

# AAPL Newsletter

## American Academy of Psychiatry and the Law



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### The Psychiatric Report Guttmacher Award

Cheryl D. Wills, M.D.



The forensic psychiatrist needs to be ambidextrous – well-versed in psychiatric medicine and comfortable addressing legal matters in medical and legal settings. The ability to utilize this skill set with the goal to maintain objectivity and foster the autonomy and dignity of the evaluatee during the report writing process was the subjects of this year's lecture by the Manfred S. Guttmacher Award winners Alec Buchanan, Ph.D., M.D. and Michael Noriko, M.D. at the American Psychiatric Association meeting in San Francisco, CA. The authors were recognized for editing *The Psychiatric Report*, which guides readers through the process of writing a forensic report. The award, which is presented annually for the best publication in forensic psychiatry, is jointly sponsored by the American Psychiatric Association and the American Academy of Psychiatry and the Law, with support from Professional Risk Management Services.

Buchanan and Noriko's lecture, titled, "The Psychiatric Report: Inquiries and Praxis" was intended to

address moral, legal, and ethical matters that are encountered by forensic psychiatrists when they prepare to write reports. Forensic psychiatry has a relatively small body of empirical research and lacks international consistency. Buchanan stated that although 20% of the Guttmacher lecture audience would not proceed to obtain collateral data if the evaluatee objected, 100% of British forensic psychiatrists surveyed require informed consent from the evaluatee prior to accessing collateral data.

Narrative, explained Noriko, is the process by which forensic psychiatrists "bring humanity to the subject." He described a fact-based creative process in which each person is given a voice to tell the story from his or her vantage point, while giving appropriate weight to each account. He described the challenge of interpreting cultural nuances and stressed the importance of authors using the narrative to clarify the data, including disparate accounts, and to offer a resolution in the psychiatric formulation. Noriko reminded us that forensic psy-

chiatrists do not have the luxury of presenting alternate conclusions like those in the bonus section of a movie DVD.

Many forensic evaluations are unavoidably coercive, especially since many evaluatees undergo serial evaluations, from experts who represent various parties in litigation. Consequently, there must be safeguards to protect the objectivity of the evaluative process, including balancing competing interests, explaining the purpose and limits of the evaluation and striving for objectivity. Noriko cited Alan Stone's comments on respect for persons and truth-telling. Self examination by forensic psychiatrists, including peer consultation and peer review, is also conducive to quality control of forensic reports.

Buchanan discussed the importance of respecting the dignity of evaluatees in medical practice and said that references to dignity in U.S. Supreme Court decisions involving mental health concerns have increased in the past 60 years. In the U.S., ethical forensic psychiatric practice incorporates respect for the individual. When competing concerns threaten the objectivity of the evaluation, the forensic psychiatrist is compelled to adhere to professional boundaries and to inform the court.

Dignity is prominent in the ethics guidelines of medical practice. Buchanan stated that respecting dignity is not the same as respecting autonomy. He used international case law to illustrate that politically correct interventions, which are designed to protect a group of individuals, can diminish the autonomy and dignity of a subgroup. It is impossible, he said, to treat all people the same way and to achieve justice by leveling the playing field. Yet, the concept of human dignity has an important role in protecting the most vulnerable individuals, including research sub-

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## American Academy of Psychiatry and the Law

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## ALL ABOUT AAPL - Committees

### Midwest AAPL Celebrates 30 Years

*Cathleen A. Cerny, MD - MWAAPL President Elect (2015)*

*Delaney Smith, MD - MWAAPL Secretary*

*Susan Hatters-Friedman, MD - MWAAPL Immediate Past President (2013)*

On March 22-23, 2013, nearly 100 psychiatrists, psychologists, residents and medical students gathered in Columbus, Ohio to celebrate 30 years of Midwest AAPL. Among those present were sixteen past presidents including co-founding member and first president, Phillip J. Resnick, MD (1983). Also in attendance were outgoing president Susan Hatters-Friedman, MD (2013) and incoming president James Reynolds, MD (2014).

The program committee for this anniversary event was comprised of Delaney Smith, MD (councilor, incoming secretary), Cathleen Cerny, MD (outgoing secretary, president-elect 2015) and Susan Hatters-Friedman, MD (2013). Together, they put an outstanding line-up of speakers. Topics for the twelve presentations included neonaticide, juvenile competency, gun policy and psychological testing. Dr. Hatters-Friedman also gave a presidential address entitled "Back to the Future: Forensic Psychiatry in the Midwest."

Five psychiatry residents were honored as Resnick Scholars at this 30<sup>th</sup> annual meeting: Brian Falls, MD; Brian Holodya, MD, MPH; Scott Johnson, MD, JD; Caleb Korngold, MD and Kristi Sikes, MD. Beginning in 2014, there will be a new resident prize in addition to the Resnick Scholar award. The MWAAPL executive committee approved Margolis Travel Scholarships to honor past-president Philip M. Margolis, MD (2001) and to give residents with Midwest connections exposure to forensic psychiatry education and mentors. The Resnick Scholar Award will now be geared towards applicants who have already had experiences and achievement in forensic psychiatry. Please look for an announcement regarding award applications in Fall 2013.

In preparation for the 30<sup>th</sup> anniversary, Cathleen Cerny put together a member survey in order to gather

some data about the organization.

Forty-nine MWAAPL members completed the survey yielding some interesting results:

- Six respondents have belonged to MWAAPL for over 25 years
- One respondent has been to all 30 meetings. Three additional respondents have been to 21 or more meetings.
- Twenty respondents have served as officers for MWAAPL.
- Four respondents have served as officers in AAPL
- Twenty respondents are currently serving or have served on AAPL committees
- Eight respondents have won AAPL awards including the Red Apple Award, the Rapoport Fellowship and Best Teacher in a Forensic Fellowship
- MWAAPL member respondents have a combined 60+ publications in the past year
- MWAAPL member respondents have a combined 120+ presentations in the past year

The survey also gathered some favorite MWAAPL member memories and mission statements which were documented in the meeting program. A few quotes from the program are included below to illustrate how valuable MWAAPL is to its members.

*I see Midwest AAPL's place, mission, and function as doing just what it is doing. It is an incubator for early career forensic psychiatrists and psychiatrists interested in forensics. Our annual meeting is a wonderful forum for the early career people to get started producing meetings, making presentations, and meeting others. I haven't missed a Midwest AAPL meeting in about 25 years.*

*I enjoy this excellent caliber meeting and the presenters more than I can express.*

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## FROM THE EDITOR

# DSM 5 – Controversies and all

Charles C. Dike MD, MPH, FRCPsych



I heard it again just the other day, “that patient is all Axis II.” The group receiving the information nodded knowingly. No diag-

nosis had been uttered/offered, but yet, everyone understood. Of course, Axis II in this context is a curse word...almost. I chuckled to myself. In only a matter of months, statements such as this will start fading away as we begin a new journey grappling with the major changes accompanying DSM 5.

Indeed, DSM 5 made landfall in May, heralded by an ironic combination of jubilation and gusts of controversy. It seems everyone had something to say, and the louder voices were mostly negative. Reviews in the media were fast, furious and sustained. Most worried about the medicalization of normal behavior. In a New York Times article titled *Heroes of Uncertainty*, published on May 27, 2013, David Brooks asserts that “When you look at the definitions psychiatrists habitually use to define various ailments, you see that they contain vague words that wouldn’t pass muster in any actual scientific analysis: excessive, binge, anxious.” Calling psychiatry a “semi-science” that uses terms such as “mental disorder” and “normal behavior” for which there is no consensus agreement on what they mean, Brooks proposed that, “If the authors of the psychiatry manual want to invent a new disease, they should put Physics Envy in their handbook.”

Perhaps the harshest criticism of DSM 5 came from respected psychiatrists such as Allen Francis, MD, Chair of the DSM IV Task Force, Robert Spitzer, MD, Chair of the DSM III Task Force, and Tom Insel, MD, Director of the National Institute of Mental Health (NIMH). Both Spitzer and Francis publicly criticized

the lack of transparency regarding the work of the DSM 5 task force. Allen Francis proceeded to author several high profile articles, arguing in one that the overly broad and vaguely worded definitions will create more “false epidemics” and “medicalization of everyday behavior.” In an article titled “DSM is a guide not a bible – ignore its 10 worst changes” published in *Psychology Today* on Dec 2, 2012, in a series called DSM 5 in Distress, Allen Francis began by dramatically observing, “This is the saddest moment in my 45 year career of studying, practicing, and teaching psychiatry. The Board of Trustees of the American Psychiatric Association has given its final approval to a deeply flawed DSM 5 containing many changes that seem clearly unsafe and scientifically unsound. My best advice to clinicians, to the press, and to the general public - be skeptical and don’t follow DSM 5 blindly down a road likely to lead to massive over-diagnosis and harmful over-medication. Just ignore the ten changes that make no sense.” He then proceeded to list the changes. Finally, in an article written by Michael Mechanic in *Mother Jones Magazine* on May 14, 2013, after the release of DSM 5, Allen Francis reportedly declared, “Don’t buy it, don’t use it, don’t teach it.”

But nothing shook the media and the APA more than statements made by Dr. Tom Insel, NIMH director, just days before the release of the DSM 5. In his blog on April 29, 2013, Insel opined, “While DSM has been described as a ‘Bible’ for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been ‘reliability’ – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity...But it is critical to realize that we cannot succeed if we use DSM categories as the ‘gold standard.’ The diagnostic system has to be based on the emerg-

ing research data, not on the current symptom-based categories...That is why NIMH will be re-orienting its research away from DSM categories.”

Despite the headwind of criticism, however, DSM 5 was introduced to the public at the Annual Meeting of the APA in May to much fanfare and celebration. There were, of course, the perpetual antipsychiatry demonstrations by the Church of Scientology which, this time, focused on the DSM 5 document as the engine of their traditional discontent with psychiatry. A casual and uninformed observer would never have believed the hostile environment under which the DSM 5 was being released, going by the events at the APA Annual Meeting alone. Indeed, the DSM has come a long way from its humble beginning with 106 mental disorders in 1952 to the current over 300 disorders in 947 pages of the DSM 5. Controversy has, however, always dogged the DSM, be it among psychoanalytically oriented psychiatrists, or psychiatrists and others worried about its use in the legal arena. Many practicing psychiatrists have watched the current controversy surrounding the DSM 5 with curiosity, with many in private practice only wondering how the changes in the DSM 5 would affect billing and re-imburement, an issue that seems to be the preoccupation of psychiatrists in 21<sup>st</sup> America.

Yes indeed, the DSM 5 is here to stay! While there are major changes that will attract academic debate in the days to come, my musings focus on some implications of the changes, lighthearted and serious alike. Then, I begin to wonder. Without the axis system of stating diagnoses, I wonder what term we would manufacture to describe individuals whose behavior drives us batty – we would no longer be able to casually summarize their behavior as “all Axis II and no Axis I.” I bet there are not many psychiatrists who would lose sleep over not having to determine a patient’s Global Assessment of Functioning (GAF), but I wonder how insurance compa-

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## PRESIDENT

### Passing the Batons

Debra A. Pinals MD



At the October 2013 meeting, I will be passing the baton as the 39<sup>th</sup> President of the American Academy of Psychiatry

and the Law (AAPL) to Robert Weinstock, M.D. In addition, AAPL will be saying farewell to Howard Zonana, M.D., our second Medical Director, and welcoming Jeffrey Janofsky, M.D. as our incoming 3<sup>rd</sup> AAPL Medical Director. As such, I would like to seize the opportunity to reflect upon the year and upon the future of AAPL, and then devote some thoughts to our future leaders.

This year has been a wonderful one for me, and I remain honored and privileged to have been the President of this esteemed organization. Each year, a President faces new challenges and has a short period of time during which to effect positive change. I am proud of what we have done and the directions we will be setting going forward. As part of our Maintenance of Certification (MOC) initiatives, we have been in touch with the American Board of Psychiatry and Neurology for the last several years to help establish products that will assist members to fulfill their MOC requirements. Many of our members worked very hard over the last few years to develop a question bank that was used as the first Self-Assessment examination in Forensic Psychiatry. By this Fall, as one of this year's Presidential goals, those questions will have been entered into an electronic database and will be able to be pulled for use in a new Self-Assessment format that is also attached to Continuing Medical Education credits. This activity is one of our improvements noted in our current application for ongoing accreditation by the Accreditation Council for Continuing Medical Education. Richard Frierson, M.D., and Eliza-

beth Ford, M.D., Co-Chairs of the Education Committee, both worked tirelessly with AAPL staff to help submit materials for our CME accreditation, and the submission included descriptions of our MOC activities.

For the Annual Meeting, there are several interesting things planned. We will be hosting, for the first time, a gathering geared toward the women of AAPL. This gathering will take place on Thursday evening, following the AAPL movie and discussion. For several years women colleagues have discussed a desire to have a gathering to be able to provide mutual support and engage in friendly conversation. The idea has gained traction and we

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*“We will be hosting, for the first time, a gathering geared toward the women of AAPL.”*

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will be putting together a coffee and dessert in order to offer an event that meets these member needs. I am hopeful that it will be well-attended and provide another opportunity to build upon existing relationships, network, and meet new friends.

For the October meeting we have selected a public sector theme, and many of the presentations accepted for the meeting are reflective of work being done in institutional settings, as well as the usual array of presentations focused on private practice and other types of evaluative work. Our terrific Program Co-Chairs, Stuart Anfang, M.D. and Barry Wall, M.D. are also busily planning “movie night” for the Thursday evening slot, incorporating entertainment themes related to our fine California setting to capture the spirit of the meeting. We are all looking forward to popcorn and conversation for that event! Given the richness of the presenta-

tions that have been selected, and a few of these pleasant additions, I know the meeting will be a great success. I look forward to seeing many people there.

