



2011 Presidential Address

Peter Ash, MD:

But He Knew It Was Wrong: Evaluating Juvenile Culpability

Kevin V. Trueblood MD



Within minutes of beginning his presidential address, Peter Ash, MD, had elucidated its title. He would be discussing the

concept of partial culpability for adolescents who committed violent acts when they were under age 18, with the hope of providing a framework for forensic experts involved in these cases.

After introducing his topic, Dr. Ash provided a number of facts about adolescent violence and other criminal activity that are relevant to the issue of their culpability. He explained that: adolescent violence is common, but most violent adolescents do not continue to be violent as adults; the peak age of onset of violent behavior is around age 15 or 16; there is a developmental progression of offending, advancing from minor to more serious offenses; and adolescent crime is different from adult crime, e.g., adolescents more commonly perpetrate crimes in groups and are more diverse in the types of crimes that they commit.

Next, Dr. Ash described the three main arguments—as well as problems with each, not included here—in support of reduced culpability for adolescents. First, adolescents differ from adults in their decision making abilities, including about whether or not to commit a crime, due to “immaturity of judgment.” In their classic paper on this topic, Cauffman and

Steinberg (2000) used the term “judgment” to refer to the cognitive and psychosocial factors that influence decisions. They found the psychosocial judgment of adolescents, including their tendency to limit impulsivity, to be inferior to adults, that is, the construct “psychosocial immaturity” applies to adolescents. Therefore, since impulsivity affects one’s ability to conform to the law, adolescents may be less culpable than adults. Second, adolescents have less control of their environmental circumstances than adults. To the extent that these circumstances, such as having a negative peer group, contribute to violence and other criminal behavior, adolescents may be less culpable. Finally, an individual’s character is not fully established until adulthood. Therefore, the idea that a bad act reflects bad character does not apply to adolescents as it does to adults, and this

may make adolescents less culpable. After providing this background information about adolescent violence and culpability, Dr. Ash turned to the U.S. Supreme Court case of *Roper v. Simmons* (2005). In this case, the Court held the death penalty to be unconstitutional for individuals who were under the age of 18 at the time of committing their crime(s). Dr. Ash explained that the Court’s reasoning hinged on its acceptance of all three arguments for decreased culpability of adolescents. Although the *Simmons* court emphasized retribution and not the other classic justifications for punishment (deterrence, incapacitation, and rehabilitation), Dr. Ash stated that rehabilitation is resurfacing, in part because of the success of evidence-based treatments for delinquency.

During the final portion of his talk, Dr. Ash applied philosopher P. F. Strawson’s construct of “reactive attitudes” to his discussion of adolescent culpability. According to Strawson, reactive attitudes precede judgments about responsibility; they do not follow from them. Dr. Ash reasoned that individuals vary in their reactive attitudes towards adolescents, from “Do

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All smiles as Peter Ash “crowns” the next AAPL President, Charles Scott.



American Academy of Psychiatry and the Law

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AAPL IN APA

AAPL Liaison to the APA Assembly Report

Cheryl D. Wills MD

The APA Assembly meets in May and December to review matters related to psychiatric care of patients, APA members, and APA governance. Two AAPL members attend each APA Assembly meeting, as well as their respective APA regional or Area meetings, to provide advocacy regarding matters of importance to forensic psychiatrists. The AAPL representative to the Assembly has one vote on the Assembly floor; the alternate representative does not vote. APA members may attend any APA Assembly meeting as guests, although guests may not always be permitted to speak on the Assembly floor.

Assembly members have lively discussions about position papers that are proffered by their colleagues. In the past year, position papers regarding Maintenance of Certification (MOC) have dominated Assembly discussions, since psychiatrists are very concerned about this matter. Fortunately, AAPL has addressed the MOC concerns of its members by establishing a MOC task force and by meeting with ABPN officials and inviting them to participate in educational meetings and webinars for AAPL members. The AAPL Maintenance of Certification Self Assessment examination also has been a cost effective tool that addresses some of the MOC needs of AAPL Members. Consequently, many APA Assembly members view AAPL's MOC efforts as "trailblazing."

The needs of correctional psychiatrists were presented to the Assembly, which passed a position paper that

supported reestablishing the Caucus of Psychiatrists Working in Correctional Settings, a group which addresses the professional and collegial needs of correctional psychiatrists. The APA Joint Reference Committee decided that although the APA recognizes the need for correctional psychiatrists to interface, a separate caucus is not needed. Instead, an assembly of correctional psychiatrists will be recognized as a group that will report to the Council on Psychiatry and the Law.

"...many APA Assembly members view AAPL's MOC efforts as "trailblazing.""

Firearms legislation also has interested APA Assembly members. In June 2011, Florida ratified controversial legislation which restricted the types of questions physicians could ask their patients about firearms. Physicians who violated the law were at risk for medical board sanctions. In September 2011, a federal judge held that the legislation is unconstitutional. Also, the matter of whether individuals who have been involuntarily hospitalized due to mental illness should be permitted to own firearms was discussed and has been reviewed more extensively by the Council on Psychiatry and the Law. (F)

Announcement - Midwest Chapter

The Midwest Chapter of AAPL, in joint sponsorship with the Southern Illinois University School of Medicine, is pleased to announce that its annual meeting will be held March 23-24, 2012, at the Sheraton Clayton Plaza Hotel in St. Louis, MO. The meeting will run Friday afternoon and all day Saturday. Further details will be following shortly. Anyone interested in presenting, or any residents interested in applying to the Resnick Scholars Program to attend the meeting should contact the current President, Phil Pan, MD, at mwaaplprez@gmail.com. This activity has been approved for *AMA PRA Category 1 Credit*TM. (F)

Maintenance of Certification: Pitfalls of Patient Feedback

Charles C. Dike MD, MPH, MRCPsych



It has been an easy clinic day so far and I am enjoying the flow. Through the years, I have found that my clinic days can

mostly be divided into easy (smooth) or difficult (rough) clinic days. Smooth clinic days are wonderful; patients come in on time for their appointment and all are doing well. There are often no challenging psychological, social, physical or family knots to untie; medications are stable and patients are stable. Each patient ends well inside of schedule, allowing for time to exhale in-between patients. These days are just blissful, like kicking off your shoes after a hard days work and relaxing with a cup of hot tea or chocolate.

Then there are the rough clinic days when everyone seems to have a knotty issue and nothing seems to be going well with anyone. Long forgotten symptoms have rebounded; medication side effects necessitating yet another change of medications for a patient running out of medication options have appeared; or multiple psychosocial stressors have finally overwhelmed a patient. Every appointment runs well over the allotted time, much to the frustration of waiting patients, and all.

On those days, I often pray no patient comes in with high risk of committing suicide, for such a patient would need well over one hour for assessment and phone calls to the Police/Ambulance, the patient's family members, and the hospital ER physician. Attending to a suicidal patient in such a setting presents multiple logistic problems: Since the time needed to complete assessment and arrange hospitaliza-

tion could run into hours, should the waiting, and now prickly, patients be rescheduled? What about those who needed to be seen that day? How would the other patients in the waiting room respond to the police coming into the clinic?

Yes, some rough clinic days are really rough indeed. Sometimes, I leave the clinic mentally exhausted, wanting only to pass out on my bed until the next day. Thankfully, the difficult days are not as common, and, there are always the easy days to look forward to.

Today, however, promises to be a hybrid of an easy and a difficult clinic day; it has been easy so far, but a quick glance down the schedule leaves me somewhat tense; my last two patients are not easy by any definition.

Take the first of the two. He has been my patient for approximately six months but I have not been able to please him in any way ever since; either he wants medications that are not indicated for his problems (mind you, he insists he has no problems - people provoke him for no reason, and when he responds in anger to "protect" himself, he gets arrested) or he wants a doctor's note from me to his employer asking to take two weeks off "on health grounds." When I smile, I am being too dismissive of his concerns, but when I look serious, there must be something wrong with me that is distracting me from paying him full attention.

In short, nothing I do is right. Each session always feels like a struggle. I have never been able to understand why he keeps coming back (and, he always keeps his appointment, making sure that he stays for the entire allotted time), after all, he has had four psychiatrists in the six months preceding our meeting.

I will not bore you with stories of

my last patient of the day; suffice it to say that she is last for a reason. I often need to unwind for a good fifteen minutes after each session.

My phone rings. My next patient is not coming in; car trouble. I am disappointed and relieved all at once. Perhaps I could complete a progress note before my next patient. But no such luck; my mind kept drifting back to my last two patients of the day. I wondered how they would rate me if I were to seek feedback from them as part of the new requirements for Maintenance of Certification (MOC) – the patient feedback portion of Performance in Practice. I shuddered a little.

I am pretty sure these two patients would rate me well below average. As a matter of fact, the second patient had once hinted in the past that only full professors of psychiatry could understand "my complex mind," insinuating that I needed to work harder to become a full professor in order to be qualified to treat her.

What about another one of my patients who begins and ends each visit with a fervent request for Alprazolam, "the only medication that stops my voices," and who subsequently becomes angry when I remind him of his alcohol and benzodiazepines addiction? Do you see any of these patients scoring me highly on any measure of my competence? Should I then kowtow to their every demand in order to obtain good scores from them, or should I drop them from my clinic in order to protect my scores?

I also wondered about forensic evaluations. Are we expected to also seek feedback from the evaluatees as well? If not, why not? Isn't forensic psychiatry considered a practice of medicine?

Yes, the patient feedback requirement for MOC is troubling and problematic. Can our patients actually divorce themselves from transference issues when asked to rate us? I wonder. The door bell chimes, announcing the arrival of my next patient. Wish me luck. ☺

AAPL – Our State of Union

Charles Scott MD, President



I am honored to serve as the 38th President of AAPL. As I begin this journey, I want to first recognize the devoted

administrative team at the AAPL home office that enables our organization to function so well. We are fortunate to have Jackie Coleman as the AAPL Executive Director, along with Marie Westlake, Associate Executive Director, Kristin Loney, Executive Assistant, and Sara Elsdon, Journal Editorial Coordinator. Although this team works throughout the year on a wide range of activities to make AAPL a successful organization, they are particularly vital to the success of our Annual Meeting. I was pleased to learn that at our 2011 Annual Meeting in Boston, AAPL had its highest total registration at 809 registrants. We broke our prior record of 739 registrants, which occurred in 2006 at our Annual Meeting in Chicago. The breakdown of the 809 registered included 537 AAPL members, 140 psychiatry residents, 125 non-AAPL members, and 7 medical students.

I also wanted to recognize the outstanding accomplishments of our immediate Past President, Dr. Peter Ash. Dr. Ash began his presidency with clearly defined goals for the organization, which included implementation of Maintenance of Certification (MOC) activities at the annual meeting, enhanced collaboration regarding forensic research efforts between AAPL and the American Psychology–Law Society (APLS), and development of a practice guideline for forensic psychiatry. In addition, he showed great leadership in his focused actions to strengthen the financial position of the organization.

As President, my primary goal is to build on the strong foundation set by Dr. Ash and past AAPL presidents. I believe that as an organiza-

tion, AAPL should continually explore opportunities to provide concrete value to its members. In the past, AAPL has assisted its membership through educational experiences at the Annual Meeting and review course, dissemination of relevant information through the journal and newsletter, and through mentoring and networking activities within the organization. Over the last two years, AAPL has initiated two Maintenance of Certification (MOC) activities at the Annual Meeting. The American Board of Psychiatry and Neurology

“...we must continue to find ways to offer “goods” of a practical value in addition to the wonderful mentorship and camaraderie.”

(ABPN) now requires specific MOC activities to maintain certification in Forensic Psychiatry and to apply for recertification.

As part of the MOC program, diplomates must participate in sanctioned self-assessment performance measures, identify perceived weaknesses in their knowledge, pursue learning activities tailored to areas that need to be strengthened, and develop quality improvement programs based on their clinical practice. The MOC program includes four components: Professional Standing; Self-Assessment and CME; Cognitive Expertise; and Performance in Practice. The MOC Program participation includes meeting all MOC requirements, not just passing the MOC cognitive examination.

Over the past two annual meetings, AAPL has provided two forms of self-assessment activities: a written multiple-choice examination with

associated explanations, references, and peer comparisons, and a live self-assessment activity through the use of an audience response system. I will work with the Education Committee and AAPL MOC Task Force to make sure AAPL provides additional avenues for our members to meet their MOC requirements. I also encourage members to familiarize themselves with the MOC process which is outlined in detail on the ABPN website. If you have not yet done so, you should update your clinically-active status through the ABPN Physician Folios at <http://www.abpn.com/folios>.

Developing and updating AAPL Practice Guidelines represents another key area to maintain the momentum initiated by Dr. Ash. AAPL Practice Guidelines help establish our organization as the leader in formulating and communicating key principles relevant to the practice of forensic psychiatry. A task force to develop an AAPL practice guideline on the forensic assessment is currently underway and is co-chaired by Graham Glancy, MD, Debra Pinals, MD, Alec Buchanan, PhD, MD, and Michael Norko, MD. The first draft of this guideline has been developed and is presently being edited before final presentation to AAPL members for further input. A process to update our current guidelines on competency to stand trial, criminal responsibility, and recording of forensic examinations is also underway.

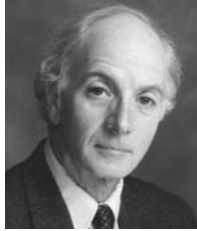
I am also interested in exploring how AAPL can further increase our members' applying for funding offered by the AAPL Institute for Education and Research. The AAPL Institute for Education and Research was founded in 2004 and offers grant funding in both education and research activities. Submissions are accepted March 1 for awards beginning July 1, and August 1 for awards beginning on January 1; the criteria for grants are located on the AAPL website.

