ETHICS CHALLENGES IN FORENSIC PSYCHIATRY AND PSYCHOLOGY PRACTICE

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To Madelon V. Baranoski and John L. Young, who taught me much about forensic ethics
And to Chester Middlebrook Pierce, a friend and mentor

INTRODUCTION

Ezra E. H. Griffith

PSYCHIATRY, PSYCHOLOGY, AND THE LAW have interacted for many years. Psychiatrists, for example, wrote about their experiences in U.S. courts in the nineteenth century and raised questions about the quality of the testimony at that time. But the formation of the American Academy of Psychiatry and the Law (AAPL), announcing the formal establishment of the new discipline of forensic psychiatry, did not occur until 1969. It was not until 1994 that candidates sat for the first examination that would lead to specialty certification in forensic psychiatry. In comparison, the American Board of Forensic Psychology (ABFP) was established in 1978 to create standards and qualifications for the practice of forensic psychology. The American Board of Professional Psychology (ABPP) was formed in 1947 to certify candidates seeking specialty qualifications in psychology. Formal forensic practice carried out by these two groups was born relatively recently and has taken time to mature, in a process that has not always been easy.

As these two young disciplines have taken form, academics and others have raised questions along the way about the ethics bases of their practice. The implication was that the ethics-based traditions that had guided the clinical practice of psychiatry and psychology could not serve the new forensic subspecialties. Some academic theorists questioned the very presence of psychiatrists and psychologists in the courtroom. This position rattled the developing fields and stimulated sustained reflection on the interaction of ethics and forensic practice.

This volume is a direct contribution to that continuing discourse and is designed to focus on a discussion of ethics dilemmas encountered by practicing forensic psychiatrists and psychologists. But this book should also be useful to forensic social workers, forensic counselors, and mitigation specialists. The

chapter authors have extensive experience in the dual areas of forensic practice and ethics.

Part 1 of this book, "Approaches to Solving Ethics Problems in Forensic Practice," begins with a review of established approaches to the solving of ethics problems. The next chapter highlights the important sociocultural factor of feminism, which has left a durable imprint on the ethics of forensic practice and on approaches to solving ethics dilemmas. Chapter 3 considers the difficulty of formulating ethics answers when there are few established human and material resources available to practitioners to facilitate a discussion of ethics challenges and their potential resolution. Chapter 4 presents contemporary discussion of the ubiquitous problem of dual allegiances, the challenge of "wearing two hats," or serving two masters, which permeates so much of forensic practice. The final chapter in part 1 discusses objectivity and boundaries of competence as ethics problems in forensic assessments. This first section should stimulate both trainees and practitioners to engage philosophically in conversations about forensic ethics.

Part 2, "Ethics in Major Areas of Forensic Practice," addresses a general method of approaching ethics-based forensic practice in certain subspecialty areas of general psychiatry and psychology. These areas, covered in chapters 6 through 9, constitute work with children and adolescents; work in correctional settings; work in the public sector, where involuntary commitment is often encountered; and work in clinical neuroscience. The task set for each chapter in this section is to describe unique and current ethics problems encountered in one of these specific arenas of forensic practice. The chapters also emphasize how these practice areas require particularized methods of conceptualizing ethics principles that are applicable to the contours of these specialized activities.

In part 3, "Specific Ethics Problems in Forensic Practice," the authors discuss sharply formulated ethics dilemmas encountered in the general practice of forensic psychiatry and psychology. Specific examples are contemplated in the following contexts: the use of psychological tests in forensic assessment, mandated video recording in forensic evaluations, the assessment and care of sex offenders, interaction of the forensic expert and the Internet, the care of Guantánamo detainees, national-security forensic evaluations, interactions of forensic specialists with the media, forensic professionals working with asylum petitioners, the work of violence-risk assessment, the treatment of children, and working in multidisciplinary clinical collaborations. These specific ethics problems were chosen because of their unique educational and practice

dimensions. They do not exhaust the potential list of ethics difficulties encountered by forensic practitioners, but they will serve effectively as exemplars of problems likely to be met in forensic practice while also providing opportunities for practitioners to engage in the consideration and resolution of ethics dilemmas.