Looking beyond the Annual Meeting, in these next several months, we will work together toward transitions in leadership, as noted above. The President transitions each year, but the transition of the Medical Director is one that has only occurred once before in AAPL's history. Now, we will see our second transition along this front. Dr. Zonana has been an inspirational leader to many of us in AAPL. His knowledge of case law, current policies, the legal regulation of psychiatric practice, as well as his in-depth understanding of the political landscapes of the APA and the AMA have provided for remarkable contributions to AAPL. Through his steady hand, he has maintained the continuity to help our organization flourish and to continue on a smooth course. Dr. Zonana was instrumental in several major accomplishments, including establishing a formalized system of governance, pursuing subspecialty recognition with the American Board of Psychiatry and Neurology, helping to shape fellowship training requirements, and having AAPL join in numerous Amicus Briefs heard by the United States Supreme Court. Working with Dr. Zonana side by side for all these years has been an incredible experience, and many of us have learned a great deal from him. I am sure our members will join me in wishing the best for Dr. Zonana as he embarks on new activities, and for Dr. Janofsky as he takes the reins to help serve AAPL in the years ahead.

The work of the President is made easier by the capable staff in the AAPL office, and I am grateful to each of them for their assistance with keeping the organization moving forward and their attention to the details that matter to our members. In particular, Jackie Coleman, Executive Director, has been an incredible support. Jackie and I have worked in various capacities together for well over a decade and I cannot imagine how

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## MEDICAL DIRECTOR

### Closing Comments

Howard Zonana MD



This is my last report as Medical Director for AAPL. Beginning in 1995, eighteen years ago, I was selected to be the second Medical Director following Jonas Rapoport, the organization's Medical Director and one of its founders. These were big shoes to fill. Writing this column has served a number of functions for me and has allowed me to express my views on newly developing areas affecting forensic psychiatry. As I look back on the topics and content of the column, I see that I have tried to use the column to discuss several themes:

Forensic Psychiatry as a subspecialty, accreditation  
Ethical challenges, such as the role of forensic psychiatrists in interrogation  
New case decisions from the courts  
The role of AAPL in the AMA  
APA and AAPL briefs in cases affecting psychiatry

My tenure in the organization has seen an evolution and consolidation of its goals and structures. The highlights have been the establishment and development of the Executive Council as the central governance model of AAPL, beginning in my presidency and continuing to the present, with a modest increase in size. The organization also altered its financial investment plan by switching from CDs to the development of an investment portfolio, with the help of our finance committee. We selected an excellent financial advisor, David Ellovitch, who has helped expand our working reserves to a little more than twice our growing annual budget. While there have always been members who thought they could do better, our finance committee has set relatively conservative and safe parameters for our investments.

Another goal was to expand AAPL's role. Initially, we were primarily an educational organization, but over my tenure we have become increasingly politically active nationally. We decided to join the AMA essentially because the AMA's Council on Ethical and Judicial Affairs (CEJA) was generating policies affecting forensic psychiatry, but without much effective psychiatric input. We joined and initially became part of the Service and Specialty Society of the AMA until we qualified for a seat in the House of Delegates a few years later. We also became a part of the Psychiatric Caucus at the AMA, which was led by the APA and included the Academy of

*“The many press calls and calls from members and non-members looking for advice, referrals, or information have provided a great learning experience”*

Child Psychiatry and Addiction Medicine initially.

Our presence and influence at the AMA has grown under the leadership of Dr. Robert Phillips, our delegate, and a few years ago Dr. Barry Wall replaced me as the alternate delegate. We have also expanded our delegation to include two young physician representatives. We have been effective in amending a number of proposed CEJA ethics guidelines and playing an active role in the passage of others. The AMA tends to see forensic psychiatry mainly in terms of its major concern regarding malpractice litigation, believing that bad testimony by experts is a big culprit. That organization has shown less interest in AAPL's broader role in the

criminal justice system and civil treatment facilities. We have been effective in blocking a number of bad policy recommendations based on this view, such as requiring a national database to be constructed to include all physicians who testify in malpractice cases.

We have continued a close collaboration with the American Psychiatric Association, and many of our members have been appointed and been active in the Council on Psychiatry and Law and the Committee on Judicial Action, the two major components related to forensic work. We have also had our members appointed to the APA Ethics Committee. At present we remain the only subspecialty organization that requires membership in the APA. Dual membership was one of the principles of the founding group of AAPL. Since my tenure, we have started to sign on to amicus briefs to the Supreme Court and other courts when forensic issues have been implicated. Thus far we have signed on to thirteen amicus briefs as an organization along with the APA.

Our research mission has been enhanced by the development of an Institute for Education and Research that was proposed and developed by Dr. Larry Faulkner during his presidential year. The membership and AAPL have supported this research endeavor with substantial contributions and a growing number of grants have been awarded.

The Association of Directors of Forensic Psychiatry Fellowship (ADFPF) training programs under the auspices of AAPL has become the primary coordinating group for forensic psychiatry training and continues to play a role in development of accreditation guidelines. The group maintains a relationship with the Accreditation Council for Graduate Medical Education (ACGME) and regularly provides comments to proposed changes in required elements.

The Journal of the American Academy of Psychiatry and the Law, under the leadership of Ezra Griffith and

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## CHILD COLUMN

## Adoptive Couple v. Baby Girl (No. 12-399)

Stephen P. Herman MD



It is uncommon for the United States Supreme Court to become involved in family law and, specifically, child custody issues.

The last major

case was *Troxel v. Granville* (530 U.S. 52 [2000]), which addressed a visitation dispute in the State of Washington. On June 25, 2013, however, the Court decided by a vote of five to four an important child custody/adoption matter from South Carolina. The case rested on the interpretation of The Indian Child Welfare Act of 1978 (ICWA).

ICWA establishes federal standards for state court child custody decisions. It was enacted to prevent unfair custody and adoption proceedings that separated Native American children from their tribes of origin, leading to the breakup of Indian families.

The facts of the case are as follows: The mother, who was primarily Hispanic, and the father, a member of the Cherokee Tribe, were engaged in December 2008. One month later, the birth mother became pregnant and so notified the father. The father, upon hearing this news, suggested the couple move up the date of their wedding but refused to provide any financial support until after the marriage. The relationship deteriorated and the birth mother ended it in May 2009. In June, the mother sent a text message to the biological father, asking if he had any interest in being involved with his daughter.

A private adoption agency selected a white couple from South Carolina to become the adoptive parents. This couple had provided emotional and financial support during the birth mother's entire pregnancy. There had been no argument that during and after the pregnancy, the biological father provided no financial support to either the mother or the child. The

planned adoptive couple was at the baby's delivery and the adoptive father cut the umbilical cord. The birth mother signed forms giving up her parental rights.

When the child was about four months old, the selected adoptive parents noticed the biological father of the pending adoption. In response, the father sought custody and did not consent to the adoption. When the child was just over two years of age, custody was awarded by the trial court to the biological father, whom she had never met. The Carolina Supreme Court ruled that under ICWA, the biological father was the child's legal parent. His parental rights could not, therefore, be terminated.

Justice Alito, writing for the majority, noted that if the South Carolina

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*"...the biological father had "never" been a father to the little girl and had even consented to the termination of his parental rights."*

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Supreme Court's decision were let stand, then "a biological Indian father could abandon his child *in utero* and refuse any support for the birth mother – perhaps contributing to the mother's decision to put the child up for adoption – and then could play his ICWA trump card at the eleventh hour to override the mother's decision and the child's best interests."

The United States Supreme Court noted that under ICWA, the biological father's parental rights could indeed be terminated, as the Act referred to "continued custody of the child." In this case, the biological father had *never* been a father to the little girl and had even consented to

the termination of his parental rights. He never had legal or physical custody of the child. The Court took the only purpose of ICWA to prevent unwarranted removal of Indian children from their Native American families.

The Court also ruled that a section of ICWA was inapplicable to this case because there had been no relationship to be continued. The breakup of this family, the Court ruled, had already occurred long before the planned adoption. Further, there was no other alternative custody request by any other person(s). Actually, the Court noted, even the biological father had not initially sought adoption – only a ruling against the termination of his parental rights.

Justice Thomas wrote a second, concurring opinion while Justice Scalia wrote a dissent, stating, "The Court's opinion, it seems to me, needlessly demeans the rights of parenthood. It has been the constant practice of common law to respect the entitlement of those who bring a child into the world to raise the child . . . the father wants to raise his daughter, and the statute amply protects his right to do so. There is no reason in law or policy to dilute that protection."

Justice Sotomayor wrote the dissenting opinion, differing with the Majority's interpretation of ICWA. Interestingly, she focused upon the intent of Congress in drafting the Act and the decision of the South Carolina Supreme Court. She wrote, "The majority's hollow literalism distorts the statute and ignores Congress' purpose in order to rectify a perceived wrong that, while heartbreaking at the time, was a correct application of federal law and that in any case cannot be undone. Baby Girl has now resided with her father for 18 months. However difficult it must have been for her to leave the adoptive parents' home when she was just over 2 years old, it will be equally devastating now, if at the age of 3½, she is again removed from her home and sent to live halfway across the country . . . it

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## FELLOWS CORNER

### The City of Roses...and much more...

Mariam Garuba, MD



Portland?  
You're moving to  
where?

Such was the  
reaction of many  
friends and family  
members whenever  
I announced

my plans to move  
across the country to  
Portland, Oregon, to  
pursue a forensic  
psychiatry fellowship.  
Yes, I would tell them,  
I was moving across the  
country to the land of  
"green, tree huggers,  
and granola eaters."  
Yes, I was moving to  
the land where you are  
frowned upon if you  
ask for a Styrofoam  
cup.

When I first went to  
medical school, my plan  
was to become a  
neurologist and discover  
the cure for paralysis.  
However, while on my  
psychiatry rotation, my  
attending asked me  
what kind of career in  
medicine I wanted. I  
told her that my career  
interests did not exist  
in full outside of  
working with athletes  
as a neurologist. I  
described my interest  
in working with  
criminals, travelling  
as a physician, not  
wearing scrubs all day,  
and testifying in court.  
By the time she  
finished describing  
forensic psychiatry to  
me, I was convinced  
enough to switch.

Picture perfect  
Portland.... at least,  
that is what I call it.  
A slice of heaven on  
earth. What an  
experience it was,  
all because of the  
fortune of obtaining  
a long desired  
fellowship!

Forensic psychiatry  
is well and alive,  
and has hidden  
jewels in the state  
of Oregon. Our  
lectures and mentors  
consisted of skilled  
and experienced  
psychologists,  
psychiatrists,  
former presidents  
of AAPL, and  
attorneys. Half of  
the year was spent  
at the State Hospital  
(OSH) learning  
about criminal  
forensic psychiatry  
(interestingly, the  
movie "One Flew  
Over the Cuckoo's  
Nest" was filmed  
at the older state  
hospital in Oregon).  
There I learned to  
write reports to  
determine a  
defendant's ability  
to participate in  
their own defense,  
assist their attorney  
in their defense,  
and understand the  
nature of the proceed-

ings against them.  
I also shadowed  
evaluations/  
reviewed reports  
written to affirm  
or negate a  
defendant's  
Guilty Except for  
Insanity plea. It  
is only in the  
state of Oregon  
that a person  
can plead the  
defense of  
"Guilty Except  
for Insanity,"  
whereas in  
other states  
defenses such  
as "Not Guilty  
by Reason of  
Insanity" are  
used. It is  
also one of  
only two states  
that has a  
Psychiatry  
Security Review  
Board (the  
other one being  
Connecticut).  
What was also  
quite impressive  
was how  
passionate the  
lay population  
was about  
protecting the  
rights of the  
mentally ill.

The first half of  
the fellowship was

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*"Having been raised by  
a mother who worked as  
a diplomat, mastered the  
English language,  
taught English, and  
corrected her children's  
essays with scrutiny, I  
was quite humbled to  
learn how much I  
needed to improve my  
writing skills."*

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truly a humbling  
experience for me.  
Having been raised  
by a mother who  
worked as a  
diplomat, mastered  
the English  
language, taught  
English, and  
corrected her  
children's essays  
with scrutiny,  
I was quite  
humbled to learn  
how much I  
needed to improve  
my writing skills.  
I learned, though  
not quickly  
enough, that a  
forensic report  
must be  
grammatically  
correct, mistake  
free, and able to  
stand questioning  
in a court of law.  
When written  
properly, it is  
one's best  
defense in court,  
and a testament  
to one's skill,  
effort, and  
expertise as a  
witness. In

addition, these  
perfect reports  
had to be  
completed  
within a  
limited time  
frame. It is  
only now that  
I understand  
why forensic  
psychiatrists  
are so  
particular  
about  
grammar,  
syntax,  
and spelling  
errors. It was  
a grueling  
experience  
for many  
reasons.

Our second  
semester  
consisted of  
treating  
forensic  
patients and  
learning how  
to write  
civil reports.  
I truly  
learned how  
to multitask.  
In one  
week, one  
typically  
worked at  
three to  
four  
different  
locations.  
We treated  
the severely  
and  
persistently  
mentally  
ill at  
Sequoia  
Mental  
Health  
Clinic in  
Beaverton,  
provided  
consultations  
to law  
students  
at the  
Willamette  
University  
Law Clinic  
(make sure  
you don't  
mispronounce  
Willamette!),  
prepared  
asylum  
reports at  
the  
Intercultural  
Psychiatry  
Clinic (aka  
IPP) in  
Portland,  
and treated  
inmates at  
Snake  
River  
Correctional  
Institute  
via  
telepsychiatry.  
This was  
the  
semester  
where I  
learned  
about the  
world of  
civil  
forensic  
psychiatry.  
Every case  
was  
interesting,  
challenging,  
and  
unique. I  
learned  
not only  
how to  
write  
asylum  
cases  
properly,  
but how  
to treat  
the  
forensic  
population.  
For me,  
working  
on  
asylum  
cases  
was the  
most  
rewarding,  
whether it  
was at  
IPP (a  
clinic that  
has  
provided  
services  
to  
approximately  
3000  
immigrants),  
or at the  
Willamette  
Law  
Clinic.  
Working  
at both  
locations,  
I was  
exposed  
to a  
myriad  
of  
cultures  
with  
immigration  
needs.  
It showed  
me how,  
no matter  
the race  
or culture,  
our needs  
as human  
beings are  
the same.