I think it is important for AAPL to expand its outreach to medical stu-

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High Profile Cases Create Pressures for Expert Witnesses to Speculate

Howard Zonana MD, Medical Director



In reviewing the Colin Ferguson case for a presentation at the 2011 AAPL annual meeting, Robert Phillips, MD, Keith Shebairo,

MD, JD, Larry Fitch, JD, and I reviewed the records, transcripts and court TV records from the trial.^{i,ii} Colin Ferguson was on a LIRR subway entering the Merillion Avenue Station on December 7, 1993 when he went on a shooting rampage, which resulted in six deaths and 19 serious injuries. At one point, while he was reloading, train passengers subdued him. He was charged with 93 counts of murder, attempted murder, assault and other related felonies. Although 50 witnesses identified him, he claimed he was asleep on the train when the real shooter took his gun and fired at least 30 rounds.

Mr. Ferguson had two competency to stand trial hearings, one shortly after his arrest, and a second about a year later as the trial commenced. He initially had several attorneys who were willing to represent him, including attorneys William Kunstler and Ron Kuby who were involved with his case on a pro bono basis for almost a year. He ultimately chose to represent himself, and was permitted to do so after he was found competent to stand trial for the second time. At that time the competence to represent oneself did not require a distinct standard from the usual competency to stand trial evaluation.

There were two court orders related to competency. The first occurred shortly after Ferguson's arrest. The state called the two court appointed experts: Dr. Expert 1 and Dr. Expert 2. They saw Mr. Ferguson on December 28, 1993 for an hour and a half in a joint session. He refused any follow-up examinations. Based on their examination and the judge's colloquy with the defendant, he was deemed

competent to proceed. About a year later when Mr. Ferguson expressed a wish to fire counsel and proceed *pro se*, the defense team requested a formal competency hearing. This hearing began on December 6, 1994.

Dr. Expert A had seen the defendant for three hours for the defense team, on May 17, 1994. Attorneys Kunstler and Kuby noted that Mr. Ferguson had refused all psychiatric evaluations and the only reason he met with Dr. Expert A was that he thought he was the eye doctor he had requested to see. Dr. Expert A also saw his school records and talked with a number of collateral sources.

At the start of the Dec. 6th hearing Mr. Ferguson made the following statement:

"I just wish to indicate to the court that I view this particular hearing as a moot forum and in fact is a mock trial which exposes me to double jeopardy to my trial in January. [A]lso, I wish to indicate that the motion granted in the last hearing (introduction of insanity defense) should be reflected on the court records as a motion granted to Mr. Kunstler and Mr. Kuby and not to Colin Ferguson."

Mr. Kuby went on to question Dr. Expert A over the objections of Mr. Ferguson. Dr. Expert A concluded that Mr. Ferguson suffered from a Delusional disorder, persecutory type. In addition:

"... [I]n this case, Mr. F is unable to develop a relationship with his attorneys that would be based on some volume of trust, and as a result of that he would be unable to really receive from those attorneys the kind of advice and concrete information required to even begin the process of assisting in his defense, because he would not be able to trust that advice and concrete information coming from the attorneys is at all accurate and not under some

sort of plot to harm him..."

Regarding his decision to represent himself Dr. Expert A opined that:

"I would say it is certainly consistent with the existence of a delusional disorder and consistent with the behavior that he has evidenced in the past that in my opinion are related to the delusional disorder."

And regarding his refusal to accept insanity defense? -

"...I believe it is a product of his disorder."

Mr. Kuby then discussed personal correspondence between Colin Ferguson and Judge Belfi, letters written to the court after Mr. Ferguson's arrest. Some of the letters involve an incident in the Nassau County Correctional Facility where several white inmates attacked Mr. Ferguson. Mr. Ferguson also complained of pervasive eye problems. Mr. Ferguson felt that he was the victim of a complex conspiracy started by Kunstler and Kuby, inmates at the Nassau correctional facility, officers in the jail, the District Attorney, and Judge Belfi, for undermining his medical interests and ultimately preventing him from identifying the actual gunman of the Long Island incident. In one letter he stated:

"I'm told that my attorneys, Mr. Kunstler and Mr. Kuby, are using these officers to break me before trial. This, I am told, is arranged by Mr. Kunstler and Mr. Kuby in response to my rejecting the so-called "black rage" insanity defense, rejecting them both as my attorneys, and rejecting any form of insanity defense. They have conspired with these officers to murder me after they withdraw from my case."

On cross-examination, the prosecutor, Richard Peck, brought up the question of whether Dr. Expert A met Mr. Ferguson under false pretenses. He was asked what he told Mr. Ferguson at the start of the interviews:

"I told him that I had been asked by his attorneys to meet with him and to do an evaluation of him. I told him we would be reviewing his history and talking about him

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High Profile Cases

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over time.

I believe he was willing to speak with me because he knew I was in fact a physician and that I may be able to help him get some better care.”

Q: Did you ever discuss that with him? Did you ever discuss with him as to what would happen to him if he were found to be incapacitated or not competent? Did you ever discuss with him that?

A: Legally, No.

Q: Did you ever discuss with him what would happen to him if he went to trial and were found not guilty by being absolved of criminal responsibility?

A: No, I did not.

In rebuttal, Dr. Expert 1, one of the original evaluators, was called and asked to review his evaluation from the year before, and whether he had an opinion about Mr. Ferguson’s current competency. Although he had done no additional personal examination, he had spoken with correctional facility staff and reviewed the letters sent to the judge. He also reviewed investigating officers’ statements.

Dr. Expert 1’s diagnosis was Malingering, which was based on a number of inconsistent statements made during their 90 minute interview three weeks after his arrest. For example, he said that he did not know the date, but that it was December. He later reported that the guards did not give him Christmas dinner. When confronted with the discrepancy, he just put his head down. When asked if he was charged with misdemeanors or felonies he said, “I know nothing about the law.” When asked if he was familiar with the term ‘murder’ he responded, “I don’t want to know what it means-I don’t care about that word.” The doctor also felt that he was not delusional but more likely had a paranoid personality disorder.

On cross-examination by Kunstler, Dr. Expert 1 was asked if he would like to have another opportunity to evaluate Mr. Ferguson.

A: I think I would like to have

another competency evaluation. We have wanted to have one since August, I would like to have one now.

Q: Without it you really can’t reach a definitive opinion, can you?

A: Without it I can rely on my initial opinion, which is valid, that he was competent, and with the additional information that I have obtained since then, based on my initial competency evaluation, he is still competent.

Q: Don’t you feel, doctor, as a professional man, a little uneasy in not having a further examination of Colin Ferguson before you reached a final decision?

A: I would like another evaluation but in lieu of not having the opportunity to do that I feel quite confident with my opinion.

Dr. Expert 2 was also called and he echoed Dr. Expert 1’s conclusions based on his joint interview the year before and not refuted by subsequent information he had received. In terms of his diagnosis, he stated:

“I believe that the diagnosis of delusional disorder is possible but it is certainly not the only diagnosis worthy of consideration. In fact, it seems as likely or perhaps more likely that Mr. Ferguson suffers from what is called paranoid personality disorder, which has already been indicated in testimony as not being a mental illness and not characterized by delusional ideation.”

The judge found Mr. Ferguson competent to stand trial, the burden having been on the state to show that Mr. Ferguson was competent by a preponderance of the evidence. In addition he found him capable of representing himself, and permitted him to refuse to introduce any evidence of insanity.

During the trial he could be reasonably coherent at times, but at other points, mounted long rambling narratives accusing police officers and political figures of conspiring against him. In his opening statement, Mr. Ferguson made the following announcement: “there were 93 counts in the indictment only because it matches the year 1993. Had it been 1925 it would’ve been 25 counts.

This is a case of stereotype victimization of a black man. A subsequent conspiracy to destroy him. Nothing more.”

The jury convicted Ferguson on 6 counts of Murder, 19 counts of Attempted Murder, Criminal Possession of a weapon, and Reckless Endangerment. He was sentenced to over 300 years in prison.

The case can be discussed on many levels. Certainly some of the laws regarding burdens of proof for competence to stand trial and requiring higher degrees of competence for self-representation have changed since 1994. The part that I would like to focus on is the pressure on experts to draw conclusions on the basis of limited and inadequate data. This seems to occur more frequently in high profile cases, such as in the Zacarias Moussaoui case, where competency was also an important question and where the defendant also substantially refused to be evaluated. Competency to stand trial evaluations are supposed to assess the defendant’s present ability to understand the proceedings and to assist in the preparation of the defense. In this case, all of the experts said they wanted to or expected to have additional time to assess the defendant and had not fully completed their evaluation. Yet in spite of that, they were willing to form opinions to reasonable medical certainty based on evaluations a year old with very limited additional data. There is frequently implicit, or at times, explicit pressure to render an opinion, or to find someone who will render an opinion.

While an expert can be subpoenaed to testify, he cannot be forced to draw conclusions from inadequate data. All the experts presumably felt they had adequate data to draw conclusions, in spite of incomplete and untimely evaluations. The apparent pressure to make an alliance and complete an evaluation led the defense psychiatrist to avoid fully disclosing his role or purpose during his initial, and only, meeting with the defendant, an ethical issue that was raised during cross-examination.

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A Monumental Experience

Jacquelyn T. Coleman CAE, Executive Director



I spent Christmas in our nation's Capital. Although I go there often and manage to take on some nonwork activities, I had not been there as a dedicated tourist in a long time.

Christmas Day was a sunny temperate day and we spent it touring all the monuments in the Mall. One of the newer monuments is the one commemorating World War II, fast fading from active memory as that generation ages and dies. I remember controversy surrounding its design and construction. As I recall it, there was concern that it was on a scale too large to be complementary to the rest of the Mall and the other monuments and it was revised several times. Like many other veterans, my father was intensely proud of his service in WW II. I think as a family we were drawn to start our tour there, and I know we were all thinking how he would have reacted if he had been able to see it. Although the central pond was shut down for the winter, the monument resonated with the sound of short but powerful waterfalls, yet it was possible to converse at a normal tone of voice. It was only upon leaving that we heard other noises from children playing or larger groups of tourists.

It is really a comfortable space and all the elements of the war have been assimilated, but also given their due – the different theatres of war, the branches of the military, the states, and a beautiful star-laden wall that gives tribute to the fallen.

From there we moved on to the Korean War Memorial. This is a much different experience. Larger than life soldiers trudge through what is easy to recognize as the mud, cold, and wet of a Korean winter. I couldn't take my eyes off the statues. Their faces reflect the intensity the real soldiers no doubt felt. Their

archaic walkie-talkies and gear caused us to comment on how differently soldiers are equipped now, something we at present sadly have too much familiarity with.

We climbed the Lincoln Memorial and it was there that I began to wonder about the large number of non-U.S. tourists, at least judging by their accents or use of other languages. Suffice it to say it is imposing in

“I realized that monuments can be a source of strength, solace, and peace, even if the participant has not personally experienced the event commemorated, and that, though lifeless themselves, they can evoke great emotion.”

every way we have all been led to believe it is. I had a better visit some years ago in the quiet of a weekday evening.

From there it was on to the Vietnam Memorial. While I appreciate the genius of the design, I found it didn't move me as much as the others did. Yet, that was the war that I actually lived with and many of my contemporaries are Vietnam veterans. I did take note of the people searching for names and it reminded me that something like that, seeking and finding a name of a loved one who left so long ago, can be a comfort.

Our next stop put us between the Martin Luther King Memorial and the FDR memorial. I had heard so much about MLK's and absolutely nothing about FDR's. You have probably heard that the King Memorial is

ensconced in a half-ring of his quotes, including an abridged one, whose abridgement makes some people annoyed. I loved the device of extracting the block from which his likeness was cut from a larger block, so that the larger block resembles two cleaved halves of a mountain. It was something to drink in, to absorb, and I found it somehow centering and calming.

Then we visited FDR's, divided into four "rooms" representing each of his terms. This monument covers a lot of land, but it doesn't feel closed in. It is possible to keep the water in view almost the whole time. It's a serene place, and each of the terms is well-depicted from what I could tell. I didn't like the tourists fitting themselves into the sculpture of people in a breadline to have their photos taken.

We only had time to drive by the Jefferson on our way to Arlington Cemetery so we just noted its familiar round shape and lovely placement.

We were pleased to find out that we had come to Arlington Cemetery on the only day of the year it was allowed to drive through the cemetery. Usually it is quite a walk and some of our group would not have been up to the attempt. However, we were able to park on the road alongside the eternal flame memorial to John F. Kennedy. His wife and two infant children are buried there. For the curious (and we were), John Junior's ashes were buried at sea. A short distance away are buried his brothers, both veterans, with only white crosses marking the sites, as required by regulations of the Cemetery. The sun was setting as we turned away to the horizon.

We drove around the Iwo Jima monument as we exited. It is such a familiar pose but the scale needs to be seen to be appreciated.

So what was I left with at the end of this day?

