become well established, but its definition is in flux and is expressed differently in different jurisdictions. The pioneering work of Goldstein, Solnit and Freud continues to weigh heavily. The recent literature also favors joint or shared custody including splits of both legal (decision-making) and physical (residential) functions.

The forensic aspects are multiple and challenging. A frequent request is for the assessment of various serious allegations. A fundamental issue is the debated syndrome of parental alienation. Advice is requested regarding whether or when it is proper to exert force on a child, financial disagreements, whether agreements are being followed, etc.

Often it seems as if the expert is being asked to fill a legal vacuum left by the lawyers involved. The accepted guidelines for a thorough evaluation are so demanding that often they are not met. Yet, pointing out how often the courts follow their experts' opinions, Ms. Garrison eloquently made their importance clear. Lawyers often

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Civil Liability

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have a justified impression that experts go further than forensic science presently permits.

Ms. Garrison went on to describe the measures that feuding parents have resorted to in custody fights, including ways to prolong them as the child grows older. She concluded with cases to illustrate this and the other informative points of her lecture.

The third presenter was Liza Gold MD. Well known to AAPL members, she is a Clinical Professor of Psychiatry at Georgetown. She spoke on "Psychiatric Evaluation in Sexual Harassment Litigation." She began by illustrating how easy it is to become distracted by non-psychiatric issues because accusations have so many other compelling dimensions. Despite this, one has to proceed based on the totality of circumstances at issue.

Perceptions differ and are subject to change. One current constant is that the requirement at stake must be a legally protected characteristic as defined under Title VII of the Civil Rights Act of 1964. Incidence of sexual harassment depends on definitions, but the most severe allegations occur the least frequently. Dr. Gold listed several factors that can lead to greater or lesser likelihood of sexual harassment. She pointed out the importance of clarity and organization on the part of managers. They have, she pointed out, many good reasons to pay serious attention.

Measures important for managers to maintain include an attentive and nonjudgmental response system that is both prompt and reliable. It must take into account such factors as power relationships, and assess for multiple specialized details, including the sensitive gathering of the accuser's data.

The expert must also take care not to force diagnostic criteria or fail to explore all the relevant past and current history of each party. Evaluating damage claims calls for great care and clarity. Causality must be distinguished from mere association and alternate explanations must not be overlooked. At the same time malin-

gering also has to be considered, beginning with a series of the familiar red flags for this possibility. An engaging question and answer period followed, focusing mainly on problems audience members had experienced in dealing with questionable claims.

The final speaker was Clarence Watson, J.D., M.D., Clinical Director of Forensic Services, Delaware Psychiatric Center and Assistant Clinical Professor in Psychiatry, Jefferson Medical College. He informed us about "Psychiatric Issues in Tobacco Litigation Cases." These cases involve making some legal distinctions in

"Lawyers often have a justified impression that experts go further than forensic science presently permits."

order to clarify where the psychiatric expert's role fits in.

The earliest plaintiffs were no match for big tobacco and had difficulty finding a sustainable basis for making liability claims. This began to change as they learned to pool their resources and present newer better scientific evidence. The Surgeon General's office became involved, and identified some 11 diseases with cigarette smoking. As a result of a 1964 report from the Surgeon General's office, the federal Cigarette Labeling and Advertising Act of 1965 was passed.

The potential role for forensic psychiatry expertise developed as tobacco's addicting potential became clearer. At the same time, evidence of manufacturers' attempts to conceal and deny it came to light, and they were caught manipulating their cigarette formulations to exploit it. In 1988 another report from the Surgeon General's Office likened the addicting effects of tobacco to those of alcohol and cocaine.

Plaintiffs came out ahead in a 1995 case, followed by the major success involving the Texas and Florida Medicare systems, supported by those of 46 other states. A class action by flight attendants based on the effects of second hand smoke reached a settlement of \$349 million. The courts have now begun to require individual plaintiffs to prove individual damages, resulting in large backlogs. An expert now must examine the existence and origins of the individual's addiction and that it caused the medical condition on which the claim for damages is based. Professor Watson then briefly cataloged the dozens of details under several headings that an expert would need to explore in order to form a sound opinion and provide a persuasive narrative. He ended by stating that the changes proposed for DSM-V would prove helpful.