In the land  
of rain,  
the  
Columbia  
River  
Gorge,  
farm to  
table  
livestock,  
and  
Powell's  
bookstores,  
nothing  
compares  
to rushing  
to get to  
work at  
an  
unforgivable  
hour,  
only to  
find a  
picturesque  
view of  
sunrise  
and  
streaks of  
red, blue,  
and  
purple  
hues  
against a  
frosty  
mist of  
clouds,  
mountains,  
and sky.  
There is  
nothing  
like the  
feeling  
of  
someone  
smiling  
at you  
just  
because  
they  
want to.  
There is  
no other  
location  
where I  
have  
eaten a  
tomato  
like a  
piece of  
fruit  
because  
it was  
so  
succulent.  
It is also  
the only  
metropolis  
I have  
lived in  
where  
flowers  
hang  
from  
lampposts,  
and  
trees are  
lit with  
Christmas  
lights at

*(continued on page 12)*

## SPECIAL POPULATIONS

# Rebel Teen Daughter Kills Shrink Mom

Stephen Zerby MD



That is not the exact headline in the story to which I will be referring but it encapsulates the point of this column - I want to

tell a very important story for all who work in correctional settings, a story that has haunted me for years. It began after my interview for a forensic fellowship position at the University of Massachusetts. For the train ride back to Philadelphia, I purchased a *National Enquirer* – this was the year 2000, still print media days. There was a story that initially confused me, then frightened me, and then dogged me for years. Granted, the writing style was sensationalistic and attention-seeking but in a way, I'm glad it did capture my attention.

The title read, "MOM WAS A SHRINK – BUT COULDN'T KEEP OWN REBEL DAUGHTER FROM KILLING HER." Being a new parent (as well as a "shrink") at the time, this caught my attention. Unfolded was their version of the story of Dr. Kathleen Thomsen-Hall, whom I later learned had been one of my predecessors in the very program for which I had just interviewed. After graduation, she worked at a female correctional facility in Framingham. Described as a "beloved healer" (that part is actually accurate, from my conversations with staff; she was truly beloved) who helped female forensic patients but was "at a complete loss when it came to taming her rebellious 16-year-old Valerie." She was described as "a world-class psychiatrist who touched the lives of thousands but she couldn't extinguish the rage in her own teenage daughter - who savagely bludgeoned her to death." Verbal arguments between mother and daughter escalated to physical altercations with Kathleen calling the police on two occasions, reporting that Valerie was assaulting her. Discipline techniques allegedly

employed by Kathleen such as making Valerie research a topic and write a paper on it, were labeled "bizarre" and "New Age." A "top New York City psychiatrist" is quoted in the article warning against the temptation to "play psychiatrist, acting very calm and not getting emotional" as it "will drive them into a greater rage." The article insinuates that Dr. Thomsen-Hall made this mistake, paying for it with her life. After an argument with Valerie, the police found her at the bottom of a flight of stairs, with head injuries sustained by hammer blows. She died two days later.

It is understandable that headlines and stories can be sensationalized in

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*"...concluding that Dr. Thomsen-Hall's training as a psychiatrist subverted normal parenting skills, leading to tragedy."*

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order to sell papers by generating strong emotions in readers. This story certainly caught my attention. It was far too simplistic though, seemingly concluding that Dr. Thomsen-Hall's training as a psychiatrist subverted normal parenting skills, leading to tragedy. It wasn't clear from the article how they could have arrived at such a conclusion, given the data in the story. But being a child and forensic psychiatrist who has children caused the story to always be at the back of my mind whenever discipline issues at home arose. Was I "playing psychiatrist" with my kids? Or was I brainwashed by the psychiatric community into adopting psychiatry-advocated discipline which in the end would prove inferior to the time-tested "old parenting" of the public at large, thus rendering me an ineffec-

tive parent, and possibly ultimately leading to my own demise? By taking such care to not be an abusive parent in any way, was I foolishly turning my kids into monsters? I knew I wanted to employ better parenting techniques than those employed in my home growing up. But was I being led astray from common wisdom? I was fairly certain nothing I was doing was "New Age" or "bizarre" – but still, this always bothered me.

Following a recent house move, a copy of that article resurfaced, and reading it again after several years, it still provoked me to think about the problems of being a child and forensic psychiatrist. We know of the detrimental effects of abuse on children. We cannot implement corporal punishment on our children for fear of losing child clearances. But here are some other problems this conflict of professional and personal responsibilities raise:

1. *The danger of being overly accustomed to dangerous environments:* After years of working in such settings, I wonder how being used to witnessing violence weakens the natural fear responses that are supposed to keep us safe by driving us away from danger. Once, while at a grocery store, a couple was arguing and I saw the woman wind up and punch the guy square in the face. I stood there and watched, unafraid, perhaps expecting safety officers to pour into the scene and put a stop to the violence. Not until I realized that I was not at work but in the community, and no safety officers were coming – it was just this battling couple and I in this grocery aisle – did my fight-or-flight response kick in. I finally appreciated the gravity of the situation. This, I am sure, is a common experience for many mental health professionals, especially those who work in acute settings. Correctional psychiatrists are commonly exposed to violence but, unlike correctional officers, they are not necessarily well trained in subduing violent actors. I can see how a trained officer could

*(continued on page 12)*



## ASK THE EXPERT

### Ask The Experts

Robert Sadoff MD  
Neil S. Kaye MD

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](mailto:nskaye@aol.com).

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

**Q.** We have chosen to address four questions that share a common theme: The art of expert testimony: what to say under certain circumstances on the witness stand.

1. What do I do when the lawyer insists on a “yes or no” answer and the question can’t really be answered that way?

2. I am aware that the pre-trial stipulations prohibit discussion of certain facts. On cross exam, I’m asked a question that would require me to answer in a way that would either reveal material I am not supposed to know or say, or else to lie. How do I proceed?

3. I am in an upcoming trial where opposing counsel owes me money from a different case where I was her expert and was stupid enough to trust her. Can I make this known?

4. How do I criticize opposing data/theory without sounding like a hired gun?



**Sadoff:** To the first question, I would turn to the judge and say that the question cannot be answered with a simple “yes or no” and may I explain my answer if the judge insists on a “yes or no” reply. If there is a jury present, I will say to the judge that giv-

ing a “yes or no” response without explanation would be confusing to the jury. (Does the judge really want to confuse the jury by not allowing me to explain?) I have never been refused by a judge when I ask to explain my “yes or no” answer.

To the second question, I would turn again to the judge and remind him that my answer to the question would violate his ruling. I would do that only if the attorney who retained me does not object to the question. He may want me to respond if it is favorable to his case as the opposing lawyer has “opened the door” that was supposed to remain closed. The judge may not allow the question or may punish the cross examiner for “opening the door” by allowing me to answer. In no case should the expert lie on the witness stand. That is perjury, which is punishable to the expert. Always let the judge make these difficult decisions.

In the third case, I would have to inform the attorney calling me of the situation since it would pose a “conflict of interest” if I agree and then I am cross-examined about the previous case to show bias on my part to “get back” at the opposing attorney. Your retaining lawyer will either confront the opposing attorney in order to get you paid so there is no conflict, or inform the judge in the case about the financial situation in order to resolve it so you may be involved without a conflict, or have you sit this one out if the matter cannot be resolved. There is no obligation on your part to keep the matter confidential. It will usually inure to your benefit as the judge may encourage the attorney to meet her financial obligations to you.

The fourth case is handled quite simply by your giving scientifically based testimony to rebut the opposing theory. Always begin by saying “With all due respect to my adversary” and then quote the data you have gathered in your search of the literature and relevant research that supports your conclusions and opinions. We cannot prevent the perception of biased others who may think of us as “hired guns” but we can use all the scientific

data at hand to prove our points and feel secure that we have given the best and most accurate testimony under the circumstances at the time.

**Kaye:** I agree wholeheartedly with Dr. Sadoff and his years of experience as an expert show with the thoughtfulness in his answers. In addition to his ideas, many of these questions bring to my mind the importance of preparation with the lawyer. By making the lawyer aware of the potential pitfalls and information you have about opposing counsel you can work together to try to keep these issues from becoming distractions in court. I too believe that turning to the judge and asking for guidance is a great strategy, but I can also say that on rare occasions I have been before judges that recognized my “experience” and decided not to “throw me a lifeline” despite my asking. My response was to simply say the question couldn’t be answered “yes or no” and that as I have taken an oath to tell the “whole truth,” I need to be allowed to answer with more than a yes or no. After such a statement, I was allowed to answer appropriately and the cross examiner abandoned her forced “yes-no” style.

When facing the “prohibited material” if preparation has gone well and the retaining lawyer is awake, there won’t be a problem. However, if the lawyer missed the opportunity to object, I will again turn to the judge and say: “Your Honor, I don’t think I’m allowed to answer that and I don’t want to cause a mistrial.” That wakes everyone up and ends the problem.

As for the unpaid bill scenario, I have had that happen just once. I was most uncomfortable and got to court early. Prior to the start of trial, when the lawyers were asking for procedural rulings, I stood up and asked the judge if I could speak to her “in cam-



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## RAPPEPORT FELLOWSHIP AWARDS 2013-2014

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

AAPL's Rappeport fellowship was named in honor of AAPL's founding president, Jonas Rappeport, MD and offers the opportunity for outstanding senior residents with dedicated interest in psychiatry and the law to develop their knowledge and skills. Fellows receive scholarships to attend the AAPL forensic psychiatry review course and annual meeting in San Diego. They are also each assigned a senior AAPL forensic psychiatry preceptor to help guide their training during their fellowship year. The Rappeport fellowship committee is pleased to announce the six Rappeport fellows for 2013-2014. The Fellows are Drs. Caitlin Dufault, Eric Huttenbach, Jacqueline Landess, Anne McBride, Michael Seyffert, and Amanda Square.

Many applicants applied for the fellowship but a limited number of awards are available. The committee noted that there are many excellent residents with an interest in forensic psychiatry, which is outstanding for our field. We are thanking the members of the Rappeport Committee, all preceptors, and AAPL Council for their continuing support of this wonderful training opportunity!



### **Caitlin Dufault, MD**

Dr. Dufault is a chief resident at the University of New Mexico Health Sciences Center. She graduated from the University of Colorado Denver School of Medicine and completed her psychiatric internship at the University of Michigan. Her interests in forensic psychiatry include traumatic brain injury, malingering, the use of functional brain imaging in criminal proceedings, and civil commitment. She is currently involved in research on international forensic psychiatry training and research pertaining to traumatic brain injury and criminal recidivism. Because her present institution does not offer a forensic psychiatry fellowship, Dr. Dufault has sought forensic training opportunities at other sites, including Case Western Reserve University, New Mexico Behavioral Health Institute's Forensic Division, and Bernalillo County Youth Services Center, a juvenile detention facility. Dr. Dufault's AAPL preceptor is Dr. Alan Newman.



### **Eric Huttenbach, MD, JD**

Dr. Huttenbach is a resident at the University of Massachusetts Medical School. He received his MD from the Medical College of Georgia. He first completed a residency in ophthalmology at Tulane. He then attended University of Georgia School of Law and received a Juris Doctor. While in law school, his coursework included bioethics, malpractice, and health care law. With a passion for both law and medicine, he realized forensic psychiatry would provide the perfect combination of both. While at UMass, he co-authored a case summary for an upcoming Legal Digest section of the Journal of the American Academy of Psychiatry and the Law. He is currently assisting in researching and writing a textbook chapter on the ethics of correctional psychiatry. Dr. Huttenbach's AAPL preceptor is Dr. Renee Sorrentino.



### **Michael Seyffert, MD**

Dr. Seyffert is a psychiatry resident at the University of Michigan. He is a board certified neurologist and sleep medicine physician who completed his undergraduate education in modern languages at the Virginia Military Institute and medical school at the Technion, Israel Institute of Technology. He is a prior service airborne infantry officer who continues his military service as a flight surgeon in the Michigan Air National Guard with the rank of Lieutenant Colonel. Dr. Seyffert is interested in three areas of forensic psychiatry: 1. the intersection of complex neuropsychiatric and sleep diagnoses in assessing criminal responsibility; 2. the neuroethical and neurolegal implications of the use of forensic neuroimaging in the courtroom, and 3. the development of a model Institute of Health Law and Bioethics to address the neurolegal, regulatory, and neuroethical issues related to practicing medicine with the aim of improving our mental health care delivery system. Dr. Seyffert's AAPL preceptor is Dr. Britta Ostermeyer.



### **Anne McBride, MD**

Dr. McBride is a child and adolescent psychiatry resident at the University of California, Davis, where she also completed her medical doctorate and general psychiatry training. She is the recipient of numerous awards, including the Resnick Scholar award, the American Academy of Child and Adolescent Psychiatry (AACAP) Educational Outreach Program for General Psychiatry Residents, and is a Gold Humanism Honor Society Inductee. Her specific interests within psychiatry and the law include juvenile forensic psychiatry and education. While training, Dr. McBride's involvement in forensic psychiatry included facilitating a group of women with mental illness at the county jail and conducting diagnostic interviews of juvenile offenders for determining mental health service and placement needs. She has conducted research investigating topics such as the relationship between malingering, trial competency, and competency restoration. Dr. McBride's AAPL preceptor is Dr. Ryan Hall.