I realized that monuments can be a source of strength, solace, and peace, even if the participant has not personally experienced the event

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the crime, do the time” (seeing them as adults) to “They’re just kids.” To the extent an individual views adolescents as “just kids,” his or her attitudes will be more parent-like and emphasize a rehabilitative, rather than a punitive, approach. Furthermore, Dr. Ash suggested that the brain development argument for decreased adolescent culpability, much favored by attorneys, works in part because it supports the idea that adolescents are different and, thereby, contributes to changing individuals’ reactive attitudes about adolescents away from seeing them as adults. Dr. Ash concluded his talk by recommending *True Notebooks*, a book in which Mark Salzman chronicled his time teaching creative writing to incarcerated adolescent offenders in Los Angeles, many of whom were serving life sentences without possibility of parole for murder. Dr. Ash stated, “It is striking in their poetry and the other things that they write how human they are underneath.” ☞

Our State of Union

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dents and general psychiatry residents to provide education regarding the opportunities offered by the field of forensic psychiatry and through AAPL membership. The current ACGME guidelines specifically note that general psychiatry residents must be exposed to the evaluation of forensic issues (such as establishing competency to stand trial, and criminal responsibility in patients facing criminal charges) in addition to writing a forensic report. AAPL has and should continue to play an important role in providing forensic psychiatry learning templates for general psychiatry programs.

Finally, an important challenge for our organization remains the need to maintain and grow our membership. To that end, I believe we must continue to find ways to offer “goods”

of a practical value in addition to the wonderful mentorship and camaraderie. I appreciate the incredible work by the members on various committees along with the dedicated efforts by committee chairs. To keep our younger members interested in and active in AAPL, I have asked many of our terrific committee chairs to help me identify AAPL members who might move up in that leadership role. I have greatly appreciated how receptive committee chairs have been to this message and their willingness to mentor the future leaders of AAPL. ☞

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Judges also have some ability to exert pressure upon a defendant to cooperate, and frequently do so when defendants are uncooperative with mandated evaluations. Non-cooperative defendants certainly present a problem for the legal system and have done so for hundreds of years.ⁱⁱⁱ Non-cooperation from a defendant is a challenging situation for experts, and is fraught with the danger that only speculation will be offered, rather than a solid basis for an opinion, to a reasonable medical certainty, or, that deception may be employed to encourage participation.

As an additional point for reflection, this case also represents an excellent example of how a defendant can mangle and exaggerate symptoms and yet still have a severe underlying mental illness. Just because someone malingerers or exaggerates shortly after arrest does not rule out the possibility of an underlying severe illness. The state’s witnesses here seemed unwilling to modify their opinions when presented with reasonable alternative hypotheses and felt committed to stick to one theory of the case: that Mr. Ferguson was unhappy with Mr. Kunstler and Mr. Kuby because they wanted to use a “black rage” defense. They also concluded that Mr. Ferguson really did not want to represent himself. They reached conclusions based only on

the premise that he was malingering. The state witnesses saw him only once, for 90 minutes, a full year before. Making premature diagnoses on the basis of a brief interview when the evaluator feels further interviews are needed reflects poorly upon the evaluators and the profession. ☞

References:

- i. Bardwell, MC, Arrigo, BA Criminal Competency on Trial: The Case of Colin Ferguson. Carolina Academic Press, Durham, NC (2002)
- ii. Any opinions here reflect only my impressions from the data
- iii. Those defendants found “obstinately mute” were subjected to *peine forte et dure*, a procedure (continued, albeit rarely, as late as the 18th century) in which increasingly heavy weights were placed on the defendant’s chest until he responded or died. See Blackstone W: Commentaries on the Laws of England. Oxford: Clarendon Press, 1765–1769, Slovenko R: Psychiatry and Law. New York: Little, Brown, 1974

Monumental

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commemorated, and that, though lifeless themselves, they can evoke great emotion. I’d like to learn more about principles of designing monuments and explore how they can be so evocative.

I also mused about the participants. What makes a non-US citizen want to visit monuments to our heroes and commemorations of our wars? As I think about other countries I have visited I don’t think I spent that much time at such monuments, but I acknowledge that in the much older European capitals they are less prominent than they are in Washington, DC. Maybe having them clustered together as they are on a great expanse of land concentrates the attraction.

And why was I so offended by the miming and the posing and sometimes the noise? Calling it a lack of respect may be too facile and doesn’t get to the “why” of it. I am not qualified to explain it. I wonder what the designers and fund raisers think about it. I wonder what our heroes would have thought about it. ☞

Pete Earley:

CRAZY: A Father's Search Through America's Mental Health Madness

Victoria Dreisbach MD



The first AAPL luncheon lecture at the 2011 AAPL Annual Meeting featured Pete Earley's riveting discussion of his award-winning

book, *CRAZY: A Father's Search Through America's Mental Health Madness*, which was a finalist for the 2007 Pulitzer Prize for non-fiction. Mr. Earley combined his gift as an award-winning journalist with the deep love for his son to write a book that conceptualizes the history, politics and economics that have driven the mental health system "crazy."

Earley, a former *Washington Post* reporter and author of a dozen books, stumbled upon this story after his son Mike, who had been diagnosed with bipolar disorder a year earlier, decided to stop his medications. Earley drove to Manhattan and learned his son had been walking around the streets of Manhattan sleepless for the past five days, and supposedly on a special "mission." As Earley was frantically speeding back to the Fairfax County, Virginia, hospital where Mike was initially diagnosed, his son asked, "Dad, how would you feel if someone you loved killed himself?"

Earley and Mike waited four hours in the ER. When his son wanted to leave, Earley grabbed the first available doctor. To his amazement, Earley learned that because Mike wasn't imminently dangerous to himself or others, he could not be admitted to receive the treatment he desperately needed.

While staying with Earley and his stepmother, he became more symptomatic. Mike slipped out one night, broke into a stranger's house and took a bubble bath, which tripped an alarm notifying police. Fortunately, no one was home. He was arrested and eventually removed from the house by five

policemen and an attack dog and was taken to an ER for medical evaluation. He was hospitalized only after Earley heeded an officer's advice and lied by telling hospital personnel his son threatened to kill him. After a veiled threat to call the *Washington Post* or Mike Wallace of *60 Minutes* when his insurance company wanted to discharge Mike after 48 hours, his son was allowed to stay and recover. Only by lying and casting aside his ethics as a journalist was Earley able to ensure his son would get the treatment he needed.

But treatment was not all Mike received. A warrant charging him

"He was hospitalized only after Earley heeded an officer's advice and lied by telling hospital personnel his son threatened to kill him."

with two felony counts for the break-in soon followed. Earley was stunned his son would be facing up to five years in prison and a police record barring him from a career for an act committed while mentally ill. When Earley despaired, his wife asked, "Why don't you do what you've always done? Write about it."

And he did. After being turned down in several major cities, Earley went to Miami and met Judge Steven Leifman who encouraged him to investigate the Miami-Dade Pretrial Detention Center, and the treatment of mentally ill offenders in the Miami-Dade County jails, the fourth-largest system in the nation. There, he met a man in a cell on the ninth floor, the psychiatric unit of the jail, who was

naked and mute. The officers controlled his behavior by offering him sandwiches in much the same way one would "train" a dog. When Earley checked the defendant's records, he learned that he had been arrested more than twenty times over the past year. However, because his charges were low-level misdemeanors, he could not be "forced" into the treatment he desperately needed.

Mr. Earley meticulously chronicled the history of mental health treatment from the mid-19th century to the present, and concluded that it had gone "full circle" from the days of Dorothea Dix, when the mentally ill were incarcerated and maltreated, to the advent of state hospitals, where mistreatment also occurred. He observed that in response to these problems, President John F. Kennedy (JFK) signed a national mental health law authorizing Congress to spend up to \$3 billion to create 2,000 community-based mental health networks. Unfortunately, JFK's assassination, the Vietnam War and the civil rights movement subsequently encouraged legislation that led to de-institutionalization of state hospitals without sufficient community-based mental health treatment programs and housing, a situation that led to what exists today which Earley referred to as "transient institutionalization;" patients inadvertently move from mental hospitals to the streets, and then, to jails and prisons.

Mr. Earley posited that the primary factor that led to the shortage of mental health beds was Health Maintenance Organizations (HMO); by 1997, the majority of mental health beds in the country were controlled by HMOs, but when they began to lose money, they were closed. In 2005, 24% of the psychiatric hospital beds in Virginia were closed due to monetary concerns. Earley also noted that public psychiatric hospitals are being filled with forensic patients who have been deemed sexual predators, leading to a greater shortage of beds for the chronically mentally ill in need of long-term care.

In Earley's opinion, the United
(continued on page 24)

Special Agent Gary Phillips: Child Exploitation in South East Asia: Can It Get Worse?

Sylvester Smart MD



I was privileged to attend the luncheon on Friday October 28, 2011, at the annual meeting of AAPL. The guest speaker was Special agent (SP) Gary Phillips, a retired FBI agent, who is currently affiliated with the University of Nebraska. His talk, titled, Child exploitation in South East Asia: Can it get worse? tackled the growing worldwide problem of child sexual exploitation, especially in Southeast Asia. He also addressed the legal implications of such acts of exploitation for United States citizens and legal permanent residents.

SP. Phillips graduated from the University of Wisconsin in 1986 with a Bachelors of Science degree in Biology, and a minor in Chemistry. He was then employed by the United States Customs Service for about 14 years, before joining the Federal Bureau of Investigation (FBI). He was on the "special response team" and served as "case agent" on several high level investigations involving narcotics, money laundering, illegal trafficking and child exploitation. He has also served on several Federal Task Forces involved with the investigation of child exploitation. He was the first agent to ever investigate US citizens engaged in international child sexual exploitation, under the US PROTECT Act (passed by Congress in 2003) while he was stationed at the US Embassy in Bangkok, Thailand. He is currently pursuing a Ph.D at the University of Nebraska.

SP. Phillips started his talk by stating that the 23 years of law enforcement experience he had prior to travelling to Southeast Asia did not prepare him for the challenges he would face there. Upon arriving in Southeast Asia, he realized that sexual exploitation of children by adults was

a universal problem. The reality was driven home by an unscientific study carried out by another FBI agent who was stationed in London at the time. This agent created a fictitious child pornography website which was linked to a map of the world. Anytime a connection is made to the website, a green dot would illuminate on the map indicating the geographical position of the individual logging to the website. The results showed that virtually people from all continents and countries of the world used the internet to find sexual images of children.

"The most common perpetrators of child sex trafficking are the victim's family members, especially their mothers, who offer these children for monetary gains."

SP. Phillips reviewed various US Federal laws that address the issue of child pornography and sexual exploitation of children. He paid particular attention to the application of these laws to the behavior of US citizens travelling abroad. He stated that prior to 2003, the main Federal law available for the prosecution of child sexual predators was the Mann Act (also known as the White-Slave Traffic Act), which forbade interstate transportation of females for "immoral acts." However, this law was limited because it did not allow for the prosecution of acts of child sexual exploitation carried out by US citizens in a foreign country. As such, many citizens travelled to other countries especial-

ly those in Southeast Asia and Latin America, to engage in illegal sexual acts with children, some as young as 5 years old. Authorities in host countries were often nonchalant and not interested in the prosecution of such US citizens because of concerns that it might affect tourism to those countries. However, things changed in 2003 after the US Congress passed the PROTECT Act, which was signed into law by President George W. Bush. This law allowed for the prosecution of US citizens and permanent residents who travelled abroad with the specific purpose of exploiting children sexually.

SP. Phillips explained that the PROTECT in the name of the Act stood for "Prosecutorial Remedies and Other Tools to end the Exploitation of Children Today." There are four important elements of a qualifying crime required by this Act that made it useful in the prosecution of perpetrators. The first important element is that the crime involves "illicit sexual contact in foreign places with anyone younger than age 18." In addition, the perpetrator must be a US Citizen or permanent resident, committing the crime in a foreign land. The last and probably the most useful element from law enforcement point of view is that there is no need to prove intent for a conviction to be obtained.

SP. Phillips reviewed some statistics to demonstrate the severity of the problem of international child sex trafficking. He reported that about 2.5 million children are trafficked as sex slaves each year. Asia represents about 1.4 million of this number. According to a study by the London School of Medicine, about 95% of children worldwide experience some form of physical or sexual abuse at some point in their childhood. In addition, about 43% of all children worldwide are used for sex in one form or the other at some point during their childhood. The most common perpetrators of child sex trafficking are the victim's family mem-

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Dennis Maher: Counseling Innocent Prisoners - An Exoneree's Perspective

Brian Cooke MD



As the impending nor'easter moved closer to Boston, AAPL members were not deterred from attending the luncheon address by

Dennis Maher, "Counseling Innocent Prisoners: An Exoneree's Perspective," given on October 29, 2011. Mr. Maher was a sergeant in the US Army when he was wrongfully convicted of several sexual assaults in Lowell, Massachusetts. He spent 19 years incarcerated, from 1984 to 2003, before post-conviction DNA testing proved his innocence.

Mr. Maher told his story calmly and simply. There were no PowerPoint slides, statistics, or political jabs. After a brief introduction, he stood up to the lectern and spoke to a captivated audience. At times, the intensity was palpable, and some audience members were seen wiping tears from their eyes. His narrative was simply compelling. He has delivered this account to many audiences at colleges, universities, and jails. I will attempt to do the story justice by summarizing it now for those unable to attend.

In 1978, Mr. Maher graduated high school and joined the Army, working briefly as a paratrooper. In November 1983, two women were sexually assaulted on two consecutive nights in Lowell, Massachusetts. On the second night, Mr. Maher was stopped by police in Lowell and arrested for the possession of marijuana. He was also questioned about the recent assaults and an unsolved rape that had occurred the previous year in Ayer, Massachusetts. When one of the recent victims identified someone else, he was released on bail.