This book does not underline specific solutions so that they become bright-line rules of what is ethical or unethical. Instead, the emphasis is on demonstrating methods that will guide practicing forensic specialists as they engage ethics challenges. The first steps in this process are to recognize an ethics dilemma, to weigh competing interests that have led to the dilemma, and then to identify the conflicting obligations. The next step is to formulate a thoughtful approach to creating a solution. In summary, sound ethics practice by a forensic expert is grounded in reasoned formulation of the ethics problem, an approach to thinking through the dilemma, and development of an appropriate way out of the thicket of complexity. The outcome never guarantees agreement from everyone holding a stake in the result. But the proper exercise of reflection and consideration should allow forensic specialists to articulate their conceptualization of the problem, describe the competing interests, and explain how and why they have weighted the different interests and reached some ethics-based behavioral outcome. It is hoped that this fundamental methodological approach to problem solving in ethics is effectively illustrated throughout the text.

Reasoned and thoughtfully framed problem-solving ethics strategies should enhance informed forensic practice. They should also lead to the formulation of ethics-based solutions that are more transparent and understandable to colleagues and those who use forensic services. This text should contribute to conversations about ethics dilemmas commonly encountered in these specialty arenas.

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ETHICS CHALLENGES IN FORENSIC PSYCHIATRY AND PSYCHOLOGY PRACTICE

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RESOLVING ETHICS DILEMMAS IN FORENSIC PRACTICE

William Connor Darby and Robert Weinstock

WE BELIEVE MOST PEOPLE enter the fields of psychiatry and psychology with a desire to act ethically and that most are interested in trying to do the right, or most ethical, action when faced with challenges. This aspiration does not disappear when entering the forensic realm, but it does become more complex when operating at the intersection of law and psychiatry/psychology. To aid practitioners, we will present a method of resolving ethics dilemmas named "dialectical principlism."

Dialectical principlism was developed specifically to help forensic psychiatrists and psychologists face ethics challenges characterized by conflicting duties and opposing principles. The method integrates ethics guidelines such as those from medical and forensic organizations like the American Medical Association (AMA) (2001), American Psychiatric Association (2013, 2014), American Psychological Association (2010), American Academy of Psychiatry and the Law (AAPL) (2005, 2013), and American Academy of Forensic Sciences (AAFS); ethics theories such as principlism, casuistry, narrative, ethics of caring, and normative ethics; and ethics models specific to forensic professionals such as the principlism approach of Appelbaum (1997), the robust professionalism of Candilis and Martinez (2001), and the narrative approach of Griffith (1998).

We will demonstrate the special features of dialectical principlism, including how it affords the balancing of conflicting ethics criteria in determining the most ethical action. The framework strives to achieve this goal by prioritizing ethics considerations according to a practitioner's specific professional role. We distinguish between "primary" and "secondary" duties to highlight how the model weighs principles in a manner dependent on the role of the practitioner. For example, a practitioner in a treatment role has a different set

of primary duties from one in a forensic role, and, thus, a different calculus occurs in these two settings.

The context of the situation and the unique set of personal, cultural, and societal values created from a practitioner's narrative are used to assign weights to primary and secondary duty principles. Finally, these principles are balanced by using the reflective-equilibrium method of Rawls (1971) to decide on what is the most ethical action for that *specific* individual, in that *specific* role, given that *specific* situation. A hypothetical ethics dilemma will be used to illustrate how dialectical principlism works practically and accomplishes this end.

SPECIAL ETHICS CONSIDERATIONS AT THE INTERSECTION OF LAW AND PSYCHIATRY/PSYCHOLOGY

Ethics in forensic work for psychiatrists and psychologists presents special challenges. That is because it operates at the intersection of two disparate fields. Psychiatry is a branch of medicine, with patient welfare as its primary concern. Treating psychologists also prioritize their clients' welfare. In the legal system, on the other hand, the major focus is to settle disputes and achieve legal justice. When engaged in forensic practice, forensic professionals bring to the legal system their own methods, goals, rules, ethics, and values, which are distinct from those of the legal system. Ethics dilemmas may arise when the ethics principles and rules that govern forensic practice are in conflict with those that govern lawyers. Ethics dilemmas also occur when the ethics principles relevant to forensic practice are themselves in conflict, thereby creating questions about which principles to prioritize.