### **Amanda Square, MD, MPH**

Dr. Square is a Child and Adolescent Psychiatry Fellow at Yale Child Study Center in New Haven, CT. She completed her residency training at Yale School of Medicine's Department of Psychiatry, internship at the National Capital Consortium in Washington, D.C., and medical school at Yale School of Medicine. She also earned an MPH from Harvard University, where she was a Zuckerman Fellow. Her interests include understanding the secondary stress placed on children undergoing forensic evaluations, custody evaluations, PTSD, and Reactive Attachment Disorder. Her long-term goal is to pursue an academic position that would allow her to integrate child psychiatry and forensics. Dr. Square's AAPL preceptor is Dr. Catherine Lewis.



### **Jacqueline Landess, MD, JD**

Dr. Landess is a resident at Northwestern Memorial Hospital in Chicago, Illinois. She received her MD from Vanderbilt University and JD from Indiana University. Throughout her training, she has interned for a federal judge, the state attorney general's office, and worked as a documentarian with pregnant adolescents. Most recently, she received the APA Child and Adolescent Psychiatry Fellowship and the AACAP Educational Outreach Award. Jackie is excited to receive the Rappeport Fellowship and further develop her interests in child and adolescent forensic issues and public policy. Dr. Landess' AAPL preceptor is Dr. Susan Hatters Friedman.

## ALL ABOUT AAPL - Committees

# What AAPL Members Do and What AAPL Members Want: Report of the Education Committee

Richard L. Frierson, MD and Elizabeth Ford, MD, Education Committee Co-Chairs

AAPL members are a diverse group. Some of our members work in full-time academic positions, some work primarily for state mental health departments, some are in private practice and others work in correctional settings. Many of our members work in a combination of practice settings. The provision of CME activities for such a diverse membership, the majority of whom are involved in ABPN Maintenance of Certification (MOC), is a daunting task. As AAPL moves forward in the planning process for future CME offerings, the Education Committee recently conducted an online survey of AAPL membership to determine the daily activities of our members and how AAPL could best meet their continuing educational needs. Our thanks go to the 222 members who took time to complete the online survey. The following is a summary of the results.

Members were asked what type of forensic evaluations they routinely perform. These are summarized in Table 1. The majority of AAPL members who completed the survey perform forensic evaluations for the criminal courts. A large minority of members perform common civil evaluations, including disability, personal injury, and malpractice. Approximately half of AAPL members perform violence risk assessments, perhaps more following the events in Newtown, CT and Aurora, CO. Civil and criminal evaluations also featured highly as topics for which members wished to improve their competence (48% and 42%, respectively). In addition to forensic evaluations, 68% of respondents were involved in teaching activities.

The survey also asked about AAPL's role in fulfilling its members' educational needs (Table 2). The majority of members get their CME credits elsewhere. A related question revealed that only a third of

TABLE 1

Type of Evaluation	AAPL Members who perform
Capacity to Stand Trial	70%
Criminal Responsibility (Insanity)	65%
Competency to Be Executed	5%
Worker's Compensation	28%
Disability	53%
Personal Injury	40%
Malpractice	41%
Sexual Harassment	16%
Guardianship/Conservatorship	35%
Testamentary Capacity	30%
Violence Risk Assessment	48%
Sex Offender Evaluations	24%
Child Custody Evaluations	14%

TABLE 2

Percentage of Educational Needs AAPL Supplies	Member Response
0-25%	43.4%
26-50%	33.3%
51-75%	18.3%
76-100%	5.0%

members have used an AAPL product to assist with MOC. As a reminder, the AAPL website contains member access MOC requirements, including Performance in Practice (PIP) clinical modules for Capacity to Stand Trial Evaluations and Disability Evaluations. These were the result of hard work by Debra Pinals, MD and Liza Gold, MD. There is also an evaluatee feedback form to be used in a PIP feedback module from a forensic evaluatee. This is a generic feedback form designed to be used across a wide variety of forensic evaluations, both criminal and civil.

There was tremendous feedback about the annual meeting and forensic review course. The large majority of

survey respondents were very satisfied with both educational experiences, but opinions varied widely about the selection of a location for the annual meeting. The detailed feedback for the annual meeting is outside the scope of this brief update, but it will definitely be used by the Education and Program Committees to plan for future meetings. The Education Committee is also actively working toward a more user-friendly evaluation process of the annual meeting so that we will be better able to capture a more representative sample of the needs of the meeting attendees. The review course evaluations continue to be uniformly superb. Thanks to Dr. Phillip Resnick and his faculty and staff who work tirelessly to provide a quality educational experience.

Table 3 summarizes the responses to the question, "What types of educational activities would help you improve your competence or performance as a forensic psychiatrist?" Clearly, the annual meeting is an important venue for education and our goal is to optimize the experi-

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## ALL ABOUT AAPL - Committees

### AAPL Celebrates 30 Yrs.

*continued from page 2*

*I value all the people I have met and gone out to dinner with and helped organize meetings with over the years. Many are some of my closest professional friends, even though they may live long distances from me.*

Celestine DeTrana, MD and Doug Morris, MD are busy planning the 2014 meeting. Please join MWAAPL for what is sure to be another excellent meeting in Indianapolis, Indiana on March 21-22, 2014. You don't have to be from the Midwest to benefit from this high caliber CME event! ☎

### The City of Roses

*continued from page 7*

night. Portland, Oregon is a beautiful place, with an amazing culture, delicious food, wonderful people, and the most extraordinary gifts.

In essence, this past year was not just a great experience testifying in court, writing forensic reports, learning case law, and answering legal questions. In those regards, I am learning, and still have a lot to learn. This past year was also a most wonderful experience of people, colors, culture, and of course, roses. ☎

#### A Serial Killer's Perspective

Executed in 1994, John Wayne Gacy was convicted of 33 murders and sentenced to death for 12. Gacy lured teenage boys to his home before brutally murdering and raping them. He buried 26 of his victims in the crawl space of his basement, another three he disposed of in a nearby river and the rest were buried in various parts of his property.

When asked about his charges, he reportedly said, "The only thing they can get me for is running a funeral parlor without a license."

Source:

<http://listverse.com/2012/09/04/top-10-serial-killer-quotes/>

### Rebel Teen Daughter

*continued from page 8*

lose his or her fight-or-flight reaction when exposed to danger in the community and be at lower risk of injury because they have a better shot than we psychiatrists at fending off violent actors. Psychiatrists are not typically as well trained in self-defense techniques. Psychiatrists and other mental health professionals can become dangerously accustomed to violent environments and we need to train ourselves to always remember that we have a "work world" which is completely separate from our "personal world" and the two should not be confused with each other.

2. *Fear of shame*: Re-read the headline of the *NE* article. People have a fascination with irony. We enjoy the stories of action-movie stars getting beat up in bar fights; preachers getting caught having affairs; frail elderly women pummeling would-be robbers, etc. Something similar exists for psychiatrists: is it not embarrassing for a child psychiatrist to have an unruly child?

Is that not one of the aims of the *NE* story – highlighting the irony that although the psychiatrist was an expert in assessing and treating female criminals, she was unable to prevent her own daughter from becoming one herself? I think the fear of shame may prevent us from seeking out the help we really need for our own troubled kids.

Is it embarrassing for a psychiatrist to be seen bringing his or her child to a mental health clinic? For the neurotics amongst us, this fear can become an obstacle to overcome. From experience, my advice is: swallow your pride; ask for help; stay safe.

3. *"I have the training to handle emotionally troubled people; I can handle this troubled relative"*: We can put ourselves at higher risk of injury by virtue of the fact that we have some special training in talking down angry and troubled individuals. When your child is acting like a Dennis Hopper character at home, the temptation is to show off your psychi-

atry skills and intervene to defuse the situation. But in order to safely remain effective parents we must be cognizant of when to call for outside help. When we put our skills to use at home – for example, talking down an angry little Dennis Hopper character otherwise known as a defiant teen having a tantrum – if successful we can achieve a sense of pride that not many people have the skills to talk down a real life Frank Booth, but we just did it. After reflection, the thought should then come: why on earth did I handle that situation myself? I should have called 911... I should have sought outside help like everyone else does...

Valerie pled guilty to manslaughter and was sentenced to 10 to 12 years in state prison; she was paroled in 2009. As a forensic psychiatry fellow, I found a few of Dr. Thomsen-Hall's personal belongings in the desk at the forensic fellows' office – one of which was her business card with a sewing needle stuck through it.

My first thought was "voodoo!" until the secretary explained how women often stashed a needle and thread in case of an unexpected mending. I asked the secretary, "So it wasn't voodoo?" She responded, no, it wasn't voodoo, it was just a stashed sewing needle. I think as a child forensic psychiatrist and father I would have been more reassured with a supernatural explanation for Dr. Thomsen-Hall's story rather than what actually took place: like many normal parents, her daughter developed emotional and behavioral problems which led to violence. This wasn't voodoo. This was part of life, part of reality, and as mental health professionals we are not immune to this. ☎

#### REFERENCES:

Mom was a shrink – but couldn't keep own rebel daughter from killing her. Philip Smith, *National Enquirer*, 2000  
Woman who killed mother is paroled. *Worcester Telegram and Gazette*, 8/15/09

## ALL ABOUT AAPL - Committees

### Assessment of Addicted Professionals

Gregory Sokolov MD, Douglas Tucker MD and Trent Holmberg MD  
Addiction and Private Practice Committees

Physicians are as likely to experience drug and alcohol addiction as anyone in the general population. Although alcohol is the primary problem in nearly half of all cases, physicians are more likely than others to abuse prescribed medications.<sup>1</sup> In a study of 16 state physician health programs that examined 904 physicians who had been placed under monitoring for drug abuse, more than half of the physicians were in five medical specialties, with family medicine representing the highest number at 20%<sup>1</sup>; however, anesthesiologists make up 5.2 percent of physicians nationwide, therefore, they are remarkably over-represented in physician health programs, and are most likely to be addicted to intravenous opioids<sup>2</sup>.

Forensic evaluations of an addicted physician may be part of any the following: fitness for duty evaluation for employer or insurance carrier, state medical board evaluation, malpractice case, or disability evaluation. In certain states, addicted physicians may be referred to a "diversion" or physician health program for treatment in lieu of loss or suspension of their medical license. In the previously mentioned study, in five-year follow-

up rates of physicians in treatment programs, 78.7% of participants were licensed and continued practicing medicine<sup>1</sup>.

Attorneys in the United States demonstrate a significant prevalence of substance abuse and other psychiatric disorders, and these often lead to impairment in their professional functioning. One study showed that overall, 33% of attorneys had depression, problem drinking, or cocaine abuse, twice the rates of the general population<sup>3</sup>. LAPs exist in most states, started in the 1980s, and usually provide both voluntary and involuntary (discipline-related) services. Similar to Physician Diversion Programs, the goal is to provide clinical monitoring and treatment for mental illness and/or substance use disorders. In 2009, for attorneys referred to the California LAP, 40% had substance abuse issues and 24% had dual diagnosis issues (mental illness and substance abuse); in addition, the majority of LAP participants were in solo practice, but only about 33% of California lawyers practice solo, so they were clearly overrepresented<sup>4</sup>.

An impaired law enforcement officer represents a significant public

health hazard. The consequences of having an officer on the streets who is psychiatrically unfit for duty are potentially dire. Underlying mental health/addiction issues in law enforcement personnel most frequently present themselves as observed problematic workplace behaviors. Clinically treated alcohol abuse rates in law enforcement are twice that of the general population. The same conclusions are usually made regarding the abuse of other substances<sup>5</sup>.

Law enforcement officers who are being evaluated for a fitness for duty evaluation should understand that the evaluation is not disciplinary in nature and is not to be used as a substitute for disciplinary action. For the forensic psychiatrist doing the evaluation, a thorough review of the officer's record should be performed, including previous remediation efforts, commendations and testimonials, any internal affairs investigations, public complaints, and use-of-force incidents. Ⓢ

#### REFERENCES:

1. McLellan AT, Skipper GS, Campbell M, DuPont RL. *BMJ*. 2008; 337: a-2038.
2. Kintz P, Villain M, Dumestre V, Cirimele V. *Forensic Sci Intl*. 2005;153:81-4.
3. Benjamin, G. et al. *Int J Law Psychiatry*. 1990; 13:233-246.
4. 2009 Annual Report, Lawyer Assistance Program of the State Bar of California.
5. Howard D, Prater A. *The Police Chief*. 2000: 162-172.

### Is There a Causal Connection Between Chronic Traumatic Encephalopathy and Suicide?

Robert P. Granacher, Jr., MD, MBA, Forensic Neuropsychiatry Committee

When Junior Seau committed suicide by gunshot wound in May 2012, newspapers immediately began the drumbeat of a proposed link between high-profile football players who suffered from long-term effects of repeated brain injury and subsequent suicide<sup>1</sup>. On the civil litigation side, lawyers stepped forward repeatedly with claims that their former NFL retired clients had been permanently harmed by repeated concussions that

changed their behavior and produced either suicidal ideation or completed suicide. Our military organizations are currently under duress from claims that blast-related combat trauma leads to chronic traumatic encephalopathy (CTE) and resulting suicide. A research task force is underway at Boston University Medical Center, with support from the National Football League (NFL) and others, to study the neuropathology of

former NFL players, who upon their death, will have their brains sent to this institution for neuropathological analysis.