At age 23, his life was about to

completely change. On January 5, 1984, Mr. Maher was arrested again and charged with Rape, Assault with Intent to Rape, Assault and Battery, and Aggravated Rape. Although there were differences in their descriptions (and possible suggestion and undue influence by police), all three victims identified Mr. Maher in photographic lineups. His case went to trial in March, and he was found guilty despite the lack of biological evidence. When asked by the judge if he had anything to say, he wryly responded, "Your Honor, if you call this justice, the whole system is a crock." The court was not as amused as AAPL members were; his sentence was extended from 10-to-15 years to 20-to-30 years.

In prison, Mr. Maher noted that he was "living the worst thing that could possibly happen" to him. He found strength by taking one day at a time. He struggled with anger and relied on his faith in God. Eventually, he was able to work and ran the staff kitchen for 12 years. He also had the support of several therapists who believed in him. Mr. Maher decided he would rather die in prison as an innocent man than to confess to crimes he did not commit.

In 1993, Mr. Maher wrote to the Innocence Project. This national organization is dedicated to exonerating wrongfully convicted individuals through DNA testing and reforming the criminal justice system. Members of the Innocence Project tried repeatedly to access the evidence from the victims in Mr. Maher's case but were told the evidence had been destroyed or lost. In 1997, the court denied his motion for DNA testing.

Four years later, a law student discovered two boxes of evidence from the Lowell case in a courthouse basement. DNA testing was

finally permitted, and Mr. Maher was soon excluded from one of the cases. Almost cruelly ironic, his attorney called him on April Fool's Day and asked, "When do you want to go home?" DNA results had come back and excluded him from the second case. A new trial was granted, and his charges were dropped. On April 3, 2003, after spending 19 years in prison proclaiming his innocence, Mr. Maher finally went home.

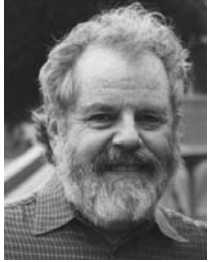
Mr. Maher's is a success story – not only for his exoneration and subsequent compensation and civil lawsuit settlement, but because he met the goals of his treatment release plan. After freed from prison, he took two months off, found employment, met his wife, got married, had two children, and now owns two homes (although his initial goal was just one!). Today he works as a mechanic for Waste Management. He named his daughter Aliza, after his former Innocence Project staff attorney Aliza Kaplan. He is an advocate for criminal justice reform frequently speaking to professionals and legislatures as well as college students and released inmates.

Mr. Maher admitted that his transition back to society has been challenging. Technology had advanced while he was behind bars, and people had changed. Although he does not blame the victims, he continues to struggle with his anger toward law enforcement. He suffers from symptoms of PTSD when he sees the then-arresting police officer on television as the now-superintendent of the Boston police force. And he wrestles with convincing his children that they can and should trust the police, although he may not believe it.

At the conclusion of the talk, I heard an AAPL member utter, "Wow! That was intense." I think many in the audience that afternoon would agree. Hopefully Mr. Maher will continue to find strength during his recovery by continuing to live one day at a time. ☪

Life Sentence for Viewing Child Pornography

Stephen P. Herman MD



Back in November of 2011, the *New York Times* reported a fascinating case. Daniel Enrique Guevara Vilca, a 26-year-old

stockroom worker, was found to have on his computer hundreds of images of child pornography. Although he had no previous criminal record, a circuit court judge in Florida sentenced him to life in prison without parole. Does he deserve the same criminal punishment as someone convicted of first degree murder? The irony is had he actually molested a child, his sentence would probably have been a lighter one.

There is a difference between those who just view child pornography and those who molest a child, a law professor said.

In Florida, according to the *Times*, possession of child pornography alone is a third-degree felony punishable with up to five years in prison. Mr. Vilca was charged with 454 counts of possession, with each count representing one image.

The local DA stated that Vilca received a fair sentence, considering the extent of his crime. He said this was not a victimless crime, as the images of the children would generally be shown over and over again. The defendant's attorney, though, called the judge's sentence "ridiculous." He claimed his client had nothing to do with the production of these images and he never molested a child. The lawyer said the sentence was "beyond comprehension."

Mr. Vilca said throughout the trial he was not aware of the images on his computer. Ironically, he turned down a plea bargain that would have resulted in a 20-year sentence. After Vilca refused the plea, the DA increased the charges. The sentence,

as you might expect, is being appealed.

Those who view child pornography do not necessarily molest children. However, this is a common view of the public and, apparently in this cases at least, the view of the judge. However, research shows that while porn viewers might not molest children; child molesters, in turn, may not want to watch such images.

According to the article in the *Times*, state and federal laws increase penalties based on the number of child pornographic images found in

“Much less is known about those who view child pornography images. It could be argued that those who do collect such photographs are less likely to act out fantasies with children because their sexual arousal has been mitigated.”

someone's possession, either in print or on computer. Guidelines recommend at least 57 to 71 months for possession of at least 600 or more.

However, there is some legitimacy to the argument that perusal of the Internet might lead to child pornographic images being downloaded in the thousands and in just a minute or less. Should the viewers be charged per picture? Also, it is conceivable that these images could be acquired without the perpetrator's knowledge. This can occur, for example, if the

photographs ride piggyback with other files – say illegal music files – which the unsuspecting computer user acquires.

Pedophilia, Seto has written, is not synonymous with molestation of children. (Seto, M. Pedophilia. In *Sexual Deviance, Theory, Assessment and Treatment*, ed. Laws, D. and O'Donohue, W. The Guilford Press: New York, 2008) It should be considered a sexual preference, it emerges early in life and is generally present across the lifespan. It occurs more commonly in men. Pedophilic offenders are more likely to have been sexually abused as children, and they may have a neurodevelopmental disorder predisposing them to such behavior.

Much less is known about those who view child pornography images. It could be argued that those who do collect such photographs are less likely to act out fantasies with children because their sexual arousal has been mitigated. On the other hand, such viewers may be stimulated enough to act out their pedophilic fantasies.

Much more research is needed into pedophilia with all of its manifestations. But a life sentence for only viewing? That seems more than harsh. Not that such offenders should necessarily receive a light sentence. This population creates the market in producing such photographs of children.

What do you think? Send me your thoughts and opinions (email: sherman8@earthlink.net) and I will report back in the next AAPL Newsletter. ☺

MUSE & VIEWS

Lawyer defined

A lawyer is a person who writes a 10,000-word document and calls it a "brief."

Franz Kafka

Submitted by Charles L. Scott MD

My Fellowship Year: A Slice of Life

Kehinde Ogundipe MD



It all felt a little surreal as I walked into the Mental Health Center for my forensic psychiatry fellowship

training. I had never imagined myself in this position when I left Nigeria almost a decade before. I was excited, nervous, expectant, and exhausted. I tried to sound confident and articulate as my heart fluttered ever so slightly in my chest, and I attempted to shake off the annoying, low-level headache, cognitive cobwebs and vague queasiness that had characterized the early weeks of my pregnancy. Yes, I had walked into my fellowship a few weeks pregnant.

My head was swirling with questions. Can I pull this off? What if the pregnancy was really difficult and I spent most of my year sick? Would I be safe dealing with potentially violent prisoners, defendants and forensic psychiatric patients? How soon should I return to work after delivery? I was determined to finish my fellowship year on time, but that meant limited maternity leave. What would such a short maternity leave say about me? Indeed I was already well on the way to the “working mothers’ guilt trip” special. My narcissism bubbled to the surface as I worried about what my new colleagues would think about me. I could not stand to think that their first impression of me would be of a perpetually queasy, listless ghost of myself. I steeled myself, determined not to be weakened by my pregnancy.

As I walked down the corridor towards my new department, I wondered when I should let my program director know, after all, it would be pretty hard to miss before long. I chuckled as I thought about a radiologist friend of mine who had felt so alienated from her department that she refused to say a word about her own pregnancy. Eventually the non-mystery was solved eight months into

her pregnancy, when her department organized a bogus abdominal ultrasound ‘training’ session on all trainees. I was one up on her though; there were no ultrasound machines at our department! As it turned out, I also had the most wonderfully supportive department and co-workers; they were simply amazing. Once I informed them, everyone was genuinely happy for me. We formulated strategies to best coordinate my schedule with that of my training needs and the department’s obligations. We brainstormed on how to

“As my belly grew, emergency plans were reviewed each time I drove to the farther flung regions of the state.”

address curious questions from patients, evaluatees, and inmates.

The first six months of training went by in a rapid, almost dream-like march: the exhaustion of the first trimester; the infuriating, mental fog of the dreaded “pregnancy brain”; the obsessing over food as I struggled to gain adequate weight to keep up with the demands of my growing baby and a hectic forensic psychiatry fellowship that required running between multiple sites all over the state. And then there were those landmark cases! They were the bane of my existence! It was hard enough learning the legal lingo, but struggling with maternity’s mental molasses made it incredibly frustrating. To manage these challenges, I exercised and kept a strict sleep schedule, told myself to be patient while I read landmark cases two or three times, scheduled and wrote down every little detail obsessively, and eventually staved off the

concerned frowns of my obstetrician by eating constantly and shoveling pints of soothing ice cream down my throat every night!

What took me most by surprise though was the emotional effect of the fellowship experience. I recognized that I was more likely to have a heightened emotional reaction anyway, but was surprised by how strong it was. I liked to think that I was one tough gal, having grown up in a tough city where people had no illusions of safety in or outside their homes. One was constantly keyed up and vigilant for real or perceived threats. So I was knocked sideways by my feelings while working as a consultant for the State Prosecutors’ office, on a high profile, gruesome murder case in a supposedly safe neighborhood. Was it the hormones, or my identification with the victims, a regular middle class family, or my access to details of the case that I would ordinarily not have? I couldn’t tell. I had never felt more vulnerable than I did during those first few months of training. Perhaps it was the implosion of the illusion that one would be safe in a neighborhood identified as safe and protected by a functioning and respected police department. I asked my colleagues if any of them had the same experience, but only one of my peers acknowledged being somewhat freaked out by the really freaky stories of child molesters, rapists, killers and cannibals that are a staple of forensic psychiatry. My supervisors were a lot more reflective; most of them told me they had some emotional reaction to the cases they had worked on earlier in their careers. I took the advice of one of my supervisors about the need for one to protect oneself physically and emotionally in this business and I became more careful about what I watched and read at home. I stopped watching CSI and any such thrillers, but rather, focused and subsequently got hooked on comedy shows.

This experience and training certainly changed the way I see the world: that soft spoken Adonis one exchanged glances with in the store
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Angela Hegarty MB, BCh, BAO

The Conceptual Tool-kit

Philip J. Candilis MD

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



Long-time AAPL member and founder of AAPL's forensic neuropsychiatry committee

Angela Hegarty

brings an approach to forensic practice that keeps pace with recent developments in medical and forensic professionalism. Trained in both neurology and psychiatry, she began constructing a “conceptual tool box” for patient evaluations during her training at Albert Einstein in the Bronx. Being ready to meet the demands of any case motivates her to maintain the instruments in her toolkit whether they are derived from functional neuro-imaging, psychoanalysis, or narrative theory.

An Irish ex-patriate, Dr. Hegarty's path after training was unclear. Colleagues suggested she attend a case conference of the Massachusetts General Hospital led by law and psychiatry chief (and AAPL member) Ron Schouten. His discussion of fitness to proceed opened up a new vista for the nascent neuropsychiatrist. The epiphany was followed by a discussion with former AAPL president and mentor Richard Rosner, who guided Dr. Hegarty to her first forensic position at the Kirby Forensic Psychiatry Center on Ward's Island, New York — a maximum security forensic facility affiliated with New York University. Dr. Hegarty's first job allowed her to develop her interest in violence as a clinical and forensic problem. Cultural competence, almost always essential when working in New York, became a necessity when working with evaluatees in her future specialty: individuals who were willing to use violence to accomplish religious, political, or social ends.

Working with such individuals, she recalls, challenged the “givens” of professionalism. Dr. Hegarty cited

a representative example: she evaluated a man who identified himself as a radical fundamentalist and was charged with a number of violent felonies. His history of mental illness would be relevant to sentencing. Though he generally worked well

“Dr. Hegarty's approach represents a practical way of putting one's own values under scrutiny and exploring how they affect one's reports and testimony.”

with his attorney, he had fired several prior experts retained to assess him. During the first meeting the evaluatee's attorney became concerned that she was about to lose another expert. No sooner had the session began when her client began to grill

Dr. Hegarty about her religious beliefs, her faith, and affiliations. It was the same process that led to his firing the previous experts. To the attorney's alarm, Dr. Hegarty answered his questions. When asked why she didn't simply deflect them, Dr. Hegarty responded that the client was asking questions that were directly relevant to her expertise: he wanted to know whether she could speak his language, whether she could respect his identity and his identifications — even if she did not agree with them. Could she hear what he was bearing witness to in his narrative? For this evaluatee it was a given that any psychiatrist would find him “crazy” because he was so fervent. Above all, she recalled, “he had to know that I would hear the story he needed to tell and stand, if only for a moment, in his shoes as he told it.”