A short business meeting capped the day. It covered the Chapter's financial soundness and outlined initial plans for its three major annual undertakings, the December Puerto Rico meeting, the January annual conference, and the springtime conference with colleagues in the U.K. ☪

MUSE & VIEWS

Employee evaluations that could lead to forensic evaluations...be careful supervisors!

"This person is not really so much of a has-been, but more definitely a won't-be."

"He's so dense, light bends around him."

"This employee should go far — and the sooner he starts, the better."

"Got into the gene pool when the lifeguard wasn't looking."

Source: <http://www.re-quest.net/g2g/humor/office/index.htm>

Submitted by Charles Scott, MD

Meeting the Forensic Training Needs of Psychiatry Residency Programs

Melissa Spanggaard DO, Michael C. Harlow MD, JD, Elizabeth Hogan MD

The American Academy of Psychiatry and the Law (AAPL) Committee on Forensic Training of Psychiatry Residents continues to work on developing a web-based forensic psychiatry curriculum for use by psychiatry residency programs.

Since 2006 the Accreditation Council for Graduate Medical Education (ACGME) has required that residency programs provide opportunities for experience and education in forensic psychiatry and also that psychiatry residents should gain experience in writing a forensic report. This is a guideline that is expected to be increasingly enforced in the coming years. Meeting these requirements has been difficult for many programs, especially those lacking forensically trained faculty or forensic training sites. A joint task force between AAPL, the Association of Academic Psychiatry (AAP) and the American Association of Directors of Psychiatry Residency Training (AADPRT) was formed in 2008 with the intent of creating a web based forensic psychiatry curriculum for psychiatry residents.

The eventual hope is to have a program including videos of lectures covering essential topics in forensic psychiatry, as well as a video of a forensic psychiatrist completing a mock competency interview. Residents will then be expected to complete a written forensic report based on that interview prior to completing their psychiatry residency. Residency directors would then score the report using a standardized scoring rubric. Lectures will be located on an AAP website with potential links to AAPL's website, an on-line forensic psychiatry bibliography, and web-sites of national forensic psychiatry experts.

Progress continues to be made on this enormous undertaking. The AAPL Committee on Psychiatry Resident Education has completed an AAP on-line survey listing topics deemed most important for psychiatry residents. Information gained from this survey will be used to guide subjects covered

as the program gets off the ground. More topics will be added as time goes on. Another project is in the works to check more closely into what resources in forensic psychiatry residency programs currently have access to.

The issue of residency training in forensic psychiatry continues to be problematic for some programs. A member of the AAPL Committee on Psychiatry Resident Education was just recently asked to contribute lectures to one such program having difficulties meeting the requirements with the resources available to them. This is an exciting opportunity for AAPL to gain recognition and generate interest in forensic psychiatry in a larger number of residents.

Members interested in contributing lectures should email both Elizabeth Hogan, MD (elizabethhogan@aol.com) and Michael Harlow, MD (mharlow68@hotmail.com). ☞

MUSE & VIEWS

Some famous quotes on "Justice"

This is a court of law, young man, not a court of justice. ~Oliver Wendell Holmes, Jr.

It ain't no sin if you crack a few laws now and then, just so long as you don't break any. ~Mae West

Injustice is relatively easy to bear; it is justice that hurts. ~H.L. Mencken

Corn can't expect justice from a court composed of chickens. ~African Proverb

Good lawyers know the law; great lawyers know the judge. ~Author Unknown

Source: <http://www.quote-garden.com/justice.html>

Submitted by Charles Scott, MD

AAPL Awards Committee Seeks Nominations for 2011

The AAPL Awards Committee would like your help. We would be interested in receiving nominations by June 1 for the following awards:

Red AAPL	For AAPL members who have provided outstanding service to AAPL, e.g., through committee membership
Golden AAPL	For AAPL members over the age of 60 who have made significant contributions to the field of forensic psychiatry
Seymour Pollack Award	For APA members (who may or may not be AAPL members), who have made distinguished contributions to the teaching and educational functions of forensic psychiatry
Amicus Award	For non-AAPL members who have contributed to AAPL
Best Teacher in Forensic Fellowship Award	For outstanding faculty member in fellowship program

Please send your nominations to Renée Binder MD, Chair of the Awards committee: renee@lppi.ucsf.edu.

President

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cases through a complex interaction of training, experience, talents, incentives, and interests. Each person has his or her own view, and the fact that one has a view, even a biased view, does not mean that there is a COI.