A recent University of Texas multicenter study has reported findings on the neuroimaging of cognitive dysfunction and depression in aging retired NFL players<sup>2</sup>. The general conclusion of this research was that cognitive deficits and depression appear to be more common in aging former NFL players compared with healthy controls. This is a small study of 34 players of whom 20 were cognitively normal. Thus, the power of the study is low.

The neuropathological findings of chronic traumatic encephalopathy

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## ALL ABOUT AAPL - Committees

# PTSD in DSM-5: Speculations on Its Impact on Forensics

Joel E. Parker, MD, and Andrew P. Levin, MD, Trauma and Stress Committee

After more than a decade of work, not to mention controversy, the American Psychiatric Association released the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5)*, in late May of this year.<sup>1</sup> Each new edition of the DSM has attempted to shape criteria to reflect current knowledge, although the final outcome has been criticized as merely a consensus reached between competing experts.<sup>2</sup> Since its introduction in the 1980 *DSM-III*, the criteria set for Posttraumatic Stress Disorder (PTSD) has contained the same basic elements: 1) Exposure to a stressor; 2) Re-experiencing of the trauma; 3) Numbing and avoidance (the latter added in *DSM-IV*); and 4) Increased arousal and vigilance. The latest iteration of the PTSD criteria presents reorganization and refinements in each of these categories.

The table presents a comparison of the prior diagnostic criteria to the new diagnostic criteria.<sup>3</sup>

These changes in the PTSD criteria may have significant implications for forensic psychiatry. Starting with the expanded criteria defining a qualifying event, the specific inclusion of individuals who have learned of trauma to a “close relative or close friend,” rather than being limited only to those exposed directly to trauma, could result in an avalanche of potential claims from significant others. The Trauma and Stress Committee predicted this danger in its 2009 advice to the *DSM-5* Committee, calling for a precise and limited definition of proximity to the stressor. Not only could this change create a new group of plaintiffs in civil matters involving injury, the impact on the prevalence of PTSD in military populations could be enormous. Military personnel could claim PTSD related to learning that a fellow soldier was killed or injured, leading to a substantial increase in PTSD disability claims, adding to the already extensive backlog in evaluation of these claims. In cases involving torture, an important dimension in immigration matters, relatives of the victim might utilize the PTSD diagnosis in removal litigation, claiming that return to their country of origin would exacerbate their existing PTSD, even when they themselves had not been victims of torture. Courts may respond to the expanded definition by invoking a narrow “zone of danger” test to limit the number of plaintiffs. The details will likely await rulings at the appellate level.

Elimination of the A2 “fear, helplessness or horror” requirement, based on its lack of predictive value vis a vis the symptoms of PTSD, will further lower the bar for the diagnosis, although available research indicates that this increase will not be significant.<sup>3</sup> This change may facilitate a PTSD diagnosis in situations where victims who sustain traumatic brain injury develop PTSD despite being unaware of their responses for weeks or months after the event.<sup>4</sup>

Regarding the development of PTSD

A1	DSM-IV-TR The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.	A1	DSM-V Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:	CHANGES More specific descriptions
			1. Directly experiencing the traumatic event(s).	Little Δ
			2. Witnessing, in person, the event(s) as it occurred to others	Little Δ
			3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.	Includes relatives
			4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).	Includes public servants
			<b>Note:</b> Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.	Excludes most media exposures
A2	The person's response involved intense fear, helplessness or horror.	A2	<b>ELIMINATED</b>	Major Δ
<b>B</b>	<b>The traumatic event is persistently reexperienced in 1 (or more) of the following ways:</b>	<b>B</b>	<b>Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:</b>	Sxs start <b>AFTER</b> traumatic event
B1	Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.	B1	Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)	Little Δ
B2	Recurrent distressing dreams of the event.	B2	Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).	Little Δ
B3	Acting/feeling as though event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).	B3	Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)	Little Δ
B4	Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	B4	Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).	Little Δ
B5	Physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	B5	Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).	Little Δ
<b>C</b>	<b>Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by 3 (or more) of the following:</b>	<b>C</b>	<b>Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:</b>	Avoidance/ numbing split



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### PTSD in DSM-5

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	DSM-IV-TR		DSM-V	CHANGES
C1	Efforts to avoid thoughts, feelings, or conversations associated with the trauma	C1	Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).	Little Δ
C2	Efforts to avoid activities, places, or people that arouse recollections of the trauma	C2	Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feeling about or closely associated with the traumatic event(s).	Little Δ
		<b>D</b>	<b>Negative alterations in cognitions and mood that are associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:</b>	New, more specific category
C3	Inability to recall an important aspect of the trauma	D1	Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).	More specific description
C7	Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)	D2	Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world e.g. "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").	More rational
		D3	Persistent distorted cognitions about the cause or consequence of the traumatic event(s) that lead the individual to blame himself/herself or others.	<b>New symptom</b>
		D4	Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).	<b>New symptom</b>
C4	Markedly diminished interest or participation in significant activities	D5	Markedly diminished interest or participation in significant activities.	No Δ
C5	Feeling of detachment or estrangement from others	D6	Feeling of detachment or estrangement from others.	No Δ
C6	Restricted range of affect (e.g., unable to have loving feelings)	D7	Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).	Little Δ
<b>D</b>	<b>Persistent symptoms of increased arousal (not present before the trauma), as indicated by 2 (or more) of the following:</b>	<b>E</b>	<b>Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by 2 (or more) of the following:</b>	Little Δ
D2	Irritability or outbursts of anger	E1	Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.	<b>Aggression added</b>
		E2	Reckless or self-destructive behavior	<b>New symptom</b>
D4	Hypervigilance	E3	Hypervigilance	No Δ
D5	Exaggerated startle response	E4	Exaggerated startle response	No Δ
D3	Difficulty concentrating	E5	Problems with concentration	Little Δ
D1	Sleep problems	E6	Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).	Little Δ

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among professionals repeatedly exposed to details of traumatic events, the new definition essentially promotes those formerly diagnosed with "secondary posttraumatic stress"<sup>5</sup> to full PTSD. A wide range of professionals including law enforcement and legal professionals, social service workers, and mental health professionals (even forensic psychiatrists!) would become potential cases. Not only might this lead to new claims for work-related injury and resultant disability, it might also interact with Americans with Disabilities Act considerations, i.e., does the ability to handle traumatic material constitute an "essential feature" of the job.

The avoidance and numbing criteria from DSM-IV are now split into avoidance behavior (C) and negative alterations in cognition and mood (D) in DSM-5, reflecting the statistical finding that PTSD symptoms sort into a four factor model rather than the three factor model of DSM-IV.<sup>3</sup> The expanded definitions of negative alterations in cognitions and mood, although not likely to have the significant impact of changes in the A criteria, create an additional set of subjective symptoms that are poorly defined, more difficult to measure, and more easily malingered. The only criteria in the C and D sections that could submit to objective determination would be C1, avoidance of activities, etc., and D5, "diminished.... participation".

The addition of aggressive, reckless, and self-destructive behavior to the E (formerly D) criteria may result in expanded use of PTSD in the criminal defense. PTSD symptoms of dissociation, hyperarousal, hypervigilance, and over-estimation of danger have previously been utilized in successful criminal defenses involving insanity, self-defense, and diminished capacity.<sup>6</sup> Aggression and reckless or self-destructive behavior could bear on diminished capacity and mitigation. The new criteria are unlikely to substantially change the use of PTSD in insanity defenses, however, as there has been no change in the dissociative phenomenon (now in D1), which has been the only PTSD phenomenon which would meet the strict insanity standards for jurisdictions using the M'Naghten Standard.<sup>6</sup> At this point, we must wait to see what unfolds when the "rubber meets the road," perhaps confirming our speculations, perhaps not.

#### References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC: American Psychiatric Association, 2013
2. Greenberg G: The Book of Woe. New York, NY: Blue Rider Press, 2013
3. Friedman MJ, Resick PA, Bryant RA, Brewin CR: Considering PTSD for DSM-5. Depression and Anxiety 28: 750-769, 2011
4. Bryant RA, Marosszeky JE, Crooks J, Gurka JA: Posttraumatic stress disorder following severe traumatic brain injury. Am J Psychiatry 157: 629-631, 2000
5. Figley CR: Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized. New York, NY: Routledge, 1995
6. Berger O, McNiel DE, Binder RL: PTSD as a criminal defense: a review of case law. J Am Acad Psychiatry Law 40:509-21, 2012

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### Passing the Batons

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AAPL would be anywhere without her. On a personal note, she is smart, funny, and has impeccable taste in all things, so her wise counsel goes far.

On a professional note, she has a great “head on her shoulders” and her terrific judgment helps us stay on the straight and narrow. The team of staff at the AAPL office is outstanding.

I would like to especially acknowledge Marie Westlake, Associate Executive Director; Kristin Loney, Executive Assistant; and Sara Elsdon, Journal Editorial Coordinator, who work together seamlessly and thoughtfully to help our members get what is needed from the organization.

Our journal continues to be top notch, with the able stewardship of Ezra Griffith, M.D., and the help of Michael Norko, M.D., Associate Editor of the Journal. Charles Dike, M.D., AAPL Newsletter Editor, has also been incredibly diligent and gifted in producing a wonderful product for our members to read. I thank each of them for their contributions to the organization.

As for future directions...AAPL remains a strong and robust organization. As I have said many times, it helps serve as a professional home to its members.

I have found that in coming to meetings and in participating in AAPL governance, I have gained tremendously- both in knowledge and skills, but also in feeling supported by a very wonderful group of colleagues.

I encourage our future leaders to continue to help AAPL remain strong by listening to the needs of the members, emphasizing sustainability, partnering with the Institute of Education and Research, and fostering a sense of growth through lifelong learning together. I am confident that the next leaders of our organization are well-suited for the tasks ahead, and will keep AAPL standing in good stead. ☎

### Closing Comments

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Michael Norko as editor and deputy editor respectively, has grown in stature, size and quality over the past 15 years and has become an important public face for the organization. The Journal is now published online, as are all past issues, for easy reference and availability.

AAPL has addressed standards for excellence in our field by putting together work groups and writing Practice Guidelines. We began with Guidelines for Criminal Responsibility and Video Recording of Forensic Evaluations. We then undertook Guidelines for Disability Evaluations and Competence to Stand Trial. Another that is close to completion is the Forensic Assessment Practice Guideline. These guidelines now have to be updated every five years. Many members participated in the development of these documents and drafts, which were made available to the membership at large for comment prior to publication.

Our Annual meetings continue to be well attended and the quality of submissions is high. The number of submissions has risen and our Education Committee has maintained our CME accreditation. The review course

under the leadership of Dr. Philip Resnick has maintained a high attendance and gets good reviews.

Not enough can be said about our Executive Director, Jackie Coleman, and her staff at S & S Management that have so ably directed our organization and maintained our history and policy discussions which enable all of us to function effectively. They are a true pleasure to work with, and their initiative, efficiency, and overall helpfulness are outstanding. The office has taken on additional roles in the publishing of the Journal and Newsletter. Jackie’s involvement with the Connecticut Psychiatric Society, the district branch of the APA, and other psychiatric and medical associations has been invaluable in providing benchmarks from comparable organizations.

It has been a privilege to be associated with AAPL and a joy to be associated with its development and maintenance. The many press calls and calls from members and non-members looking for advice, referrals, or information have provided a great learning experience. I will miss the role and challenges. ☎

### Speculations on its Impact on Forensics

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E	<b>DSM-IV-TR</b> <b>Duration</b> of the disturbance is at least one month: Acute-when the duration of symptoms is less than three months. Chronic-when symptoms last three months or longer, with delayed onset at least six months have elapsed since the traumatic event and onset of symptoms.	F	<b>DSM-V</b> <b>Duration</b> of the disturbance (criteria B, C, D, and E) is more than one month.	<b>CHANGES</b> <b>Acute vs. chronic distinction eliminated.</b>
F	Requires significant distress or functional impairment	G	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Little Δ
		H	The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.	Consistent with most other diagnoses
			<b>With dissociative symptoms</b> (with either depersonalization or derealization)	Specifier added
			<b>With delayed expression:</b> if the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).	Specifier added

## ALL ABOUT AAPL - Committees

### Whose Life is it, Anyways? How one guardianship evaluation changed my perspective

Sherif Soliman MD

As I set out on a sunny Saturday morning, I struggled to keep an open mind. All the facts seemed to point in one direction: Mrs. Billingsly suffered from dementia and required nursing home placement for her safety. Or so it seemed. I had earlier received a referral from an attorney who is an expert in mental health law. He was representing Mrs. Billingsly, who was seeking to have her guardianship removed. Mrs. Billingsly was a widowed 91-year-old first generation immigrant with three adult children. Mrs. Billingsly had suffered a stroke five years ago. She required a walker due to her unsteady gait and had been diagnosed with vascular dementia. Her daughter, Caroline, moved into Mrs. Billingsly's home to help care for her. Caroline had recently divorced and was unemployed. Caroline told me that her mother was incontinent, forgetful, and uncooperative with home care staff. Caroline had sought and obtained guardianship over Mrs. Billingsly and, under the guise of taking her to breakfast, took her to Placid Lake Home. Mrs. Billingsly had lived in her home for 45 years. She lived next door to her sister, Margaret.

Mrs. Billingsly was a charming woman who was glad to see me. She fluently described her personal history and told me with some anger about her placement at the nursing home. She alleged that Caroline was destitute after her divorce and had concocted the guardianship as a way to take control of Mrs. Billingsly's home and assets. On mental status examination, she was fully oriented but had marked short term memory deficits and word finding difficulty, consistent with mild dementia. She knew the approximate value of her home but was not able to realistically discuss her income or expenses. She was aware that she had physical limitations and told me she was willing to accept help at home. She had diffi-

culty recalling important safety information, such as "9-1-1." She said she'd call "that number" in an emergency. I interviewed her sister, Margaret, by telephone. Margaret did not believe her sister was unusually forgetful. She said that she would be able to check on her sister daily. Margaret was very suspicious of Caroline's motives, stating that Caroline wanted her mother's money.