In Irish culture, the relationship between narrative and places is known as *Dindsenchas*, a descriptive text that integrates identity with past events. It grounds places in tradition, time, and point of view. In this tradition, narrative helps orient the listener to the perspective of the narrator. The tradition overlaps with key dimensions of culturally competent listening and interpretation. In Irish litera-

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AAPL Research Poster Award

Robert L. Trestman PhD, MD, Chair, AAPL Research Committee

At the 2011 AAPL Conference in Boston, the Third Annual Research Poster Award competition was held. The intent of the award is to enhance the research orientation of its membership and recognize those efforts. Members of the Research Committee served as judges. Each Judge reviewed the posters displayed on Thursday, Friday, and Saturday of the conference. Clarity of Hypothesis, Methodology, Analysis, Scientific Value, and Practical Significance to the field of Forensic Psychiatry were considered in the overall evaluation. This year, 42 posters were exhibited. Seven members of the AAPL Research Committee served as judges. The Winner of the Annual AAPL Research Poster Award is the work of Douglas Morris and Nathaniel DeYoung for the poster entitled, “Psycholegal Abilities and Successful Competence Restoration.”

We look forward to continued enthusiastic participation in research efforts more broadly, and in the submission of research (both empirical and scholarly) to the Annual AAPL Meeting. ☪

Ask The Experts

Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send question to nskaye@aol.com. This information is advisory only for educational purposes. The authors claim no legal expertise and should not be held responsible for any action taken in response to this educational advice. Readers should always consult their attorneys for legal advice.

Q. I just received the opposing expert's report in a case. In the report, the other expert not only attacks my opinion but also goes on to say that I must not have read the records and suggests that the lawyer wrote my report? How do I get any recourse?

A. Sadoff: Fortunately, this kind of personal and professional attack in the adversarial nature of our judicial system has become less frequent than in the past. Unfortunately, there are still those "experts" who have such low self-esteem that they feel the need to attack their adversaries. It is one thing to rebut the scientific and professional opinions of one's adversary through evidence-based comments, but another to personally attack one's adversary. There is no place for that, in my opinion, in a respectful profession as we experience it.

Having said that, there are also those "experts" who do have the reports dictated or written by the attorney, or, in some cases, the final version is suggested by the attorney who has a particular need in his/her case. We do know that attorneys write the affidavits or declarations that are submitted. However, the expert has the option to modify or change the wording of the document if it is not in keeping with his/her professional opinion.

The writer asks about recourse. The best recourse is in the courtroom, where one can professionally

defend one's opinion by pointing out, to the court, the weakness of the adversary's argument and the strength of one's own proposition. One type of recourse occurred when I was accused by my adversary of not having a "mental status examination" in my report. I, in fact, had a mental status examination, but I did not label it as such. However, in court, with my adversary sitting in the audience, I pointed out the clarity of the mental status examination and made the comment that if he needs to have a title with neon lights, I could do that, but a clear reading of the paragraph showed that, in fact, it was a comprehensive mental status examination. His comment attacking me for not having it showed the weakness of his opinion and the jury showed him no mercy. Judges and juries are very astute in picking up the attack mode of a person whose own opinion is weak and, therefore, the expert has to bolster his/her opinion by inappropriately attacking his/her adversary.

In my new book, "Ethical Issues in Forensic Psychiatry: Minimizing Harm," I point to the vulnerable populations that we serve and how we may minimize harm within a harmful adversary system. We should not be aggravating the harm to each other, but rather helping the legal system in the least harmful way. One chapter points to the expert witness as a vulnerable person within the system. We should be able to work effectively, professionally and with dignity in presenting our opinions, even when our adversaries disagree. According to the old adage, we should be able to disagree without being disagreeable.

A. Kaye: I too have had to endure scathing attacks of a very personal nature that are clearly unprofessional at best and libelous at worst. In my experience, these reports invariably come from an expert who works almost exclusively for one side, a point worth discussing with the retaining lawyer who can use this to show bias during voir dire.

I am proud to say that rarely do these attacks come from other psychiatrists and it is especially rare for such attacks to come from trained forensic psychiatrists and AAPL members. However, it is not infrequent for a non-psychiatrist to attack me for rendering "medical" opinions, especially in the areas of traumatic brain injury, neuropsychiatry, pain, somatic disorders, and dementia. Too many medical colleagues still believe that psychiatrists are not "real" doctors and there are numerous cases where judges have limited testimony by a psychiatrist to only the non-medical issues. Many doctors, judges, and jurors need to be reminded that I am fully capable of ordering and interpreting imaging studies, labs test, and other functional assessments even though I am "only" a psychiatrist. I make it a point to discuss how this is exactly what I do daily in my clinical practice.

I strongly advise against any type of engagement with the other expert, or as we would advise a patient in couples therapy: "Don't take the bait." Avoid the temptation to write a stinging and pithy reply. Rather, carefully examine the other expert's criticism, critiques, and comments and see if there is any validity to any of what has been claimed. Understanding the opposite vantage point can significantly strengthen your hand as you prepare for cross-examination. Usually, if the other expert is stooping to character assault it is because that expert has no better evidenced based medical/science to best your written opinion.

Do discuss your feelings and conclusions again with retaining counsel so that this issue is in the open. This allows for any weaknesses to be addressed as part of direct examination. Also, keep a file of such reports, so that when you cross paths with this "expert" again, you have prior written opinions for you and the lawyer.

I agree that the best recourse is in the courtroom. For me this requires

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PHOTO GALLERY



Ezra Griffith receives the Golden AAPL Award.



Elissa Benedek strikes a pose with Renée Binder, contestant for APA President-Elect.



Bob Trestman presents the Young Investigator Award to Paul Christopher.



Bird's eye view of the splendor of the "high table."



Liza Gold receives the Seymour Pollock Award from Renee Binder.



Run! Hide! The nor'easter is coming.

PHOTO GALLERY



A rare quiet moment at the bookstand.



Outstanding teacher, Ken Weiss, receives his well deserved award.



Catching up with friends from around the world at break-times.



Voila! The new Rappeport Fellows with Jeff Janofsky.



Peter Ash with some of the incoming Officers and Councilors: Douglas Mossman, Debra Pinals, Marilyn Price, Charles Scott, and Gregory Sokolov.



Dr. Jagannathan Srinivasaraghavan smiles as he receives the Red AAPL Award.

Child Exploitation

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bers, especially their mothers, who offer these children for monetary gains. Other common perpetrators include the child's father, older sister, brother or boyfriend. Victims often include both male and female children from as well as young adult females of low socioeconomic status. Many perpetrators often went to garbage dumps to find underprivileged victims to prey on.

SP. Phillips then outlined the procedures and process of investigating suspected cases of child sexual exploitation under the PROTECT Act. He surmised that the best source of information to initiate an investigation was usually the Non Governmental Agencies (NGOs). Other sources include the local police, intelligence agents, and tips from others in the community. There are basically three types of investigation that can be initiated; Reactive, Proactive and Undercover. Reactive investigations are those that are initiated after a report of an actual incident or ongoing acts of child sexual exploitation. Proactive investigations are those carried out to prevent such acts of exploitation, while Undercover investigations are carried out as part of an ongoing program to identify notorious areas and perpetrators of such acts of child exploitation.

SP. Phillips then proceeded to discuss some of the cases that have been prosecuted under the PROTECT Act, beginning with the case of Michael Clark, the first individual to be successfully prosecuted under this Act. He indicated that it was a challenge for him to convince his superior to go after Mr. Clark because the case was "tremendously expensive" and time consuming.

Mr. Clark, a former military officer, travelled to Cambodia from Central America to have sex with young boys. Upon receiving information about him from the local NGOs, the FBI set up surveillance. He was subsequently arrested while raping two

boys. A search of Mr. Clark's house revealed child pornographic magazines, bottles of Viagra, lubricants, bulletins, bank account information and information about sponsoring children in Asia. Thereafter, he was arrested and placed under the care of the FBI.

Upon being confronted with the evidence against him, Mr. Clark confessed to being a pedophile. He told them that he has had sex with about 40 to 50 children worldwide. He also admitted to becoming more dangerous and physically assaultive towards his victims. He was ultimately sentenced to 8 years in prison.

Other cases prosecuted under the PROTECT Act include the case of Walter Schirra, Jr. who solicited for sex with minors through a website set up by the FBI. He ultimately purchased a ticket with the intent of meeting his potential victim, thereby providing law enforcement with the basis for successful prosecution. There was also the case of Carl Tishell who had been travelling to Cambodia for years to abuse children, some as young as 5. He was successfully prosecuted and got 10 years in prison. Steven Prowler, another child molester, got 10 years in prison. Lastly, Kent Frank who travelled to Cambodia to have sex with young girls was sentenced to 40 years in prison. His main defense was that those girls were women and not children.

SP. Phillips discussed the challenges involved in the investigation and prosecution of international child sexual exploitation. The most common and important challenges are time and cost. Other challenges include the language barrier and the customs and cultures of the host country. In addition, since most of the victims are very young, getting them to testify against the defendants is often very difficult. Logistical problems such as getting a passport for witnesses, as well as obtaining the right visas and other travel documents, can be challenging.

SP. Phillips finished his talk by noting that a lot of children world-

wide are suffering tremendous pain due to exploitation by adults. He opined that the problem will get worse unless more resources are devoted to identifying and prosecuting perpetrators. ☪

Ask The Experts

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ample preparation time with the retaining lawyer and being certain that during the credentialing process, an adequate basis for my medical expertise and subsequent testimony is laid. I ask the lawyer to have me admitted not simply as an "expert in psychiatry" but as a medical doctor, a pain expert, a neuropsychiatrist, a psychopharmacologist, or whatever moniker will assure my ability to testify across the full spectrum of diagnoses and conditions are expected to arise during the case. Of course, these areas must actually be within my true expertise, but being "blessed" by the court as an expert in advance is important.

In one case, an attorney tendered me simply as an "expert" and opposing counsel never objected. The judge approved the request and for the first and only time in my life I can say I was legally approved as a "know-it-all."

Sadoff/Kaye: Take home point: There is no place for unethical behavior in the medical-legal system and we have a duty to practice to the highest standards possible in order to preserve the dignity and decorum of our profession. When an opposing expert fails to live up to the expected professionalism required in our work, we must continue to show the way by example and resist the temptation to lower ourselves. Juries are insightful and they can easily tell which expert is more credible. Let the facts do the talking. Lastly, as experts, we are there to teach and should have no stake in the outcome of the litigation. Let your neutrality be empowering. ☪

Volume, Numbers, and My Fantasy Correctional Psychiatry League

Stephen Zerby MD

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



Correctional Psychiatry seems to be hitting a wall. While I do not currently work in a jail setting, I supervise

fellows who do. Their stories of being handed a stack of charts and being expected to see large numbers of patients are unnerving. These stories have been echoed by other correctional psychiatrists at national meetings. While acknowledging the limited mental health resources available in correctional settings, the goal of mental health treatment in such scenarios is called into question. I have worked in other mental health settings in which the premier mission of the service was diverted from excellent patient care to something else.

Theoretically speaking, an inpatient psychiatric unit with a novel yet compassionate and effective treatment model would seem to be a boon to psychiatry. New and advanced methods of evaluation and treatment can power the field forward toward better horizons.

The caveat is that this would be a positive development only as long as the primary mission of the service was to provide the highest quality patient care. Should the mission of such a hypothetical unit shift toward promoting their novel treatment approach, ethical problems can arise. For example, should the novel unit have a patient who does not respond well to their novel techniques, would staff attitude and the care of said patient become negatively impacted? Would patients be used as pawns in efforts to promote the novel program? This is all entirely possible.

In a similar vein busy services can

lose their focus from patient care to what becomes their highest priority: managing large volumes of patients in the “most efficient” – i.e. fastest – manner. The risk of this is that in time, greater attention will be paid to efficient management of patient volume at the expense of quality of care. That is, quality-of-care indicators progressively morph into analysis of a psychiatrist’s patient volume, or in the terminology of the industry, the psychiatrist’s “numbers.” It is

“...quality-of-care indicators progressively morph into analysis of a psychiatrist’s patient volume, or in the terminology of the industry, the psychiatrist’s “numbers.””

unfortunate that some professionals with high achievement in education – undergraduate, medical school, psychiatric residency, and sometimes forensic psychiatry fellowship – take pride in, and mostly focus on their “numbers.” Simultaneously, administrators can become tempted to focus on “numbers” as the supreme “quality indicator.”

This state of affairs combined with playful imagination has led me to my own modest proposal for a new quality indicator: The Fantasy Correctional Psychiatry League (FCPL). This is a nod to popular online games such as Fantasy Football Leagues in which team “man-

agers” select a roster of professional players who score “points” for their team through various means: yards rushed, yards received, yards passed, touchdowns passes and receptions, and so on.

For our proposed FCPL, we can envision teams of correctional psychiatrists who earn points through numbers of medication checks, initial evaluations, hospital diversions, orders written, etc. Administrators would then motivate their psychiatrists by posting their comparative statistics – i.e. “stats” – in an effort to motivate them to compete with each other by boosting their “numbers.” The winner of the competition would be the psychiatrist who earns the greatest number of points. Through this technique administrators would tap into the naturally competitive nature of their psychiatrists to make them ever-vigilant about their statistics, driving them to work in a more efficient manner, boosting their numbers and hence, their “fantasy value.”

While this proposal is obviously tongue-in-cheek, the focus on numbers and statistics is very real. Despite this, I cannot recall seeing many workshops, courses, or lectures on increasing productivity – i.e. boosting one’s numbers.

A quick review of the program for our recent American Academy of Psychiatry and the Law Annual Meeting reveals nothing focusing on efficiency despite its prominence and importance in our field.