So which model is more appropriate for the forensic presenter? A key difference between the two situations is the issue of who benefits from the presentation. In the case of the speaker with pharmaceutical company support, part of the disclosure rule stems from a concern that the presenter has a financial incentive to hold a view that will financially benefit the pharmaceutical firm (the stronger version of which would be if the presenter actually recommends a medication manufactured by the firm). The potential COI arises because the speaker may have a financial incentive to skew his/her thinking in a direction that benefits the pharmaceutical firm that paid him/her and which then stands to gain from the presentation. In the case of the psychopharmacologist and the psychoanalyst recommending their own approaches, there is no single entity that financially benefits – that the presentation may result in more patients being referred to psychopharmacologists or psychoanalysts in general is too diffuse a consequence to be very concerning. There may be bias in choosing a treatment approach, but there is not much conflict of interest.

In the case of the forensic psychiatrist's presentation, the retaining law firm that paid the presenter is unlikely to benefit from the talk. Even if the presenter changed the minds of most of the audience to support his approach in future cases (highly questionable at AAPL!) the retaining plaintiffs who paid the psychiatrist are unlikely to benefit. This lesser benefit to the payor significantly lowers the presenter's secondary interest in utilizing the presentation to advance the payor's cause. This in turn lowers the presenter's secondary interest (the financial interest) in the content of the presentation. While the audience may

be interested in the presenter's overall view, or even bias, this analysis suggests that any conflict of interest in the presentation is fairly indirect. A weighing of the limited benefits of disclosure against the problems requiring disclosure would create (what would the presenter disclose? — just listing law firms wouldn't communicate much) suggests that additional disclosure rules for forensic practice would not be helpful in this situation.

There are many other areas where AAPL needs to address COI issues.

“...higher standards of disclosure are likely appropriate for AAPL members who are involved in writing practice guidelines or who are on the Education Committee.”

For example, higher standards of disclosure are likely appropriate for AAPL members who are involved in writing practice guidelines or who are on the Education Committee. As the AAPL Council continues to address COI issues in the organization and develop reasonable policies, your thoughts and suggestions are always welcome. ☞

References:

1. American Psychiatric Association: APA Policy on Conflicts of Interest. Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research. Policy 201005. Adopted 2010. Available at <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/201005.aspx> Accessed February 21, 2011
2. Lo B, Field MJ, Institute of Medicine (U.S.). Committee on Conflict of Interest in Medical Research Education and Practice.: Conflict of interest in medical research, education, and practice. Washington, D.C., National Academies Press, 2009

Serotonin Syndrome

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try, and medicine as a whole, for years to come. This is evident from the work-hour regulations that have gone into effect after the Libby Zion tragedy. Additionally, if the legislation being proposed for foster children in Florida is a bellwether for the future, there may be new regulatory issues in medicine to contend with. Although a rare entity for any physician to encounter, a vigilant attitude toward serotonin toxicity is warranted. Serotonin syndrome is preventable and often occurs iatrogenically. Missing the diagnosis may have a profound effect not only on the patient's health but the practice of medicine in general. ☞

References:

1. Lerner B. A Case That Shook Medicine: How One Man's Rage Over His Daughter's Death Sped Reform of Doctor Training The Washington Post Tuesday, November 28, 2006
2. Brensilver JM, Smith L, Lyttle CS. Impact of the Libby Zion case on graduate medical education in internal medicine. Mt Sinai J Med. 1998 Sep;65(4):296-300.
3. Hall RC, Hall RC, Chapman MJ: Central Serotonin Syndrome: Part I—Causative Agents, Presentation, and Differential Diagnosis. Clinical Geriatrics, 15(12):18-25, 2007.
4. Miller C. Miami psychiatrist dropped from Medicaid program. Miami Herald April 21, 2010
5. Florida Senate reference bill 2718c2. <http://www.flsenate.gov/data/session/2010/Senate/bills/billtext/pdf/s2718c2.pdf> Downloaded on September 23, 2010
6. Kalueff AV, LaPorte JL, Murphy DL. Perspectives on genetic animal models of serotonin toxicity. Neurochem Int. 2008 Mar-Apr;52(4-5):649-58. Epub 2007 Sep 1.
7. Gillman PK. A review of serotonin toxicity data: implications for the mechanisms of antidepressant drug action. Biol Psychiatry. 2006 Jun 1;59(11):1046-51. Epub 2006 Feb 7.
8. Sternbach H. The serotonin syndrome. Am J Psychiatry 1991;148(6):705-713.
9. Dunkley E, Isbister G, Sibbritt D, et al. The Hunter Serotonin Toxicity Criteria: simple and accurate diagnostic decision rules for serotonin toxicity. Q J Med 2003; 96: 635-642
10. Buck M. Serotonin Syndrome: Pediatric and Neonatal Considerations Pediatr Pharm. 2006;12(3):1-5.