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*"...well intentioned interventions, such as guardianship, can, without adequate protections unjustly deprive vulnerable people of their liberty."*

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I interviewed Mrs. Billingsly a second time. She greeted me by exclaiming triumphantly, "I'd call 9-1-1!" She did slightly better but still had significant impairments in short term memory and word finding. She said that she knew she was in more physical danger living at home but was willing to accept the risk. As I got up to leave, she grabbed my arm and looked intently at me. Her eyes welled with tears as she said, "Doctor, please pray for me. Pray they let me go home." Those words echoed in my mind as I sat down to write my report that evening.

As a resident and later as a geriatric psychiatry fellow, I viewed the guardianship system as inherently and almost universally good. Guardians protect vulnerable patients from neglect, exploitation, and abuse. Treating physicians, who complete the vast majority of guardianship evaluations, are guided in relevant part by the ethical principles of

beneficence and nonmaleficence. We often regard guardianship as the more "conservative" option and tend to discount the substantial "side effects" of guardianship. The loss of autonomy over basic personal decisions can have a profound impact on a ward's well-being. The importance of this loss of legal personhood should not be overlooked or understated. Guardianship evaluations often consist of a one to two page evaluation form that is filled out quickly by busy physicians. In a review of 298 guardianship evaluations, Moyer and colleagues [1] found that documentation of functional strengths and weaknesses was "particularly rare" in guardianship evaluations, though functional impairment should be the central focus of such evaluations. They found that statutory guardianship reform in Colorado yielded higher quality reforms.

Forensic psychiatry training gave me an entirely different perspective on guardianship. Justice Brandeis' admonition, "The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding, [2]" rings as true today as when he wrote it 75 years ago. Meeting Mrs. Billingsly brought these words to life for me. Even well-intentioned interventions, such as guardianship, can, without adequate protections unjustly deprive vulnerable people of their liberty. Our role as forensic psychiatrists should be to carefully assess functional capacities in order to allow legal decision makers to select the least restrictive alternative. Further, we should address the likely prognosis: Are the deficits likely to improve, remain stable, or worsen over time? Forensic psychiatrists are also uniquely positioned to teach our colleagues in primary care, neurology, and psychiatry about performing guardianship evaluations that appropriately balance respect for autonomy with the need to protect vulnerable people. We should also be involved in multidisciplinary efforts to review existing guardianship laws and procedures.

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## ALL ABOUT AAPL - Committees

# Perspectives on Forensic Training in General Psychiatry Residency

*Brian Holoyda MD, MPH; Jessica Ferranti MD, William Newman MD and Anne McBride, MD, Forensic Training in General Psychiatry Programs Committee*

Training and education in forensic psychiatry is one of the curriculum requirements for general psychiatry residency programs. The Accreditation Council on Graduate Medical Education (ACGME) lists forensic psychiatry as a “required clinical experience” and states that a residency program must “expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others” (ACGME Program Requirements, page 17). On the one hand, the imprecise language of the requirement allows residency programs to tailor the clinical and didactic exposure to forensic psychiatry topics to meet the program’s emphasis and educational resources. However, by not being explicit regarding the goals and objectives of a core curriculum in forensic psychiatry, programs may not provide strong enough training in aspects of forensic psychiatry that are relevant to all general psychiatrists.

Areas such as violence risk assessment, suicide risk assessment, informed consent, capacity assessments, disability and mandatory reporting are key forensic topics for all psychiatrists. Residency should be the beginning of a firm foundation in these important aspects of clinical practice. How exactly should general psychiatry residency training approach the field of forensic psychiatry? What are the key topics that need to be addressed, and what is the most effective way to do so? How much is too much? How can we best engage the learner encountering forensic topics at the general residency level? And importantly, how can AAPL provide support and resources to general residency programs lacking forensic psychiatry faculty and/or

a paucity of forensic clinical rotation sites? These are questions that the Forensic Training in General Psychiatry Residency committee has been struggling to answer, with the development of a model forensics curriculum as its goal.

At the general psychiatry level, good forensic training must be accomplished in the setting of all the other core competencies residents must master. The educational priorities of a general psychiatry program are a delicate balance that can be complicated to keep in equilibrium. The Education Policy Committee, a required committee in all general psychiatry programs, has a key role in assessing whether educational needs are being met. Feedback from the relevant stakeholders, including the faculty and residents of a program, must be taken into consideration when making any curricular decisions. Often these perspectives can lend important insight into strengths and weaknesses of a program’s forensic curriculum. For example, some perspectives on forensic training in the general psychiatry program at UC Davis Medical Center are included below:

A PGY2 resident perspective (Brian Holoyda, MD, MPH): One of the main reasons I chose to complete my general psychiatry residency training at University of California – Davis Medical Center was the breadth and depth of the forensic training available to residents. Though I have only completed one year of residency, the exposure to forensic principles and practice has been outstanding. All PGY-1s complete a one-month rotation at the Sacramento County Jail under the direction of forensic specialists. In addition, there is a block of lectures on legal issues in psychiatry during the PGY-1 year that is invariably hailed as one of the most

outstanding lecture series of the program. PGY-2s have the opportunity to complete a forensic psychiatry rotation, participating in forensic evaluations with UC-Davis’s forensic psychiatry fellows in addition to writing parallel reports. Some intrepid residents have even taken the stand in forensic mock trials alongside the forensic fellows, while their co-residents watch them undergo questioning by a district attorney who never fails to generate a sense of excitement and dis-ease in those observing.

Though I have personally enjoyed the exposure to forensic psychiatry during my general residency training, some residents feel that our training is a bit forensics-heavy, which raises the question: How much is too much? Or alternatively, how much is not enough? How can we educate general psychiatry residents about the importance of forensic principles and practice without alienating those without an interest in the field and not educating residents about forensic issues they may experience in general practice? Currently, the Forensic Training in General Residency committee of AAPL is discussing these very important questions.

A PGY5 child and adolescent psychiatry resident perspective (Anne McBride, MD): I had a strong interest in forensic psychiatry prior to choosing to train in general psychiatry at UC Davis. Having completed my medical doctorate training at UC Davis, my choice to stay was influenced by both the unique forensic psychiatry opportunities at UC Davis and the accessibility of outstanding faculty mentors. As I completed my general psychiatry training, two key factors of the training program greatly influenced my course: program flexibility and mentorship. Throughout my training I presented numerous proposals to our education policy committee involving further training within forensic psychiatry, and the program allowed me the flexibility to explore more areas in forensics. During my PGY-2 year I took part in the month-long forensic psychiatry elec-

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tive that Dr. Holoyda previously discussed. I also created a year-long continuity clinic experience where I worked with both juvenile offenders at the Sacramento County Juvenile Hall and adults at the Sacramento County Jail. Additionally that year I sought out a forensic faculty research mentor and conducted research involving malingering, trial competency, and competency restoration. As a PGY-3 resident I created a year-long longitudinal open-ended women's mood disorder group therapy at the Sacramento County Jail, supervised by a forensic psychiatry faculty mentor. The flexibility of my program combined with such strong mentorship allowed me to explore my specific interest in forensic psychiatry and ultimately led me to further specialize in juvenile forensic psychiatry. As a current child and adolescent psychiatry resident at UC Davis, I continue to have excellent forensic mentors and opportunities in juvenile forensic psychiatry.

I realize that my own initiative and the already strong foundation of forensic psychiatry opportunities played significant roles in my forensic training within my general psychiatry program. However, the flexibility I was afforded and the forensic mentors I could access were imperative factors that led to such outstanding forensic training within my general psychiatry program. I imagine that these same factors within different programs would go a long way to strengthen the training for those residents already interested in forensic psychiatry while not inundating residents who are more interested in forming a solid forensic foundation without necessarily specializing in the field.

A faculty perspective (William Newman, MD): After completing my forensic psychiatry fellowship at UC-Davis, I remained in the department as a faculty member. In my current role, I have the incredible opportunity to supervise and teach forensic fellows, general psychiatry residents, and medical students. As an attending psychiatrist on the inpatient teaching service, frequent opportuni-

ties arise to discuss pertinent forensic issues such as suicide risk assessment, violence risk assessment, court testimony (for civil commitment hearings and involuntary medications), and competency restoration of misdemeanants. The forensic issues serve to easily engage many of the residents and students who rotate through the service. Fortunately, I also get to participate in more structured activities that expose general psychiatry residents to forensic psychiatry.

Over the last few years, Dr. Ferranti and I have worked together to further bring the forensic fellows and general psychiatry residents together for training experiences. One of the best examples of this is the mock trial experience that occurs here twice a

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year. For that experience, we arrange a courtroom from Sacramento County and have a very skilled district attorney (and member of the volunteer faculty) participate. Each forensic fellow submits a report they have written for review by the district attorney, Noah Phillips. When time has permitted, some brave residents have also submitted reports and participated by giving mock testimony. Mr. Phillips carefully reviews each

report and develops a well-prepared cross-examination. The residents who attend this protected teaching activity witness the cross-examination and offer feedback to each participant from the perspective of potential jurors. In previous years, we've had residents highlight subtle and interesting perspectives on the fellows' testimony that they would otherwise rarely have the opportunity to hear from actual jurors throughout their careers. The forensic faculty members also attend and discuss other important teaching points to the fellows and residents. Both the fellows and the residents annually laud the mock trial experience. The mock trial is just one of the many teaching activities I enjoy as a faculty member at UC-Davis. In my opinion, establishing a firm foundation in forensic psychiatric principles during general psychiatry residency training facilitates training more complete clinical psychiatrists, no matter the specific career trajectory of each graduate.

A training director's perspective (Jessica Ferranti, MD): As a training director of the general psychiatry training program at UC Davis Medical Center and also a forensic psychiatrist, I have the unique opportunity to be able to blend two great passions of mine: teaching residents and the field of forensic psychiatry. However, along the way there have been some challenges that I did not expect. One challenge for me (and I suspect other faculty who have busy forensic practices) has been that it is very difficult to bring people along in forensics. I mean that figuratively and literally. The nature of litigation, confidentiality requirements, the security restrictions of correctional institutions and the often solitary nature of much of the work (record review, report writing, etc.) make it difficult to give trainees a window into the world of consultative forensic work. Synergy between my two roles has been hard to come by but one place I have been able to find it has been in my work on the AAPL Forensic Training in General Psychiatry Committee.

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### Report of the Education Committee

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ences there and throughout AAPL's educational offerings. Many of the responses are reflective of the digital age where convenience and easy access to training opportunities are important to membership. At the

**TABLE 3**

Venue Type	Percentage Responding
Annual Meeting	77%
Forensic Review Course	62%
Journal of AAPL CME	58%
Live web conference	12%
Web-based access on demand	47%
Online grand rounds	32%
Case analysis	43%
Other	8%

time of this report, the AAPL office is uploading a Self Assessment Examination for MOC onto the AAPL website to be available to members this fall. We are also exploring potential time-limited web based CME offerings and attaching CME to the Journal.

On behalf of the Education Committee, thank you again to all who completed the online survey and to all AAPL members for your dedication to improving the educational experience of the organization. ☺

### Is There a Connection?

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were first described almost 40 years after the first clinical reports. A recent meta-analysis and literature review of CTE has noted primarily the diagnostic markers of a progressive tauopathy, including the presence of numerous neurofibrillary tangles, rare neuritic plaques, and widespread expression of TDP-43 (transactive response DNA binding protein 43).<sup>3</sup> Timely neuropathological studies have noted that after the acute insult, there is a neuroinflammatory response, which develops within the

first week and persists for several months after the brain trauma. It then returns to baseline levels after several years. In cases with diffuse traumatic axonal injury, the microglial reaction is particularly pronounced in the white matter.<sup>4</sup>

While the neuropathology of CTE and TBI is fairly straightforward and follows basic principles of neuropathology, when one moves into the realm of neuropathological correlates of suicide, the scientific findings become murky. There are no significant structural findings with either CT, MRI or neuropathology that show strong correlations with suicidal behavior or completed suicide. The most that can be said for the literature is that it is mostly based on functional neuroimaging or molecular biology and inferential. For instance, post-mortem studies following completed suicides have suggested that abnormalities of certain receptor subtypes, components of signaling systems, and cyclic AMP responses, may play an important role in the pathophysiology of suicide.<sup>5</sup> The serotonin system in the brain is hypothesized to be involved in both the diathesis for suicidal behavior in terms of decision making, and in response to a major stressor, to wit episodes of major depression.<sup>6</sup> Victims of suicide have also been found post-mortem to have altered functional protein networks in the prefrontal cortex and amygdala.<sup>7</sup> The morphometry of dorsal raphe nuclei have been found to be decreased in size in those individuals committing suicide versus controls.<sup>8</sup>

From a forensic psychiatric or neuropsychiatric standpoint, it should be obvious that there is limited ability to draw a causal connection between the histopathology of CTE and a complex behavior, with probable multifactorial components, such as suicide. Using Bradford-Hill criteria for specific causation will not allow the forensic psychiatrist to draw a significant conclusion to give a sound opinion to a trier of fact regarding the question of whether chronic traumatic encephalopathy and suicide are related. While people with traumatic brain injuries are at elevated risk for suicide,

it is now well accepted that postinjury cognitive limitations, personality factors, and psychological problems may independently, or in conjunction with preinjury correlates, contribute to suicidal thoughts and behaviors. The neuropathology of CTE is fairly uniform and straightforward, whereas the psychobiological aspects of suicidal behavior are not.<sup>9</sup> Thus, the claim that CTE causes suicide cannot currently be supported by the scientific literature. ☺