In fact, I cannot recall coming across many symposia, lectures, workshops, and so on, which deal with efficiency and maximization of “numbers.” I must confess that until writing this article, the idea of such a project had never occurred to me. Therefore, I am as guilty as the next person in neglecting this critical area for our practice. There is, of course, a risk that focusing on efficiency might create a negative image for our profession, but with the current focus on numbers being so prominent, it is a difficult topic to avoid. ☹

Update on Maintenance of Certification

Sohrab Zahedi MD

In October 2011, the Annual Meeting of the American Academy of Psychiatry and the Law was held in Boston, Massachusetts. Amid the many lectures, among the best attended was one given by Larry R. Faulkner MD on Maintenance of Certification (MOC). Many psychiatrists have expressed concerns about the new requirements for MOC. In the following paragraphs, Dr. Faulkner's more salient points are summarized.

MOC includes four specific requirements. The first involves maintenance of unrestricted license to practice medicine in at least one state or territory in the U.S. If that license is ever restricted or interrupted, the psychiatrist is no longer considered board certified. Remedy of the situation starts with contacting the American Board of Psychiatry and Neurology (ABPN).

Dr. Faulkner reported that ABPN is looking to organize its requirements to actively keep a reasonable advance notice over what is anticipated to become future state licensure requirements. However, details of ABPN's requirements can be confusing. Adding to the confusion is that requirements have changed during the launching and implementation of MOC.

The second requirement is that of Self-Assessment and Continuing Medical Education (CME). Self-assessment CME is defined by the ABPN and designated by each accredited CME provider. Self-assessment CME requires 25 items minimum and participants must receive feedback about their performance against their peers. In the decade after board certification, ABPN requires 30 CME credits per year or 90 credits every 3 years. On average, a minimum of 8 out of every 30 annual CME credits should involve a self-assessment component. In the future AAPL hopes to provide such a self-assessment online for CME credit. Pricing is yet to be determined, but the desire is to offer substantial reductions for AAPL members. Commercial programs are also available that provide the same service for a fee.

'Cognitive Expertise' is the third

requirement of MOC. Since 1994, all diplomates are expected to renew their certification by passing an examination every 10 years. What is new, and coming down the pike, is ABPN's fee-schedule for the cognitive examinations. ABPN currently offers diplomates a free online service that keeps an electronic record of all CMEs, dates of certification, upcoming deadlines, and so on. I find the service helpful as it also provides documentation for state licensure. In the near future, however, the service will no longer be free; an annual fee of \$175.00 will be required to use those services. What the fee also buys is one free cognitive exam every 10 years. If one fails to pass, there will be a fee to repeat the exam. Moreover, diplomates with certification in more

“What the fee also buys is one free cognitive exam every 10 years. If one fails to pass, there will be a fee to repeat the exam.”

than one specialty can choose to combine the examinations and take these all at once. For example, in my case, and assuming I had paid my annual fees of \$175.00, I could choose to take both my general and forensic psychiatry recertification examinations in 2019 for free—if I pass both on my first attempt.

The last requirement of MOC is called Performance in Practice (PIP). Within a decade of board certification, the diplomate is expected to complete a PIP unit every three years. Every PIP unit consists of two modules. A clinical module includes review of 5 charts from the diplomates' clinical practice and establishment of a personal plan by the diplomate to assess and improve on his or her clinical care via review of current literature and recommendations. A hospital quality improvement program, where available, is an easy way

to satisfy this requirement. ABPN will not seek copies of actual patients' charts, but simply a statement by the diplomate that the requirement has been met. AAPL's first PIP checklist, based on the AAPL guideline on Competence To Stand Trial Evaluations, will be online shortly and free to members.

PIP's other component, the feedback module, includes solicitation of feedback from five peers and five patients. The latter groups are expected to evaluate the diplomate's clinical performance over a three period interval. Peers include other psychiatrists, psychologists, social workers, physicians, counselor, and nurses. I am aware of a number of psychiatrists who have expressed concern about the patient feedback module. The issue is that such a gesture can have a profound impact on the therapeutic relationship between patient and psychiatrist. Could a patient truly be honest about the performance of a psychiatrist if he or she is dependent on the care provided by the psychiatrist? Could it be that the psychiatrist's approach to patients is colored by the evaluation that is received? Is it possible that the psychiatrist's aim of acting in his patient's best interest will not overlap with the aim of receiving high marks from the patient? I expressed these concerns to Dr. Faulkner and his response was generally that in the day-to-day aspects of patient care, psychiatrists are often confronted with scenarios where different interests are in conflict with what is best for the patient. The ABPN patient feedback requirement is no different from these scenarios.

In conclusion, while Dr. Faulkner recognized that the MOC requirements can pose a challenge to diplomates, he observed that the organization is striving to stay ahead, and in some cases, buffer the demands that various social and political forces are pressing upon the entire house of medicine. He closed by stating that ABPN is flexible in its approach and urged diplomates to contact the organization if they believed that activities not mentioned above could satisfy any of the needed requirements.

(Editor's Note: A version of this article also appeared in *The Connecticut Psychiatrist*.)

The 2011 AAPL Research Survey and the AAPL/APLS Forensic Research Collaborative

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This past summer, the AAPL Research Committee sponsored a web-based survey of the research activities and interests of its membership. The intent was to establish a baseline of potential interest and experience in research. One of the specific goals in mind was to prepare for potential partnerships/collaboration between (typically) clinically grounded AAPL members and (typically) research minded American Psychology–Law Society (AP-LS) members. Over the past two years, an evolving collaboration with AP-LS has developed. This has included a joint presentation at the 2010 AAPL meeting and a joint presentation at the 2011 AP-LS meeting in Miami. At the AP-LS meeting, attendees were educated about AAPL and forensic settings where AAPL members work and how such settings may serve as rich resources for forensic research.

Background: To support the future of Forensic Psychiatry, there is growing recognition that the field must become more evidence based in each of its facets. To become so, a cadre of skilled researchers is needed to guide the development and implementation of meaningful research that will advance the field. In practice, research continues to become more demanding and sophisticated at all levels: funding opportunities and quality expectations; design of studies; IRB management; data management; and project management. There is an evolving standard that research should have an interdisciplinary perspective. The research model has shifted from the single investigator to a research team that is able to provide designs and results that are meaning-

ful to applied fields. One component of this kind of translational research is the use of multisite opportunities to increase the utility and generalizability of results.

Further, expanded research may effectively support career development for academically-based AAPL members. In truth, about half of AAPL members have academic appointments. Advancement is usually linked to academic/scholarly productivity; research is always the “coin of the realm.”

Survey Results: Ninety four (94) AAPL members responded to the survey. Of those, the reported academic rank was: Assistant Professor (25), Associate Professor (15), Full Professor (16), Voluntary Faculty (13), and None/Resident or Fellow/Other (25).

Research Funding: We asked about four different kinds of research funding a member may have received during their careers. We looked for a history of institutional grants, foundation grants, federal grants, and unfunded research. We found that, in each faculty status, 50% or more have con-

ducted research. For each faculty category, most of the research was unfunded (85%). Funded research, not surprisingly, was primarily conducted by faculty who are at the Assistant Professor level or above.

Potential Role in Grant Collaboration: Consistent with our expectations, the majority of respondents to the survey were interested in collaboration. Fully 80% said they were interested in participating in generating the core ideas to drive the grant. Fifty five % of respondents stated that they have access to unique or difficult to access populations (e.g., correctional, NGRI, sex offenders or victims, and TBI or PTSD populations).

Skills/Experience/Interest: When we drilled down to the level of actual experience and areas of interest, several categories emerged as dominant. Not unexpectedly, the top skill and interest category was in Scientific Writing (62%), followed by Psychopharmacology research (49%), Clinical Trials more broadly (33%), and Psychotherapy research (33%).

Next Steps: One of the goals of AAPL is to invigorate Forensic Psychiatry with a research agenda that supports the growth of the clinical field. One aspect of meeting that goal is cross-discipline collaboration. Such collaboration, represented by the developing linkage between AAPL and AP-LS, may yield synergy and benefits for the investigators themselves and all forensic mental health

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Faculty Status	Number	Institutional Grant	Foundation Grant	Federal Grant	Unfunded Research
Assistant Professor	25	6 24%	2 8%	7 28%	19 76%
Associate Professor	15	5 33%	5 33%	5 33%	11 73%
Professor	16	8 50%	5 31%	6 38%	8 50%
Voluntary Faculty	13	4 31%	1 8%	0 0%	11 85%
None/Other	25	4 16%	1 4%	1 4%	15 60%

Sexually Exploited Children: Victims or Criminals?

Allison V. Downer MD, Enrico Suardi MD, Gary Phillips BS
Child and Adolescent Committee

It is estimated that up to 300,000 minors in the U.S. are sexually trafficked every year. The child sex trafficking industry operates across the United States and internationally. The globalization of world economies, the weakness of national borders, and the internet have made access to minors for international traffickers easier than ever before. With the increased use of the Internet, law enforcement and the National Center for Missing and Exploited Children (NCMEC) have received over 1,226,000 reports of the manufacture, possession, sale, and on-line enticement related to the sexual exploitation of children¹.

The domestic sex trafficking of minors has reached such proportion that the Innocence Lost Initiative was created in 2003 by the Federal Bureau of Investigation (FBI) and the Justice Department's Child Exploitation and Obscenities Section (CEOS), in partnership with the National Center for Missing & Exploited Children, in order to focus on child victims of interstate sex trafficking in the U.S. The United States Department of Justice has also expanded its international sex trafficking laws to include domestic trafficking of youth². The Department of Homeland Security, Immigration and Customs Enforcement has taken a proactive stance in combating child crimes with the advent of "Operation Predator." Operation Predator has successfully arrested well over 10,000 individuals since 2003 for sexual exploitation of children³.

Historically, if an adult paid a minor to have sex, the law treated the minor as a perpetrator. Both social service agencies and the criminal justice system viewed juvenile prostitution as simply another act on the spectrum of delinquent behavior⁴. However, over the past two years, in such states as New York⁵, California⁶, Connecticut⁷, and Minnesota⁸, legislation has deemed under-age prostitutes

victims, so that they can no longer be prosecuted. Resources such as housing and community-based programs are required to be provided since legislators have realized that "services should be created to meet the needs of these youth outside the justice system"⁵. Furthermore, victims of sexual exploitation overseas can apply for and be granted trafficking visas, which means that the victim can be relocated to the United States if victimized by an American perpetrator⁹.

Studies have identified consistent risk factors associated with childhood sexual exploitation, such as female

"Historically, if an adult paid a minor to have sex, the law treated the minor as a perpetrator."

gender, history of abuse and/or sexual victimization, being a runaway, gang association, drug dependence, and caregiver mental illness and/or substance abuse¹⁰. At the time these sexually exploited minors are identified, their needs may vary greatly. They are at risk for having suffered physical injuries, acquired sexually transmitted diseases (including HIV), and experienced unwanted pregnancies. A study performed using the Brief Symptoms Inventory and the Harvard Trauma Questionnaire indicates that children who suffered injuries and sexual violence during trafficking showed high rates of PTSD and clinically significant depression and anxiety¹¹. Involvement of forensic child psychiatrists in evaluating cases of child sexual trafficking is increasingly being sought.

What about "pimps" and "Johns?" Sexual trafficking of minors is a profitable and relatively easy line of busi-

ness. Minors can be recruited and retained using brutal psychological and physical coercion, including rapes, beatings, isolation, and threats. Their situation sometimes can be compared to being brainwashed by a cult. Pimps can create pseudo-family environments that appeal to children who come from dysfunctional homes. In a number of international cases, the pimps are the parents, with the person responsible for selling the child typically being the mother.

According to a study conducted by the Chicago Alliance Against Sexual Exploitation, fifty-seven percent of the Johns surveyed thought that women in the sex industry had experienced childhood sexual abuse; 32 percent believed that most women had entered the sex industry as minors; 20 percent believed that these women had been trafficked, either internationally or domestically, against their will¹².

Rachel Lloyd, the founder of Girls Education and Mentoring Services (GEMS), an organization devoted to helping girls who have been trafficked into the commercial sex industry, wrote that Johns "are statutory rapists and child abusers. That said...most of ...[them] are what we consider 'normal.' Many...wouldn't dream of sexually abusing the girl next door but when it comes to a prostitute...they figure it does not really matter." At his final hearing, Gary Ridgway, the notorious "Green River Killer," stated: "I picked prostitutes as my victims because...they were easy to pick up without being noticed. I knew they would not be reported missing right away, and might never be reported missing." It is not a coincidence that 27 of his 48 known victims were under the age of 18¹².

Sexually exploited children are preyed upon easily because they are vulnerable and anonymous. They are commonly perceived as different from the rest of the children in their community. They do not have adequate caregivers and lack social and political representation. They are victims, unlike pimps and Johns, who

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California's Mentally Disordered Offender Law

Joseph R. Simpson MD, PhD and Pantea Farhadi MD
Criminal Behavior Committee

"Criminal's letters leave San Diego woman in fear?"

Sent from Patton State Hospital by a patient with a criminal history of violence and psychiatric problems, the letter had an affectionate opening — "Dearest Suzanne" — and ended with a promise "to see you and be reunited as two common people soon."

The patient in question (who had randomly selected the woman from a San Diego phone book) had been remanded to a high-security hospital under California's 25-year-old Mentally Disordered Offender (MDO) law. This type of law appears to be much less common among the states than the sexually violent predator (SVP) statutes familiar to forensic mental health professionals in many U.S. jurisdictions. Many psychologists and psychiatrists perform evaluations to assist the courts in addressing the certification, extension, treatment venue and release of patients in California's MDO program.