Michael Norko MD

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tion, then cross-examined by the attorney who agreed to represent Mr. Ross' expressed wishes to waive appeals, T.R. Paulding. Ultimately, the court found Mr. Ross competent. Mr. Ross' former defense attorneys filed numerous appeals and stays, in partial response to which Attorney Paulding submitted the videotape of Dr. Norko's December 2004 interview of Mr. Ross – which then became public information and was widely broadcast.

But the most challenging part of the case for Dr. Norko occurred less than 12 hours before the scheduled (but stayed) execution on a Friday afternoon in January 2005 - a full month after Dr. Norko's involvement in the case had ended with his court testimony. The former defense attorneys asked Dr. Norko to review 150 pages of previously unavailable documents. After consultation with Dr. Zonana, he agreed to do so, knowing that the stay continued for 2 more days to allow appeal to the U.S. Supreme Court. But he was asked hours later to review them immediately that evening.

Although the documents did not alter his ultimate opinion, Dr. Norko noted to the attorneys that there were two documents written by Mr. Ross that he would have asked Mr. Ross about if he had them earlier. As the evening unfolded and the stay of execution was unexpectedly lifted by the USSC, Dr. Norko realized the potential that the attorneys would file another motion for a stay based on those two documents, and that he could be asked to go to the prison and ask Mr. Ross about the documents. He would have to refuse to do so, however, because that would put him in the position of being the final arbiter of the death sentence in the absence of an intermediate court decision, violating the AMA's CEJA opinion E-2.06 on capital punishment. No such request was made, however, because Attorney Paulding requested a postponement for further review, in the aftermath of having been threatened that afternoon by a Federal District judge that he would "have [his] law license."

Several months of further evaluations by Dr. Norko and other experts ensued, as well as the court's appointment of a special attorney to investigate the competence of Mr. Ross in his decision to waive appeals. Cognitive understanding of the proceedings was never a question in the case, but it was a challenging task to evaluate Mr. Ross' motivations in waiving appeals, given his expressed concerns for the victims within the context of his history of depression and suicide attempts. Dr. Norko maintained his opinion that Mr. Ross understood his rights and was waiving them voluntarily, primarily motivated by his concerns about inflicting further pain upon his victims, though noting that Mr. Ross was at least partially ambivalent in his feelings about dying. The court did not comment on those ambivalent feelings and ruled that Mr. Ross was competent and had the right to make a voluntary decision about further appeals. Mr. Ross was executed on May 13, 2005 without making any further public comments.

Final thoughts: The case of the execution of Mr. Ross was of such high profile, and so emotion-laden that every member of Dr. Norko's family was pulled in. His children's teachers and friends engaged them in questions about the case, newspaper articles, and reported court testimony as if they were the expert themselves. Whether or not one should prepare family members when one's high profile case hits the media is up for debate.

Also, Dr. Norko never anticipated his videotaped interview of 2004 to end up on the 11:00 news for the consumption of the public near and far; that it could be played in the courtroom was no doubt, but on the evening news was another matter. It raises the question of whether this possibility should be discussed as a warning with defendants at the beginning videotaped evaluations

Finally, Dr. Norko stated that he was fortunate to have had Howard Zonana down the hall from him when he got the call to review 150 pages of new documents hours before Mr. Ross' scheduled execution. The crucial questions regarding what evalua-

tions to conduct so close to a scheduled execution required consultation with a senior colleague. His concluding advice? Do not hesitate to call on senior colleagues for consultation. ☞

Computer Crimes

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indicates that pornography, even deviant pedophilic pornography, tends to be more cathartic than incitive. In reply to another query, Rogers indicated that China is more advanced in using digital technology for warfare whereas the United States and Canada lead in the development of digital technology for military defensive purposes. European countries in comparison lead the world in applying digital technology to investigation involving cell phones.