ORGANIZATIONAL GUIDELINES

To help forensic experts facing these conflicting obligations to the law and their practice, many organizations have ethics guidelines applying to forensic work that frame the boundaries of what is or is not ethical practice. These organizations include the AMA, American Psychiatric Association, American Psychological Association, AAPL, and AAFS. For example, AAPL requires that practitioners be honest and strive for objectivity in their forensic reports and testimony (American Academy of Psychiatry and the Law 2005), and AAFS guidelines preclude the distortion of a practitioner's qualifications, experience, and data.

Ethics dilemmas occur when practitioners encounter competing guidelines. If one guideline is completely neglected for another, then the risk for unethical action increases. That is, following any guideline rigidly while neglecting all others is potentially problematic; such actions may cause conflict with other duties, other responsibilities, and even other guidelines.

For example, a forensic expert could disregard the ethical problem of the potential for misleading the person being evaluated by omitting an explanation of his role and purpose of the examination in order to obtain the most honest and objective conclusion to the legal question. But this would mean being dishonest with the evaluee and not showing him respect. This example illustrates how attempting to adhere to only one guideline to the exclusion of all others risks violating fundamental ethics values. Familiarity with the guidelines is important so that practitioners can adhere to them and identify when conflicts exist. Such situations require determining which guidelines to prioritize. This process of prioritizing may subsequently lead to different conclusions on how to act most ethically.

To deal with the problems related to conflicting ethics guidelines, forensic experts may implement relevant ethics theories and models to help lay out and emphasize what criteria should be considered.

ETHICS THEORIES PERTINENT TO FORENSIC PSYCHIATRY AND PSYCHOLOGY

Some of the major ethics theories relevant to forensic work are normative ethics (including virtue, deontology, and consequentialism), ethics of caring, principlism, narrative, and casuistry (closely related to and possibly including narrative).

Virtue ethics originated in the virtues delineated by Plato and Aristotle. In recent years, it has had a resurgence, emphasizing the need to have moral character in order to behave ethically and to be reflected in the usual practice of virtuous professionals (Candilis, Weinstock, and Martinez 2007). That is, it is insufficient simply to have been educated on ethics theories or aware of the important considerations; it is also necessary to have moral character and the intent or desire to carry out the right action.

Other types of normative ethics include duty (deontological ethics) and consequentialism (utilitarian ethics). Consequentialism contends broadly that the morality of an action be judged based on its consequences: the right action is the one that produces the best outcome or does the most good (Hope 2004).

Deontological ethics, on the other hand, judges the morality of an action based on rules such as "always tell the truth." For example, a deontologist might argue that it is never moral to lie or not to tell the whole truth and also that it is never ethical to kill a person (Hope 2004).

There are limits to how far either of these methods alone can rule and determine our most ethical action. For example, most would disagree with killing one person to harvest his organs so that a number of other people could live; nevertheless, doing so could be argued as an extension of consequentialism. But in this situation, the strong deontological principle of not killing others would be determinative. In a parallel manner, strictly adhering to deontological ethics values alone might lead to serious consequences, such as when the Gestapo in Nazi Germany asks where to find hiding Jews and not lying would lead to their capture and torture.

There is also Gilligan's (1982) ethics of caring, which is in part an outgrowth of feminist ethics. It is an alternative to the developmental principlist model of Kohlberg for moral development. Kohlberg (1984) considered thinking in terms of principles to explain that the morality of an action is the highest stage of moral development and that most people never achieve it. But it has been argued that this can lead to a "cold" kind of morality. That is, should we as individuals in contrast to society really aspire to treat all people the same? Should we give our family, our friends, and ourselves no more consideration than anybody else?

The two major conceptions of the practice of bioethics include principlism and casuistry (Cudney 2014). Modern principlism such as that proposed by Beauchamp and Childress (2013) involves balancing context-dependent conflicting principles. Contemporary advocates of casuistry such as Jonsen and Toulmin (1988) argue for a more "bottom-up" approach of starting from paradigm cases and then drawing the relevant principles, rights, and rules to apply to new cases (Paulo 2015).