So what exactly is the MDO law? Like SVP laws, it provides for the civil commitment of prison inmates at the time of parole. Potential candidates for MDO certification are acutely mentally ill and have been convicted of a crime involving force or violence. To be certified, an inmate approaching parole must meet all of the following criteria:

1) The prisoner has a severe mental disorder, which is not in remission or cannot be kept in remission without treatment; 2) The severe mental disorder was one of the causes of or was an aggravating factor in the commission of a crime for which the prisoner was sentenced to prison; 3) The prisoner has been in treatment for the severe mental disorder for 90 days or more within the preceding year; and 4) by reason of his or her severe mental disorder the prisoner represents a substantial danger of physical harm to others².

Unlike many mental health statutes, the MDO law goes into detail regarding the types of disorders which qualify. The term "severe mental disorder" means an illness or disease or condition that substantially impairs the person's thought, perception of reality, emotional process, or judgment; or which grossly impairs behavior; or that demonstrates evidence of an acute brain syndrome for which prompt remission, in the absence of treatment, is unlikely. The term "severe mental disorder" as used in this section does not include a personality or adjustment

"The MDO parolee can be returned to prison from the hospital or outpatient program for violations, including non-adherence with treatment."

disorder, epilepsy, mental retardation or other developmental disabilities, or addiction to or abuse of intoxicating substances³.

The burden of proof is on the state to establish beyond a reasonable doubt that the inmate meets the statutory criteria. The inmate has the right to examination by two independent professionals, the right to an attorney, and the right to a jury trial⁴.

Once certified as an MDO, the inmate begins his or her three-year parole term in a state hospital. They may subsequently be transferred to an outpatient conditional release program. The MDO parolee can be returned to prison from the hospital or outpatient program for violations, including non-adherence with treatment.

At the conclusion of the parole term, the prosecutor in the county of the original conviction can petition to have the patient's MDO status continued. The same procedures apply as at the original commitment. However, the criteria for extension are somewhat different from the criteria for initial certification. It must be determined that the patient has a severe mental disorder, that the disorder is not in remission or cannot be kept in remission without treatment, and that by reason of his or her severe mental disorder, the patient represents a substantial danger of physical harm to others. It is not necessary to revisit the question of whether the mental disorder was a factor in the original crime. MDO status can be renewed with one-year extensions indefinitely⁵.

The California Legislature enacted the MDO law in 1986 "to provide mental health treatment until the severe mental disorder which was one of the causes of or was an aggravating factor in the person's prior criminal behavior is in remission and can be kept in remission" for the purpose of protecting public safety⁶. Currently there are 1263 MDO patients in California's state hospital system. An additional 156 patients are in county-run or private conditional release programs⁷. To the authors' knowledge, there has been virtually no research examining the demographic, criminological or diagnostic characteristics of inmates certified under the MDO law, or of their outcomes (including recidivism) after release from the program⁸. Such research could be quite informative for legislators in other states who might be contemplating the establishment of an MDO-style program, and for the experts advising them. ☐

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My Fellowship Year

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aisle could be a serial killer/rapist, shopping for tools to carry out his crimes; and, the nice elderly man in the elevator could be a child molester. I met them all; the charming baby faced rapist, the shy, stuttering killer, and the serial sex offender who talked about how much he loved his family. Simply scratch beneath the surface, and you might be surprised what you see: humanity's seething, monstrous, underbelly, in inexplicable tandem with the damaged and the vulnerable.

As my belly grew, emergency plans were reviewed each time I drove to the farther flung regions of the state. Unexpectedly though, the most awkward moments did not occur in the jails, prisons, or forensic psychiatric units. The inmates and patients who expressed their curiosity did so respectfully. Their comments ranged from hesitant questions about the delivery date or sex of the baby, to expressions of goodwill. Frankly, I was more worried about surviving the short walk from my home to the office without slipping on ice in the middle of one of the worst winters in recent history than being assaulted in a courtroom, jail or forensic unit. I remember one day climbing as elegantly as my condition would allow on hands and knees over icy, three-foot banks of snow between the road and the curb, thinking: "This is ridiculous." The most bizarre incident actually occurred in the supermarket of all places, when a complete stranger simply walked up to me and wordlessly began to stroke my abdomen, while I stared in stunned silence! As she smiled and walked off in the store's brilliant, soulless light, I felt a shiver ripple down my spine as I thought of the horrible cases of fetus-grabbing crazies! That day, I made sure I wasn't followed home.

Well, we made it through the trimesters three, and my daughter was born. My mother came from Nigeria to help. I had decided to nurse my child, and for various reasons, also to work without a day's vacation outside of my maternity leave, in order to

complete my program on time. So needless to say, when I returned to work exhausted and bleary-eyed after a six-week leave of absence, I was metaphorically and literally drained.

It was tough going back to work, but knowing my baby would be with my mother at home was a blessing words cannot express. I shuttled between home and work, desktop and breast pump. I worked on completing my reports while I nursed my baby. Like most new mothers just returning to work, I sometimes felt like I was sleepwalking, and simply focused on placing one foot in front of the other.

It was one of the most challenging times of my life. Fortunately, I had never imagined a peach tinted haze of perfection. It was a lot of hard work and raw emotions, but now when I look at my beautiful daughter, it was totally worth it. I could never have made it through without the unflinching help of my mother, who sometimes had to comfort my bawling baby while I worked and tried to study for yet another seminar. My husband's steady support, encouragement and his calm counsel helped to soothe me whenever I got upset. If I had to comment on the lessons I learned through this experience, it would be: build a support team around you and lean on them without hesitation, pace yourself, protect yourself and your time, and cut yourself some slack - sometimes what you need to do is simply put one foot in front of the other for a while. It certainly helped that my department was supportive. Some of the best advice I received was: "Get a routine and everything else will fall in place."

I suspect that many of my colleagues feared I would conk out either sometime during the pregnancy, or not make it back after the delivery. To be honest, sometimes I feared the same. Happily, that was not the case. As I now reflect on the fellowship year, I am reminded that people did various things during the year in addition to completing their fellowship. Having a baby was a wonderful bonus for me.

Dr. Kehinde Ogundipe is a recent graduate of the Yale Forensic Psychi-

atry Program. She is Assistant Clinical Professor of Psychiatry, University of Texas Southwestern Medical Center. ☯

Pete Earley

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States has turned mental health problem into a criminal justice problem. Ironically, communities are spending millions to develop correctional facilities which now house those in their system with mental illness. He discussed how San Antonio, Texas saved \$1.3 million in 2005 by diverting mentally ill offenders away from the criminal justice system to treatment, highlighting that an effective diversion program is cost-effective as well as humane. However, to what useful end is jail diversion if there are no community-based mental health programs, supportive housing, or assertive community treatment (ACT) teams?

He concluded that an inadequate community-based mental health system contributed to this problem, and the criminal justice system should not be expected to solve this problem. Earley pointedly illustrated this by stating the obvious—no one would call the police for chest pain suggestive of a heart attack – likewise, we should not demand answers from the criminal justice system for an "illness" in the community mental health system? We can't talk about mental health reform without talking about housing, and we can't realistically talk about housing without talking about jobs, and we can't talk about jobs without talking about affordable transportation, and finally, we can't talk about finding answers without asking the "experts"—the people working on the front lines of mental health treatment, such as forensic psychiatrists and other mental health professionals, for answers. He concluded his lecture by inviting all of us to continue to be advocates not only for our patients, but also for legislation to fix the system that almost ruined his son's life and hurts many others who are chronically ill and in desperate need of our care. ☯

American Medical Association 2011 Annual Meeting Highlights

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

The American Medical Association's (AMA) Interim Meeting focuses on advocacy issues. Your AAPL delegation participated in the November 2011 AMA Interim Meeting, held in New Orleans, Louisiana.

This policymaking meeting had less debate about the Patient Protection and Affordable Care Act (PPACA) than the past few meetings. Instead, a chief focus of discussion remained on finding a permanent solution for the Sustainable Growth Rate (SGR) formula, part of a complicated mechanism that determines physicians' Medicare payments. As of this writing, Congress has still not intervened to avoid large cuts in physician Medicare payments in 2012. AMA delegates also reaffirmed support for the Medicare Patient Empowerment Act, which would allow private contracting with Medicare patients, and called for a grassroots campaign to secure the bill's passage in Congress. Policy adopted on Health Insurance Exchanges supports using the open marketplace model for such exchanges so long as strong patient and physician protections are in place. Protections include maximizing patient choice, minimizing patient churning, and ensuring physician and patient involvement in government activities.

Other meeting highlights include the following:

Physician Stewardship of Health Care Resources: The Council on Ethical and Judicial Affairs is working on ethical recommendations pertaining to stewardship of health care resources. While the House referred the report back to CEJA for further work, the final document aims to help physicians make fair, cost-conscious individual patient care decisions while balancing availability of health care for others.

National Drug Shortages: The House adopted policy addressing national drug shortages that affect patient care and safety. While those of us who prescribe psychotropics are all

too familiar with recent shortages, House testimony documented the impact of drug shortages across the specialties. The new policy calls on the AMA to advocate that the Food and Drug Administration and/or Congress

“...a chief focus of discussion remained on finding a permanent solution for the Sustainable Growth Rate (SGR) formula, part of a complicated mechanism that determines physicians' Medicare payments.”

require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible.

Prescription Drug Abuse: In addition to addressing drug shortages, the

House addressed prescription drug abuse. It voted to encourage the use of standardized screening tools and urged physicians to query their states' controlled substance database to ensure proper prescribing of drugs for their patients.

Stopping Implementation of ICD-10: The House voted to work vigorously to stop implementation of the ICD-10 code set for medical diagnoses. New coding requirements are seen as onerous and unnecessarily burdensome to physicians. While the House voted to support a replacement system for ICD-9, such efforts may not be feasible or practical for AMA to implement.

Long-Term Prescribing of Atypical Antipsychotic Medications: The House passed policy for AMA to work with relevant organizations to help implement non-pharmacological techniques to manage dementia symptoms in nursing home residents. It cautions use of antipsychotic medications and supports providing additional research on other medications and non-drug alternatives to treatment such conditions. It also opposed a proposed Congressional requirement that physicians who prescribe medications with black-box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare.

For more information on the actions of the AMA House of Delegates at the 2011 Interim Meeting go to <http://www.ama-assn.org/ama/pub/meeting/index.shtml>. ☎



AAPL's AMA delegation at the Interim AMA Meeting – from left to right: Robert Phillips, Jacquelyn Coleman, Howard Zonana, Barry Wall, Ryan Hall and Katya Frischer.

Jane Doe: Pregnant Minor and Forensic Evaluee

Susan Hatters Friedman MD, Todd Hendrix PhD, Abhishek Jain MD, Jessica Haberman MA

Pregnant minors can obtain abortions without parental consent, through a judicial bypass procedure, in thirty-five states. In 1986, Ohio became one such state, enacting a law allowing a pregnant unmarried, unemancipated minor to petition the Juvenile Court for authorization to obtain an abortion without parental involvement. To grant such a petition, the Court must determine, by a standard of clear and convincing evidence, that the young woman is either “sufficiently mature and well enough informed to intelligently decide whether to have an abortion,” or that she has been a victim of parental abuse and notification of her parents is “not in her best interest.”¹ The court is required to maintain the anonymity of the girl; thus the evaluee is referred to as *Jane Doe*.

To make her way through this process, Jane Doe will likely need to skip school in order to have an intake appointment at the court, to meet her attorney, and to be evaluated by a mental health professional. She also needs to have proof from a physician that she is pregnant and proof that she has engaged in pregnancy counseling^{1,2}.

The American Psychiatric Association and the American Psychological Association have historically joined amicus briefs to protect women’s autonomy regarding their reproductive health care rights. Recently, the American Psychiatric Association joined a brief challenging a 1995 Illinois law requiring the notification of an adult family member before a pregnant minor may undergo an abortion.³ In the brief, the APA and other opponents of such legislation argued that “parental involvement laws have not been shown to affect abortion rates or birth rates among minors,” “the physical risks of abortion are less than the physical risks of carrying a pregnancy to term,” and “abortion does not increase psychological

risks for minors.”

The central question for mental health professionals evaluating a *Jane Doe* is whether or not she is “sufficiently mature” and “well enough informed.” However, these terms have been inconsistently defined, especially in the context of judicial bypass. Mental health professionals seeking guidance from research to prepare themselves to participate in this politically charged process will find few resources to draw upon. The current body of literature focuses on the

“Currently, a minor who is determined to lack the maturity to make the decision to have an abortion is still assumed mature enough to have a baby, to make medical decisions regarding her pregnancy and child, and to place her child up for adoption.”

legality and ethics of judicial bypasses, parental notification or consent statutes and their application in different states. Mental health professionals will find that little has been published standardizing how to evaluate maturity, such as what behavioral landmarks should be used. Currently, a minor who is determined to lack the maturity to make the decision to have an abortion is still assumed mature enough to have a baby, to make medical decisions regarding her pregnancy and child, and to place her child up for adoption⁴.

Without a clear definition of *matu-*

riety, judges and mental health professionals have been left to apply their own interpretation. This can lead to value-laden misperceptions, such as “If she were truly mature, she wouldn’t be in this situation,” or “If she were mature she would tell her parents.” Recent studies have shown that with enough support and information, and with being clear of emotional and social influences, adolescents are generally as capable as adults in making a mature and reasoned decision.⁵ Consistent with what is known about brain development and the formation of executive functioning abilities, an adolescent’s decision-making ability may substantially differ from an adult’s decision-making ability in pressured situations that are emotionally-charged and time-constrained, such as in these judicial bypass procedures. The heart of the maturity and informed consent issue, however, would appear to be: the adolescent is capable of making a rational, well-informed decision that is consistent with her personal values and she has not been coerced or influenced by others or the emotionality of the situation.