"Police can copy the hard drive including what has been erased," observed Edward Fischer, Ph.D., in opening remarks to his talk on sexual computer crime and its investigation. Fischer is a member of the Psychiatry and Behavioral Science of AAFS who is experienced in evaluating individuals charged with sexual computer offenses. He drew a comparison with marijuana in California, which was legalized for medicinal purposes and is now being taxed and increasingly accepted for recreation. Unlike marijuana, pornography does not have to be grown, just copied or sent. One can easily "bring up thousands of child pornography files" said Fischer, which (on PTHC) "constitutes only 1 to 2 percent of what's available." Centralized networks that carry pornography have given way to "new, non-centralized networks."

Laws concerning child pornography and computer sex crime are defined based upon age, such as subjects under 21 or under 18 years of age. Fischer explained that most individuals who have achieved puberty have adult-like sexual interests, and adult sexual interests commonly are directed at fellow adults or post-pubertal adolescents, but not prepuberty children. Most of the users of child pornography, like most users of marijuana, are post-puberty adolescent males who are "full of testosterone." Further challenging the legal

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Computer Crimes

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definition of child pornography is the recognition that a prior history of sexually offending behavior, and sexually offending behavior with victims outside of the family are predictive of future sexually offending behavior, but sexual relations between stepfathers and stepdaughters which do not often predict future offending behavior, though not uncommon, are highly condemned by society.

Research is needed in this area to establish an empirical basis for definition of child pornography. The Police does not support research on this topic and neither does federal regulatory law. Security procedures, which make research difficult are much higher for child pornography than for illicit drugs. Whether child pornography serves “substitute gratification or incitement” is a critical research question. In trying to understand the resistance to such research, Fischer opined, “Women are no longer in control of erection of men.” Research per se should not however be influenced by a particular viewpoint.

In contrast to earlier times, today’s children have greater visual exposure to rape and other deviant sexual behaviors on digital and celluloid media. Until the *NY v. Ferber* decision, all pornography was considered legal. Now child pornography is illegal. If child pornography is not outlawed in all countries, it is not enforceable.

Following the two presentations, one of the questions concerned “age regression child pornography.” This genre of erotic material is made in Belarus and Russia for use by investigative officers.

For purposes of investigation, recordings on U-Tube, for example, are saved. Any Google covered entity saves everything “forever.” This is part of the service agreement. To destroy digital evidence, the Canadian military “degausses the drive,” explained Rogers, by putting it into a shredder and mixing the fragments with pieces of granite. The mixture is used for paving roads. This illustrates the difficulty in destroying digital evidence. Before donating a computer to a high school, one might well consider having the hard drive removed. ☞

Technology

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mendations. Furthermore, in keeping with informed consent doctrine, physicians are held responsible for communicating key information about treatment options to patients such as risk of serious side effects. With a computer in virtually every doctor’s office, computer assisted literature searches are readily available, inexpensive and able to reduce risk. Courts may view computer-assisted literature searches as professional custom, and liability may exist for individuals who do not utilize this technology. Many questions remain about when to search, how to search and how to document computer-assisted searches. “Googling,” is another form of computer-assisted information gathering which can be helpful to treatment but can also damage the patient-doctor relationship. Acting on unverified internet information creates risks such as involuntarily admitting a patient, giving a *Tarasoff* warning, etc. In the forensic setting, the internet potentially provides a wealth of data about evaluatees but we may not all have the necessary training or experience to adequately and accurately evaluate someone’s “digital footprint.”

Emailing with patients (or attorneys) is another recent technological challenge. Recommendations from the Federation of State Medical Boards regarding use of email with patients include that emails can supplement personal interactions but should not replace them. In advance of emailing with patients, parameters should be set, including that email can be used for refills, scheduling, and psychoeducation, but not emergencies. Turn-around time and security measures should be discussed, as well as consideration of a written hold-harmless clause for information lost in technical failures. Copies of emails should be placed in the medical record.