### References

1. Kahn A.: Junior Seau: Apparent suicide follows deaths of athletes with brain trauma. *Los Angeles Times*, May 2, 2012, pA1
2. Hart J, Kraut MA, Womach KB, et al.: Neuroimaging of cognitive dysfunction and depression in aging retired National Football League players: A cross-sectional study. *JAMA Neurol* 70: 326-335, 2013
3. Lakis N, Corona RJ, Toshkezi G, et al: Chronic traumatic encephalopathy: Neuropathology in athletes and war veterans. *Neurol Res* 35: 290-299, 2013
4. Smith C, Gentleman SM, Leclercq PD, et al: The neuroinflammatory response in humans after traumatic brain injury. *Neuropathol Appl Neurobiol* Dec 11, 2012 [Epub ahead of print]
5. Pandey GN and Dwivedi Y: What can post-mortem studies tell us about the pathoetiology of suicide? *Future Neurol* 5: 701-720, 2010
6. Mann JJ: The serotonergic system in mood disorders and suicidal behavior. *Philos Trans R Soc Lond B Biol Sci* 368(1615): February 25, 2013
7. Kékesi Juhász G, Simor A, et al: Altered functional protein networks in the prefrontal cortex and amygdala of victims of suicide. *PLoS One* 7(12): 2012 [Epub 2012 December 6]
8. Matthews PR and Harrison PJ: A morphometric immunohistochemical in situ hybridization study of the dorsal raphe nucleus in major depression, bipolar disorder, schizophrenia, and suicide. *J Affect Disord* 137:125-34, 2012
9. Dennis JP, Ghahramanlou-Holloway M., Cox DW, et al: A guide for the assessment and treatment of suicidal patients with traumatic brain injuries. *J Head Trauma Rehabil* 26:244-56, 2011



## AAPL At Large

### IALMH Holds 33<sup>rd</sup> Meeting in Amsterdam

John L. Young MD

Several thousand forensic mental health students and professionals from around the world gathered in the magnetic Dutch city of Amsterdam for the 33<sup>rd</sup> Congress of the International Academy of Law and Mental Health (IALMH), 4 – 19 July, 2013. They found the city in a festive mood, celebrating several milestones including among others the 400<sup>th</sup> anniversary of its unique system of canals, the 200<sup>th</sup> anniversary of the Dutch Republic, and the reopening of the city's centerpiece Rijksmuseum after a decade of renovation and expansion.

Preceding the conference and included with registration was a day-long symposium on Spinoza, the 17<sup>th</sup> century Jewish philosopher and probably Amsterdam's best known citizen - Kenneth Seeskinfrm of Northwestern University opened with a talk contrasting opinions drawn by Spinoza and Maimonides despite their closely similar intuitions. Anne Benvenuti of Cerro Coso College charmed and challenged her audience with reflections relating Spinoza's ethical system to how we humans relate to animals. In turn, David Novak of Toronto University then applied Spinoza's ethics to current mental health issues. Hamilton College's Heidi Ravven concluded with her Spinoza-inspired vision on how current findings in neuroscience that are seen as questioning free will bear on moral agency or responsibility.

Spread over four days, the meeting schedule was divided into nineteen two-hour time blocks. Each contained ten or more simultaneous thematically titled sessions of five or six papers. Most were in English, with a few each in French, Italian, and Spanish. The 500-page abstract book included as a CD with registration is also now available free, along with the program booklet, as pdf files at the Academy's website [www.ialmh.org](http://www.ialmh.org). The conference Chair was David Weisstub of Montreal University and the Co-Chair was Hjalmar van Marle of Erasmus University, Rotterdam.

Eight sessions carried titles related directly to forensic psychiatry. In addition three discussed involuntary hospitalization, and another three, correc-

tional work. Many headings referred to varied aspects of aggressive behavior including new findings in both diagnosis and treatment. Sexual offending was well covered, along with PTSD.

Legal issues abounded, along with a variety of court decisions.

This reporter spoke about the value of attention, patience and creativity in meeting the challenges of caring for forensic patients who prove especially difficult to discharge from the maximum-security setting. Victoria Dreisbach described in helpful practical terms her experiences with geriatric forensic patients. Chinmoy Gulrajani contributed one of many papers on cultural aspects of forensic psychiatry, speaking on common pitfalls resulting from ignorance of the cultures of non-dominant groups. Additional AAPL members on the program included John Bradford, Harold Bursztajn, Alan Felthous, Tom Gutheil, Joe Penn, and many others. Also the well-known legal scholar Michael Perlin appeared prominently on the program.

In accord with longstanding IALMH tradition, the richness of the professional offerings for the mind were at least equaled for the palate by the lavish opening and closing receptions and the five incredibly splendid luncheons served in the uplifting winter garden of the Grand Hotel Krasnapolsky, the conference venue. The Academy also has a custom of featuring a cultural event, and this time it was an evening of baroque music held at the 300-year-old Spanish Portuguese Synagogue, its many large candelabra alight since the building is deliberately and strictly preserved and therefore has no electricity. The Academy is planning to meet again in two years, and you can also view its prior meetings in Berlin, New York City, and Padua on the above website. Stay tuned there for information on the 34<sup>th</sup> Congress as it becomes available. Italy is rumored to be the country, but where? Its Padua gathering was exceedingly well received, and it has met at least three times in Siena over the years. Palermo anyone? Rome? ☺

### Letter to the Editor

To the Editor:

WHO's Global Clinical Practice Network (GCPN) for the ICD-11: An invitation to lend your expertise in Sexual Disorders, Sexual Health and Related Forensic Issues.

The World Health Organization (WHO) is currently developing the next version of the International Classification of Diseases (ICD-11). Significant changes have been proposed for the ICD-11 that relate to the classification of sexual disorders and related sexual health conditions, many of which have important forensic implications. Given the extent of the changes, WHO will conduct thorough field-testing of the proposals in order to ensure their acceptability, clinical utility and global applicability.

WHO is specifically appealing to professionals with expertise in sexual health, sexual disorders or those who have experience working with sexual issues in forensic settings, because it is critically important that there are a sufficient number of health professionals with the relevant expertise to evaluate the proposals. As a mental or sexual health professional we invite you to lend your clinical experience and expertise to the ICD-11 development process by participating in the internet-based field-studies of the proposed diagnostic guidelines. The first step is to register for the Global Clinical Practice Network (GCPN), an international and multilingual network of health professionals that are contributing directly to the ICD revision. The GCPN currently has over 7,500 members.

Changes to the classification of sexual disorders and other sexual health conditions will directly influence practice around the world, in both clinical and forensic settings, so your participation is crucial! We encourage you to register and participate in this important project.

Thank you for your anticipated participation and support.

Sincerely,  
Richard Krueger, Peer Briken and  
Geoffrey M. Reed

## ALL ABOUT AAPL - Committees

### Perspectives on Forensic Training

*continued from page 19*

Locally at my institution, synergy between my two roles happens in my oversight of the forensic curriculum in the general psychiatry program at UC Davis.

I have the advantage of being at an institution that has a nationally strong forensic psychiatry fellowship under the direction of Dr. Charles Scott, clinical forensic psychiatry rotation sites including a jail and a state hospital, and many excellent forensic psychiatrists on faculty to teach my general residents. We are a complex department of psychiatry with many training programs (a general psychiatry program, two combined training programs with family practice and internal medicine, and three fellowship programs) and many competing politics and agendas. As a training director, I am aware that I have been criticized for perhaps over-emphasizing forensic material in our curriculum. In fact, I am very aware of this risk and I am quick to point out the elements of forensic psychiatry that are inherent in all psychiatric encounters with patients. With the trainees, especially those interested in subspecializing in forensic psychiatry, I emphasize that one must first be an excellent psychiatrist to be able to be an excellent forensic psychiatrist. In our forensic curriculum, we have legal issues courses in every year of the residency program. We also have innovative experiences for the general residents to participate in such as a mock trial and parallel report writing. We have done special half-day seminars for all residents on the topics of suicide and violence risk assessment. As a training director, I have grappled with how to address the residents'

anxiety about forensic topics. Some residents have difficulty confronting forensic issues, such as violence.

They can be quick to reject information, request and be satisfied with concrete answers to the issues (such as "panic buttons," etc.), and may turn away from forensic psychiatry. I find that the answer to this problem is usually based in the mentoring relationships of our forensic faculty who inspire residents to view forensic issues with curiosity and feel empowered by knowledge.

From recent discussions at meetings of the AAPL Forensic Training in General Psychiatry Committee, it is clear that general psychiatry programs are taking vastly different approaches to implementing forensic training. Some programs offer a variety of training opportunities, including rotations in correctional settings such as jails, prisons, forensic state hospitals or forensic clinics. Some programs with forensic psychiatry fellowship programs offer dedicated forensic psychiatry electives, mock trials, and advanced legal lectures. Some programs struggle to have any specific forensic clinical exposure at all due to limited clinical site resources and a lack of subspecialty-trained faculty to teach the topics. The Committee has received requests for curricular resources and guidance from two such programs in the last year. As a Committee, we will continue to explore how we can best provide guidance and resources to general psychiatry programs in efforts to promote the highest level of forensic psychiatry training for general psychiatrists. ☺

### Classifieds

**Springfield Hospital Center** in Sykesville, MD is accepting applications for a **Forensic Psychiatrist**. Eligible candidates must have board certification including added qualifications in forensic psychiatry (or equivalent). Duties include pretrial evaluations of competency to stand trial and criminal responsibility, competency restoration, and training of residents and students. Please forward a CV and inquiry to Erik Roskes, MD, Director, Forensic Services, Springfield Hospital Center, by fax 410-970-7105 or email [erik.roskes@maryland.gov](mailto:erik.roskes@maryland.gov).

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### MUSE & VIEWS

#### **A Lawsuit you can't lose! Me vs. Me**

Robert Lee Brock, an inmate at the Indian Creek Correctional Facility in Virginia filed a \$5 million lawsuit...against himself. Evidently he had become so distraught over the fact that he had gone out and committed grand larceny that he felt as though he deserved to pay that amount. The problem was, he didn't have a job, so naturally he asked the state to pay him for him.

*Submitted by Charles L. Scott MD*

## AMERICAN MEDICAL ASSOCIATION

# American Medical Association 2013 Annual Meeting Highlights

Robert T.M. Phillips MD, PhD, Delegate, Barry Wall MD, Alternate Delegate, Ryan Hall MD, Young Physician Delegate, Howard Zonana MD, Medical Director

AAPL requalified for its seat in the House of Delegates at the Chicago annual meeting. We thank all AAPL members for recognizing the importance of our presence in AMA. Psychiatry continues to have a strong presence within the elected and appointed positions of the AMA and

*“Physicians and medical students unanimously voted to accept Gay and Lesbian Medical Association’s application for representation in the AMA’s House of Delegates.”*

within state delegations. Jeremy Lazarus, a Colorado psychiatrist, stepped down as AMA President at this meeting.

In his final address, he reflected on such events as the Supreme Court of the United States’ ruling on the Affordable Care Act, which upheld the constitutionality of personal responsibility to obtain health insurance coverage but struck down mandatory Medicaid expansion. The gun tragedies in Colorado and Connecticut, and the bombings at the Boston Marathon, occurred during his term, and at this annual meeting in Chicago, the House of Delegates reaffirmed many policies ensuring that as many patients as possible have access to mental health care, and that physicians address gun violence and reduce the stigma around mental illness.

Dr. Lazarus commented that there has been a shift in attitudes toward mental health and in funding for mental health care. This is evidenced by the mandate for mental health coverage to be an essential benefit and in

the growing focus on collaborative care; the expanded mental health coverage for Medicaid patients; the emphasis on community-based psychiatric services; and increased concern about violence and gun regulation.

Other annual meeting highlights include the following:

**Updates on the AMA Insurers Report Card:** Since its launch in 2008, the AMA’s annual report card has revealed the physicians’ burdens when it comes to being paid by insurers.

For the first time, the AMA’s National Health Insurer Report Card examined the portion of health care expenses that patients are responsible for through copays, deductibles and coinsurance. Patients are responsible for nearly one-quarter of the medical bill. During February and March of this year, patients paid an average 23.6 percent of the amount that health insurers set for paying physicians.

**Board Certification Process:** The House of Delegates directed the AMA to commission an independent study to evaluate the impact of Maintenance of Certification (MOC) on physician practices. It will work with the American Board of Medical Specialties and its specialty boards to explore whether mandatory examinations are still needed with MOC, and whether they could be eliminated. There is broad opposition to continuing mandatory examinations in the face of extensive new MOC requirements.

**Obesity as a Disease:** The AMA adopted policy that recognizes obesity as a disease requiring a range of medical interventions to advance obesity treatment and prevention. While some indicated concern that disease classification will not improve health outcomes, others expressed hope that the declaration will improve physician payment for efforts to prevent and treat it.

**Supplemental Nutrition Assistance Program (SNAP) new policy:** Millions of Americans from low-income households receive assistance from the SNAP. Studies have shown that sugar-sweetened beverages account for 58 percent of beverages purchased under SNAP.

New AMA policy passed calls on the AMA to work to remove sugar-sweetened beverages from the SNAP and encourage state health agencies to include nutrition information in routine materials sent to SNAP recipients.

**Mechanics of the House of Delegates:** Physicians and medical students unanimously voted to accept Gay and Lesbian Medical Association’s application for representation in the AMA’s House of Delegates.

This clearly shows how far the organization has evolved over the years. However, the House of Delegates also voted to continue holding two yearly meetings, by retaining its Interim meeting, instead of using the Internet and electronic communication to continue communication while cutting meeting time and costs.