Although mental health professionals may be familiar with the general concept of informed consent, adolescent informed consent is complex and empirical data is limited. Thus, when evaluating Jane Doe, a mental health professional may apply general principles of informed consent, such as ascertaining whether or not the decision is made voluntarily, knowingly, and with sufficient decision-making capacity. Specifically, the mental health professional may consider: 1) whether or not the minor believes she is being forced into getting an abortion; 2) her understanding of her options, including abortion, adoption, and keeping her baby; 3) how well she appreciates each option’s risks, benefits, and consequences; and 4) the presence of any impairment in her reasoning.

In the process of assessing informed consent, mental health providers must be familiar with the risks involved with abortion and decide how much of this information

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Sexual Assault: Forensic Nursing and Psychiatry Address Offenders and Victims

Alan R. Felthous MD, Committee on Liaison with Forensic Sciences

Sexual assault presents forensic issues concerning both offenders and their victims, requiring focused attention from various forensic disciplines including criminalistics, pathology, odontology, physical anthropology and toxicology. Forensic nursing and psychiatry addressed forensic and clinical aspects of sexual assault at the annual Forensic Sampler, during the AAPL Meeting in Boston. Dean DeCrisce MD, member of AAPL and the Psychiatry and Behavioral Science Section of the American Academy of Psychiatry and the Law, summarized diagnostic and pathological dimensions of the offender. Forensic Clinical Nurse Specialist Constance A. Hoyt MSN, RN, FAAFS, from the General Section, AAFS, explained the examination of rape victims and suspected offenders as well as the proper collection of forensic evidence.

The forensic psychiatrist should meticulously investigate evidence and discriminate between true paraphilia and other potential causes for sexual misconduct, stressed Dr. DeCrisce. Sexual psychopathology is so protean, there must be over a hundred different paraphilias, but only a limited number are recognized in the DSM. Yet most who commit a sexual offense do not have a paraphilia. Sexually offending behavior can be committed by individuals with antisocial personality disorder or an “antisocial attitude.” It is important to examine in detail the sexual offending behavior itself as well as the events leading up to and following after it, with special attention given to the psychology and motivation of the offender. The antisocial offender may first attempt conventional seduction for sexual involvement and use coercion only if his initial attempts fail. In contrast the paraphilic rapist seeks control, terror or suffering as essen-

tial to sexual gratification. Therefore conventional styles of courtship are of no interest to the paraphilic rapist.

In anticipating the DSM 5’s definition of certain paraphilias based on the number of sexual acts of a particular paraphilia, Dr. DeCrisce questioned whether for some diagnoses the absolute number was too arbitrary. Some forms of psychopathology should be recognized and addressed before the number of victims climbs.

The sexual assault exam should be conducted by a qualified forensic examiner, SANE-A or SANE-P (Sexual Assault Nurse Examiner Adult/Adolescent, Pediatric) stated Ms. Hoyt. Exams should be done on both the victim and the suspected perpetrator, the latter more easily accom-

“Yet most who commit a sexual offense do not have a paraphilia.”

plished if he is in custody. In some states reporting rape is mandatory. The victim’s name is known and is brought to the examination center by a law enforcement officer. (In these jurisdictions, the jurisdiction provides funds for the maintenance of the centers.) In Massachusetts reporting is not mandatory, and the Sexual Assault Examination Kit is identified by code numbers which are affixed on the evidence kit which is taken by a Law Enforcement officer to the State Crime Lab. The code numbers are placed in the victim’s hospital record and the record must be subpoenaed. While the kit is in the possession of the crime lab, the victim remains anonymous.

With photographic illustrations, Ms. Hoyt gave examples of examina-

tion methods and useful findings. Characteristic perianal lacerations, for example, are consistent with forceful anal penetration. Staining by Toluidine blue dye of the mucous membrane can help to identify physical trauma, although false positives are possible. Other examples are “patterned injuries,” hematomas, abrasions and lacerations that suggest forcible oral penetration, consistent with “oral copulation.” Such patterned injuries can be recognized by prepared examiners and must be photographed.

Many adolescent girls report having been raped after drinking alcohol and placing themselves in vulnerable situations, which some men will exploit.

Women have also acted as sexual offenders. For male suspects the exam consists of obtaining a detailed medical history, swabbing the penis, anus, scrotum and mouth, and photographing lesions and any identifying tattoos, moles, lesions obtained while alive or scratches and markings made by victims.

Consent to be examined is important as are separate consents to be photographed and to authorize presentation of the findings in court. The victim is given several weeks’ time to decide if the case is to be prosecuted. For proper examination of the perineum the woman is placed in the lithotomy position and a speculum exam is performed. Adjuncts to the exam may be a colposcope equipped with a camera and a TV screen, and the use of a forensic light source with appropriate goggles to detect fluorescence of semen and seminal fluid upon the victim and on the victim’s clothing, though with a risk of false positives. This helps the examiner to pinpoint the areas to be swabbed. The examiner must become familiar with anatomical landmarks which are not likely to be familiar to a general clinician. These terms are used to identify normal anatomy and to document abnormal findings and trauma.

The exam itself can take up to three or even five hours. Specimens

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Letter to the Editor

Dear Dr. Dike,

I read with some interest the report of the Committee on Trauma and Stress regarding the proposed criteria for PTSD being considered for DSM-5. I was pleased with the Committee's comments especially regarding proposed revisions which will be more restrictive concerning the type of threats that qualify as the potential basis for causing PTSD. The "learning about" component while improved with these proposed revisions still has the potential for labeling individuals as having experienced PTSD who perhaps should not be grouped in with others who have experienced combat, rape or armed robbery. I certainly share the Committee's concerns with respect to the concept of "actual or threatened sexual violation" as a qualifying event for PTSD. The magnitude of the threat is something that we all know makes a difference. Improperly asking a supervisee out on a date is certainly different than a rape which takes place on a company sponsored business trip.

Like many of my colleagues, I am concerned that frivolous claims will continue as long as the fields of psychiatry and psychology assign individuals subjected to vastly different severities of psychological stressors to essentially the same category of diagnosis. Aside from medical-legal concerns, whether involving civil or criminal issues, there are research implications as well. Studying individuals who genuinely are struggling with what we can all agree to be PTSD in with others who might better be viewed as having an adjustment disorder or some type of hysterical reaction will produce findings regarding more heterogeneous populations leading to less powerful research outcomes. Simply put, we have the potential for less than stringent criteria leading to "garbage in, garbage out."

I would like to thank Dr. Kleinman and the Committee on Trauma and Stress for their review of the pro-

posed revisions to the diagnosis of post-traumatic stress disorder.

Sincerely,

Robert C. Larsen MD, MPH
Clinical Professor, Department of
Psychiatry
UCSF School of Medicine ☎

Sexual Assault

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collected with swabs must be air dried before they are placed in a container. This means additional time after the physical exam is completed. All of the clothing worn by the victim are preserved in paper evidence bags to be sent with the evidence kit to the Crime Lab, and appropriate clothing stocked at the center is given to the patient to be worn for discharge from the facility. Subjects should be tested for HIV and other sexually transmitted diseases. Prophylactic medicine for pregnancy may be indicated. In Massachusetts HIV results are to be handled confidentially and delivered only by the physician.

If injuries are present the victim should be re-examined at a later time to monitor healing, answer further questions and make appropriate referrals as necessary. In a group of victims who were allowed to observe their anatomy and injuries on the TV screen during colposcopy, the women suffered much less abdominal pain during convalescence.

The presumptive victim of rape is referred to a patient advocate who will look into her therapeutic needs and attend to her in court. The Sexual Assault Response Team (SART) which consists of a physician, a police officer, a nurse, the victim advocate, and a representative from the criminal justice system once activated, assesses how the victim is coping, arranges for a medical follow-up check and makes appropriate referrals to trauma counseling specialists. If the police is not already involved, the victim is referred as well to law enforcement, having been advised of

her rights in advance.

Upon intake into the examining facility, victims are not permitted to rinse their mouths, smoke, eat, brush their teeth, urinate, shower or douche so as not to destroy evidentiary specimens. Sperm can live up to five days in the vaginal vault or 72 hours in the oral cavity, even after eating or mouth rinsing. Thus, an exam need not be conducted immediately after assault to be useful, though the sooner to the time of assault the better the specimen retrieval.

Dr. Weinstock, who moderated the panel, as well as Dr. DeCrisce, pointed to the benefits of participating in AAFS with its eleven forensic sections/disciplines. The Liaison with Forensic Sciences Committee has selected Manuel Lopez-Leon MD, and Karen Rosenbaum MD, as co-chairs of forthcoming Forensic Samplers. Congratulations to both! ☎

Angela Hegarty

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ture and culture the approach grounds places and people in narrative and lore. Increasingly, it is a part of the discussion of rhetorical tools available to forensic psychiatry, as those who write reports or prepare testimony use what some call "a weaving of fact and interpretation." It is an approach that recognizes the subjectivity reflected in one's point of view, the choices to include or exclude history, or to emphasize or de-emphasize information. In the evolution of forensic practice, Dr. Hegarty's approach represents a practical way of putting one's own values under scrutiny and exploring how they affect one's reports and testimony. It allows self-reflection to inform evaluations that are often held up as purely objective. Yet the conceptual tool-kit that recognizes a narrative subjectivity in the story of the evaluatee does more than enrich the evaluation's objective focus. It demonstrates the often indistinguishable difference between them. ☎

Jane Doe

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they expect the evaluatee to know. Conflicting literature exists, including studies that suggest abortion increases mental health problems⁶, and studies that suggest childbirth, more than abortion, increases mental health problems. Studies are often limited by an inconsistent definition of “mental health problems,” by inconsistent baseline demographic and psychosocial factors between comparison groups, and by not comparing those who have an abortion with those who have an unwanted child.⁷ Overall, insufficient evidence exists to conclude that abortion of an unwanted pregnancy is a significant risk factor for psychiatric illness. Studies indicate that abortion does not cause psychosocial problems; rather, psychosocial problems play a role in unwanted pregnancies and in the decision to abort unwanted pregnancies^{7,8}. Having a previous psychiatric history remains the most consistent predictor of post-abortion mental health issues.

Compared to other forensic evaluations, Jane Doe evaluations are fraught with unique disadvantages due to time constraints and the absence of collateral information. By statute, judicial bypasses must be heard within days of filing, creating significant limitations. Evaluations often occur the same day of the hearing. Psychological testing is usually not available; however, even if it were, it would be of dubious value because emotional maturity is not explored in most personality measures. Collateral information is also not available due to the anonymous nature of the proceeding. Without the ability to verify information provided by Jane Doe or to gauge her maturity and functioning in the community, the evaluator is left with whatever information can be garnered through the interview process.

Future research should investigate the difference in characteristics between teenagers who are successful and who are unsuccessful in obtaining judicial bypass for abortion, because it has not been well-described in the

literature. Those seeking judicial bypass for abortion are likely quite different from teenagers who have experienced denial or concealment of their pregnancies, because they are pro-active in noting their pregnancy and decision-making. ☯

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Victims or Criminals?

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are predators. Society and the legal system need to act accordingly. The change that is underway should continue. States should enact laws not only to prevent prosecution of these victims, but also to provide resources to support them in their efforts to heal and rehabilitate^{13, 14}. ☯

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Research Survey

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fields. We will be pursuing expanded linkages and support in the months ahead.

One aspect of this is the recently-approved appointment of the Chair of the AAPL Research Committee to participate with the AAPL Institute for Research and Education (AIER) Research Committee. It is expected that this new collaboration will further enhance the research productivity of AAPL's members and support AAPL's ability to continue leading the development and growth of the field of Forensic Psychiatry. ☎

MDO

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Victims or Criminals?

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95-128. <http://ir.stthomas.edu/cgi/viewcontent.cgi?article=1178&context=ustlj>

Dr. Downer is with the Department of Psychiatry, Albert Einstein College of Medicine; Dr. Suardi is with the Division of Child Psychiatry, Georgetown University; Mr. Phillips is a retired federal law enforcement agent and is pursuing his Ph.D.

FORENSIC PSYCHIATRISTS

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

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Nominations for AAPL Sought

The Nominating Committee of AAPL will be presenting a slate of Officers and Council candidates at the Semiannual Business Meeting in May, 2012.

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 Charles Scott, MD, Chair, Nominating Committee, AAPL, P.O. Box 30, Bloomfield, CT 06002 by March 31, 2012. ☎

MUSE & VIEWS

Funny Insurance Claim Form Submissions

The claimant had collided with a cow. The questions and answers on the claim form were

Q: What warning was given by you?

A: Horn.

Q: What warning was given by the other party?

A: Moo

“The car in front hit the pedestrian but he got up so I hit him again”

“I pulled away from the side of the road, glanced at my mother-in-law and headed over the embankment.”

Source: <http://www.businessballs.com/insuranceclaims.htm>

Submitted by Charles L. Scott MD

FORENSIC PSYCHIATRY FELLOWSHIP DIRECTOR

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



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



Make plans now!

AAPL activities at the APA Annual Meeting

Saturday, May 5

Committee Meetings

Reception for Committee Members

Loews Hotel, Philadelphia, PA

Sunday, May 6

Semiannual Business Meeting

Guttmacher Lecture

Room 113A-C, Level 1, Pennsylvania Convention Center



AAPL Newsletter

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HIGHLIGHTS

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