Since the 1932 tugboat case of *TJ Hooper*, it has been clear that in court, professions may be held to a standard of practice in which they are expected to utilize available technologies to increase safety, even if the technology

has not yet been adopted by the field at large. (The court found that failing to equip tugboats with radios fell below the standard of care, even though most companies had not adopted them.) In *Helling v. Carey* (1974, Washington Supreme Court), an ophthalmologist was found negligent for failure to diagnose glaucoma in a patient when tonometry testing would have been available, inexpensive and safe. This was despite the testing not being part of standard of care in patients under age 40, where the risk of glaucoma was 1/25000. Subsequent legislation sought to overturn *Helling*; however, not until after ophthalmologists began giving routine tonometry testing to younger patients. In 2011, many electronic technologies are available, inexpensive and safe—including electronic medical records, literature searches, information gathering, electronic prescriptions, drug-interaction websites, and emailing.

In conclusion, forensic psychiatrists should: manage their online persona—think before posting facebook photos or blogging; consider having a dedicated computer for forensic work; consider metadata—perhaps turning reports into PDFs or TIFFs; use secure email and remember that emails may be discoverable; think before googling, and be aware that an evaluatee’s online persona may be different than one’s offline reality. ☞

MUSE & VIEWS

Freud on Trial! Actual court transcript

By Attorney: Have you ever heard of Sigmund Freud?

By Juror: Yes.

Attorney: What have you heard?

Juror: He’s in Las Vegas.

By the Court: I think you’re thinking of Siegfried & Roy, aren’t you?

Juror: That’s what I’m doing.

Attorney: This guy was a little older than that.

Source: <http://www.request.net/g2g/humor/courtroom/index.htm>

Submitted by Charles Scott, MD

DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for several general and forensic psychiatrists (clinical track) for our growing department, at the Assistant/Associate Professor level. Candidates must have completed an approved general psychiatry residency and be board certified/eligible in general psychiatry and forensic psychiatry, respectively. Responsibilities will include direct patient care, teaching of medical students and house officers, and research (clinical and basic science) at various state hospitals, state correctional institutions, and at Tulane University Health Sciences Center. Time allocations will be based upon individual situations. Applicants must be eligible to obtain a Louisiana medical license. 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. Applications will be accepted until suitable qualified candidates are found. Email (winstead@tulane.edu) or send CV and list of references to Daniel K. Winstead, MD, Heath Professor and Chair, Department of Psychiatry and Behavioral Sciences, Tulane University School of Medicine, 1440 Canal Street TB48, New Orleans, LA 70112. For further information, you may contact Dr. Winstead, at 504-988-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

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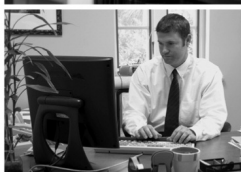
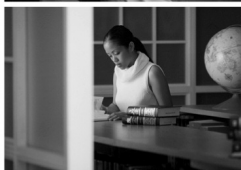
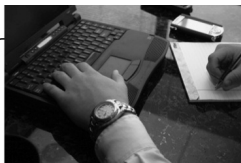
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The Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine is recruiting a forensic psychiatry fellowship training director for a full-time faculty position. The candidate selected for this position will assume the 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.

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Isaac Ray Award

The American Psychiatric Association and the American Academy of Psychiatry and the Law invites nominations for the Isaac Ray Award for 2012. This Award honors Dr. Isaac Ray, one of the original founders and the fourth President of the American Psychiatric Association, and is presented to a person who has made outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence. The Award, which will be presented at the Convocation of Fellows at the Annual Meeting of the American Psychiatric Association in Philadelphia, PA, in May 2012, includes an honorarium of \$1,500. The recipient obligates him or herself to deliver a lecture or series of lectures on these subjects and to present the manuscript for publication.

Nominations are requested as follows: (1) a primary nominating letter (sent with the consent of the candidate), which includes a curriculum vitae and specific details regarding the candidate's qualifications for the Award, and (2) a supplemental letter from a second nominator in support of the candidate. Additional letters related to any particular candidate will not be accepted or reviewed by the Award Committee. Nominators should not submit letters on behalf of more than one candidate. The deadline for receipt of nominations is **July 1, 2011**. Nominations will be kept in the pool of applicants for two years.