AAPL welcomes Jennifer Piel, M.D. as its new Young Physician Representative position to the AAPL AMA delegation. She is a Staff Psychiatrist at the VA Puget Sound Health System in Seattle, Washington.

In 2012, she completed her fellowship in forensic psychiatry at the University Hospitals/Case Western University in Cleveland, Ohio. We thank all young physicians who applied and interviewed for the position. We are fortunate to have many interested members who did so.

For more information on the actions of the AMA House of Delegates at the 2013 Annual Meeting go to <http://www.ama-assn.org/ama/pub/meeting/index.shtm>



## ALL ABOUT AAPL - Committees

### Adoptive Couple v. Baby Girl

*continued from page 6*

can be said with certainty that the anguish this case has caused will only be compounded by today's decision."

Thus, the Majority seems to have focused on its interpretation of ICWA leading to a best interest's case for the child, while the dissenters focused on Constitutional issues and its belief in the primacy of parenthood. The Dissenters failed to consider the psychological impact upon the child of leaving the only parents she knew to live with a complete stranger. While it may seem to turn ICWA on its head, the outcome rests upon the standard of child custody and placement issues, the best interests of the child.

**Update:** In a July 17, 2013 decision by the South Carolina Supreme Court by a vote of 3 to 2, the court ruled that the adoptive parents and NOT the Native American biological father are the only proper parents for the child. The Supreme Court ordered a Family Court to finalize the adoption. ☞

### Whose Life is it, Anyways?

*continued from page 17*

I opined that every reasonable effort should be made to allow Mrs. Billingsly to return home with appropriate support. I recommended expert evaluation of her home to recommend appropriate physical modifications, twenty-four hour home care, and the appointment of a neutral guardian of estate in light of the family discord. I later learned that Mrs. Billingsly had been permitted to return home and was much happier there than she had been in the nursing home.

#### References:

1. Moye J, Wood S, Edelstein B, et al. Clinical evidence in guardianship of older adults is inadequate: findings from a tri-state study. *Gerontologist*. 2007;47(5):604-612.
2. *Olmstead v. United States*, 277 U.S. 438 (1928).

### Ask The Experts

*continued from page 9*

era." I was invited to her chamber where I explained my situation and she instructed me to say nothing, but she also spoke to the lawyer involved and my bill was paid. It served as a reminder to me to get paid in advance of doing work or releasing reports, a lesson on which I still need refreshers periodically.

Reviewing opposing experts report in advance is critical. Try to be able to refute her opinion using the best science you can muster. At the same time, be humble. There is such a thing as a "respected minority opinion" and your willingness to countenance such an opinion will help you to appear reasonable and impartial. When I hold the respected minority opinion, I remind the jury that at one point the minority opinion was that the world was round and not flat. They quickly understand that my minority view may simply be cutting edge thinking.

**Sadoff/Kaye:** Take home points: In summary, these four questions all go to the quality of expert psychiatric testimony. In the courtroom, when in doubt about how to respond, turn to the judge for help. Remember, if things are too hot, you can ask for a break to recompose your thoughts. Do not panic and do not lie on the stand. Be as prepared as possible by going over direct and cross examination testimony with retaining attorney well in advance of the trial. Know the data and the research as well as the details of the case. Finally, never badmouth a colleague on the stand. Judges and juries respect experts who show respect to those whose opinions may differ. ☞

#### PSYCHIATRY FELLOWSHIP IN FORENSIC PSYCHIATRY

The Ohio State University now offers a fellowship in forensic psychiatry. In conjunction with Ohio's only maximum security forensic hospital at Twin Valley Behavioral Healthcare and the world renowned Nationwide Children's Hospital, this fellowship offers specialized training in the intersection of psychiatry and the law. Fellows will have the unique opportunity to be involved in many different aspects of forensic patients' assessment and evaluation. Fellows will aid in evaluation of defendants' competency and sanity at the time of the act both in jail and hospital settings. Treatment opportunities, juvenile evaluations, and civil cases will round out the fellows' experience. Additionally, there are opportunities for interested fellows to become involved in advocacy and policy matters at the state level through the Ohio Department of Mental Health also located in Columbus.

One year appointment, 07/01/14 to 06/30/15:

- ACGME approved fellowship
- 5 day, 40-50 hour/week schedule
- No evening or weekend call
- No typical managed care demands

**Interested?** Candidates must be board eligible and obtain an unrestricted Ohio medical license.

Send your CV, letter of interest, 2 writing samples and 3 letters of recommendation, including one from your residency training director to:

**Delaney Smith, M.D.,**  
**Twin Valley Behavioral Healthcare,**  
**2200 West Broad St., Columbus, OH, 43223**  
**Deadline for application is 10/01/2013**  
 For additional information contact  
**Julie Niedermier, MD**  
 at [julie.niedermier@osumc.edu](mailto:julie.niedermier@osumc.edu) or (614) 293-4540

## ALL ABOUT AAPL - Committees

### CHILD AND ADOLESCENT PSYCHIATRY RESIDENCY TRAINING DIRECTOR


The Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine is recruiting for a Training Program Director in Child and Adolescent Psychiatry, including the Tulane University Triple Board Training Program. This is a full-time faculty position with half-time devoted to the residency training program and half-time to other academic pursuits. An associate director is available to assist with program leadership and administration. The person selected for this position must be professionally competent and be board eligible/certified in general and child and adolescent 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. This is a fully accredited child psychiatry program for 6 child and adolescent psychiatry residents and an additional 10 triple board residents. 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 an email of interest, updated CV and list of references to Charles H. Zeanah MD, Sellars Polchow Professor and Vice Chair for Child and Adolescent Psychiatry, at [czeanah@tulane.edu](mailto:czeanah@tulane.edu) or a letter to the Section of Child and Adolescent Psychiatry, Tulane University School of Medicine, 1430 Tulane Avenue #8055, New Orleans LA 70112. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.

### Psychiatric Report

*continued from page 1*

jects, and persons who are subjected to discrimination.

Praxis - that is, compassion in forensic report writing, was reviewed by Norko. The act of preparing a forensic report requires the author to strive for objectivity, and to use compassion and respect for the dignity of the person being evaluated. Evaluators should make every effort to conduct fair interviews regardless of what the evaluatee is alleged to have done. At times, this can be a challenge for forensic psychiatrists.

Norko described the moment prior to writing the report as a "hallowed moment" in which the author endeavors to become centered and mindful as s/he begins to prepare the document. The forensic report may be the only opportunity to present a coherent story with objective opinions to influence the reader. He describes the "transformative stance" in which narrative reflects the author's capacity to be flexible and compassionate in the forensic evaluation. Experts are ephemeral and limited. Our skills are not perfect and our knowledge is relative. By acknowledging our limitations we work through Alan Stone's "moral adventures" of crafting the forensic report. 

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### Book Reviewers Wanted!

The Journal of the American Academy of Psychiatry and the Law is looking for reviewers of texts of interest to forensic psychiatrists. Book reviews of 750-900 words are printed in the Journal four times a year. If you are interested in becoming a book reviewer please contact AAPL at [office@aapl.org](mailto:office@aapl.org) or Cheryl Wills, MD, JAAPL Book Review Editor, at [cwforensic@earthlink.net](mailto:cwforensic@earthlink.net).

## ALL ABOUT AAPL - Committees

### From the Editor DSM 5 - Controversies and all

*continued from page 3*

nies and other agencies would make decisions about payment and disability determinations without the GAF. I wonder what it would mean for US Supreme Court's Atkins ruling now that IQ is no longer used for diagnosing developmental/ intellectual disability. I wonder how the changes (some would say expansion) in the PTSD diagnosis will play out at VA hospitals and in the courts. I wonder why the change from Roman numerals to numbers - DSM I, II, III, IV to DSM 5. I wonder... ☎

### Nominations Sought

The Nominating Committee of AAPL will be presenting a slate of Officers and Council candidates at the Semiannual Business Meeting in May, 2014.

Any regular AAPL member who would like to be considered for a position should send a letter to the AAPL Office with a statement regarding his/her interest in serving and a brief summary of activities within AAPL.

Open officer positions are: President-elect (one year); Vice-President (one year); Secretary (one year). Councilors serve for three years. Attendance at both the Annual and Semiannual Council Meetings is expected of all officers and councilors.

Please send statements of interest and activity to Robert Weinstock, MD, Chair, Nominating Committee, AAPL, P.O. Box 30, Bloomfield, CT 06002 by March 31, 2014.

CHILD PSYCHIATRISTS – DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for BE/BC child psychiatrists, salary commensurate with experience and academic rank. Clinical responsibilities available in the areas of inpatient psychiatry at Northlake Behavioral Health Systems, consultation liaison psychiatry, community based child and adolescent psychiatry, and early childhood mental health. Teaching responsibilities include the supervision of residents, clinical psychology fellows and interns, and medical students rotating through the clinical facilities serviced by this position as well as the presentation of grand rounds and participation in the didactic series in child psychiatry. Clinical research is strongly encouraged. The persons selected must be professionally competent and be board eligible/certified in general psychiatry. She/he must be eligible for medical licensure in the State of and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at 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. Send CV and list of professional/academic references to Charley Zeanah, Jr, MD, Professor and Vice Chair, Child and Adolescent Psychiatry, Tulane University School of Medicine, Department of Psychiatry and Behavioral Sciences, 1430 Tulane Avenue #8055, New Orleans, LA 70112 (czeanah@tulane.edu). Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.



Oregon Health & Science University (OHSU) has an outstanding opportunity for a BC/BE forensic psychiatrist for both clinical and forensic work in a new State forensic hospital. The position involves four days of clinical work and one day of protected time to pursue community service and academic interests. Opportunities include competency and insanity evaluations, risk assessments, court testimony, resident and fellow supervision and patient care.

Academic rank begins at the level of assistant professor and may be higher depending on credentials and experience. We provide very competitive pay and benefits, and will pay for moving expenses.

OHSU is Oregon's only academic medical center and is highly ranked nationally. Here at OHSU, we highly value a diverse and culturally competent workforce. When you join us, you join a dedicated team of caregivers, educators, researchers and administrative professionals who diligently pursue the advancement and application of knowledge to directly benefit the individuals and communities we serve.

We sincerely invite your interest in this very unique and rewarding opportunity. If you would like more information, please contact Christopher Lockey, M.D. We look forward to hearing from you.

#### Contact Information:

Christopher J. Lockey, M.D, Assistant Professor of Psychiatry, OHSU  
OHSU Chief Psychiatrist, Oregon State Hospital  
[lockeyc@ohsu.edu](mailto:lockeyc@ohsu.edu)



## ADS

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, salary commensurate with experience. 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](mailto: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](mailto:winstead@tulane.edu). Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

## The AAPL Institute: On the Verge of Great Things!


No medical specialty can consider itself to be legitimate without a solid foundation of research and education to support it. After almost 10 years of planning and development, the AAPL Institute for Education and Research seems poised to deliver on its promise to help forensic psychiatry in that effort. With the generous support of AAPL and its members, to date the Institute has been able to provide over \$135,000 to fund eleven education and research projects. More important, the number of grant applications has steadily increased, and six new proposals are under review.

Testimonials from past grant recipients underscore how important the type of funding provided by the Institute can be to a beginning academic career.

“The grants from the AAPL Institute for Education and Research were crucial to my academic career and research.” (Drew Barzman)

“The AIER provided an inspiration for me to leap into forensic related research during my early academic career.” (Terry LeBourgeois)

“Receiving this grant from the AAPL Institute for Education and Research has been a true honor, and has helped me advance professionally in my goals to employ innovative teaching methodologies to trainees and students.” (Debra Pinals)

As important as its early success has been, the Institute has the potential to do much more to promote the academic infrastructure of forensic psychiatry. The limiting factor does not appear to be in the number of excellent research and education proposals but in the available resources to fund worthy projects. There are no shortage of creative ideas coming from AAPL members. The challenge lies in obtaining the money to see them to fruition. A variety of new fundraising activities are planned by the Institute over the coming year, but the key to that effort will remain with the AAPL membership. 



### STATE OF CALIFORNIA Department of State Hospitals

CALIFORNIA

#### BOARD CERTIFIED/BOARD ELIGIBLE STAFF PSYCHIATRIST

The California Department of State Hospitals (DSH) is recruiting board certified/board eligible psychiatrists for our eight facilities throughout the State to work with an extremely interesting and challenging forensic and civilly committed patient population. You will have the opportunity to consult directly with experts in the fields of psychiatry such as **Stephen Stahl, MD, PhD** and **Charles Scott, MD**. The diverse locations of our hospitals offer the opportunity to choose an environment which appeals to your personal interests. Our monthly salaries for Board Certified psychiatrists start at **\$18,622 - \$19,554** and for Board Eligible **\$18,146-\$19,052**. We allow for a flexible work schedule (e.g. four 10-hour workdays for a 40-hour workweek). In addition, some of DSH's other excellent benefits including medical, dental, and vision packages, **CalPERS retirement system with life-long retirement pension** (defined benefit plan), license fee reimbursement, DEA fee waiver, malpractice insurance, tax-deferred compensation up to \$35,000 per year, paid vacation, 12 paid holidays plus one personal holiday, and seven days per fiscal year of Continuing Medical Education leave. Voluntary on-call duty is compensated on an hourly basis over and above base salary. For consideration, email CV to [Laura Dardashli, MD, Clinical Operations Division](mailto:Laura.Dardashli@dsh.ca.gov) at:

Recruit.Psychiatrists@dsh.ca.gov or visit our website to fill out an on-line application.

Phone: 916.651.5330.

Web: [http://www.dsh.ca.gov/jobs/psychiatry\\_jobs.asp](http://www.dsh.ca.gov/jobs/psychiatry_jobs.asp)



## AAPL Newsletter

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