Nominations, as outlined above, should be submitted to:

Renee L. Binder, M.D., Chairperson
c/o Lori Klindedinst, Staff Liaison
Isaac Ray Award Committee
American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209
E-mail: advocacy@psych.org

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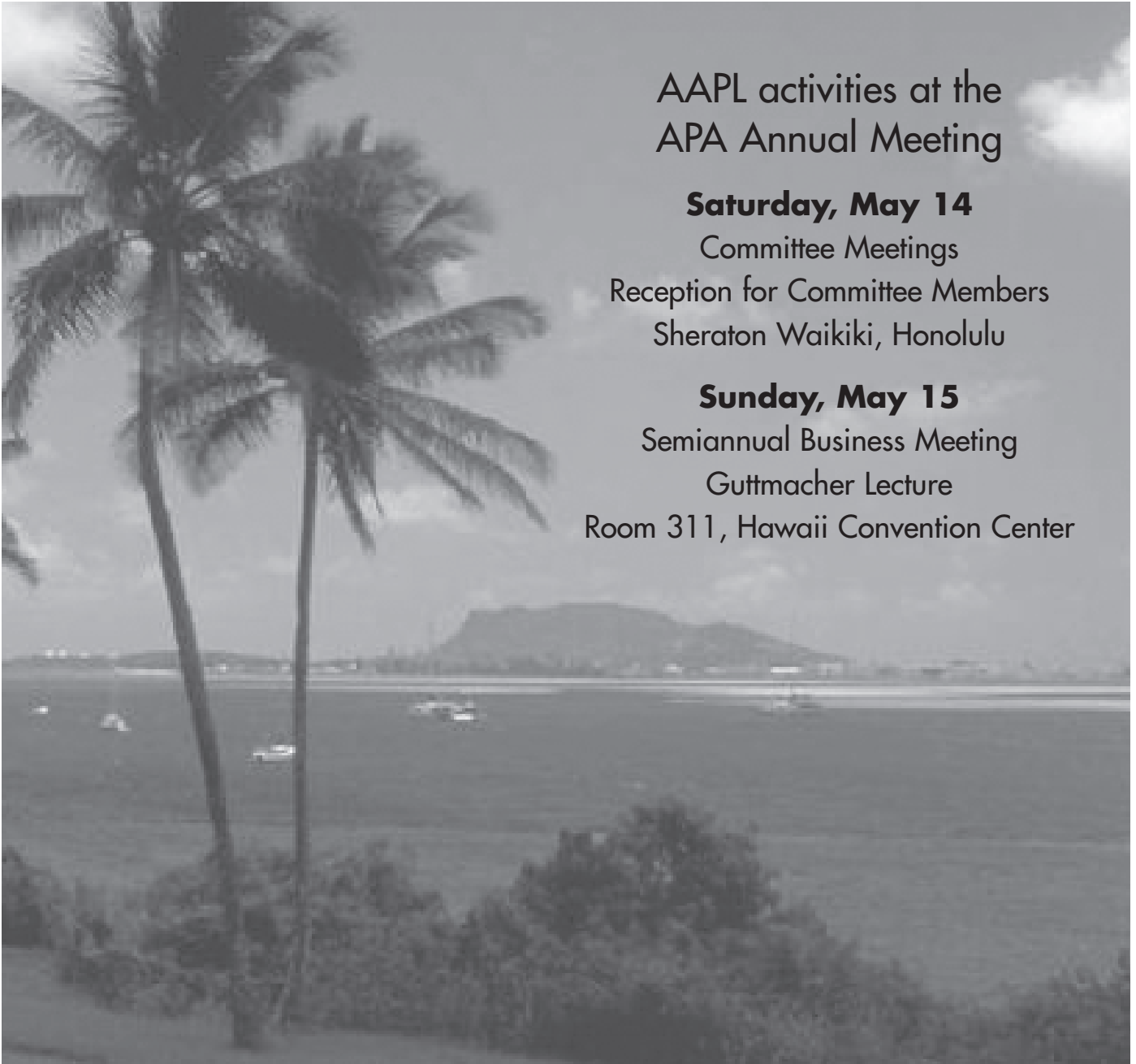
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AAPL activities at the
APA Annual Meeting

Saturday, May 14

Committee Meetings
Reception for Committee Members
Sheraton Waikiki, Honolulu

Sunday, May 15

Semiannual Business Meeting
Guttmacher Lecture
Room 311, Hawaii Convention Center



AAPL Newsletter

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

Charles Dike, MD, MPH, MRCPsych, Editor

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HIGHLIGHTS

Malingering Wellness
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Factitious D/O by Proxy