Beauchamp and Childress (2013) developed four principles of biomedical ethics: autonomy, beneficence, nonmaleficence, and distributive justice. Distributive justice is not legal justice. It refers specifically to the fair allocation of limited medical resources. There have been incremental revisions of their views in the various editions of their book. In the 2013 edition, they clearly assert that common morality is relevant. When the four principles of medical ethics conflict with one another or with common morality, they assert that they need to be balanced using Rawls's reflective equilibrium to determine the most ethical action.

Principlism is often contrasted with casuistry (or a version of it called narrative). Casuistry in the past was used pejoratively and equated with ethical relativism devoid of higher principles and theory. Modern casuistry and principlism have been moving closer to each other in recent years (Cudney 2014).

In modern casuistry, paradigm cases are developed. When faced with a new situation, a paradigm case is selected with a similar ethics dilemma implying a similar solution. It is not unusual, however, for disagreements to arise regarding how much weight to apply to one facet of the case over another and which paradigm to use. This requires identifying the relevant facets to consider. These facets can then be weighed using the reflective-equilibrium method of Rawls as described by Beauchamp and Childress (2013) and becomes similar to the methods employed by principlists who apply and balance mid-level principles.

MODELS OF FORENSIC PROFESSIONAL ETHICS

In forensic professional ethics, principlism has best been applied by Appelbaum. In a response to Stone's (1984) challenge to provide an ethics framework for the field, Appelbaum (1997, 2008) developed principles for forensic psychiatry to distinguish it from treatment psychiatry. Appelbaum claimed that ethics requirements are determined by the role of the profession. In forensic psychiatry, the goal is to promote legal justice. That goal is fostered ethically by subjective and objective truth telling as well as by demonstrating respect for persons.

Although Appelbaum's model accurately defines the principles to help practitioners act ethically in most forensic contexts, there are some limitations on how it can guide ethical behavior. An example is which principle should take precedence in his model when they collide. For illustration, what do we do when fostering justice comes into conflict with showing respect for persons? Should we intervene when the legal system is not showing respect for the evaluee? Should we reject a case if we think the goal of an attorney is inappropriate or unethical, even if allowed by the law? That is, does answering the legal question honestly trump respecting persons when these conflict, or vice versa?

Appelbaum appropriately cautioned that forensic psychiatrists risk misleading the evaluee when they simultaneously adhere to the duties of a forensic role while also taking the ethical position of a treating psychiatrist, what he

calls a "mixed model" (Appelbaum 1997). The rationale is that an evaluee can mistake the forensic psychiatrist as trying to help him even when hired by the prosecution. He contended that the risk is greatest if the psychiatrist him- or herself is confused as a result of considering traditional medical-ethics principles as relevant in a case. Although these are valid criticisms, Appelbaum did not directly address whether there is any place for traditional medical ethics in forensic psychiatric work.

Another forensic-ethics model, robust professionalism, does assert a role for traditional medical ethics in the field (Candilis, Martinez, and Dording 2001; Martinez and Candilis 2005; Candilis 2011; Candilis and Martinez 2011). In their model, the forensic professional acts most ethically by going beyond just answering the legal question to include efforts to resolve underlying conflicts and problems that benefit the individual being assessed. For example, this model could be used to achieve the most ethical outcome when consulted to make end-of-life decisions involving initial conflict between patient and family (Candilis, Weinstock, and Martinez 2007). These theorists argued that going beyond the narrowly defined forensic role is a central tenet of the forensic practitioner's robust professional duty and not merely an afterthought.

Robust professionalism has elements related to narrative in that they both assert that as more information about the situation is obtained, the most ethical action becomes apparent. However, similar to Appelbaum's principlism model, robust professionalism does not clearly address how a forensic expert should resolve conflicting ethics considerations. It also is not evident whether Candilis and Martinez develop paradigm cases or principles to compare and apply to new cases as in modern casuistry and whether their model implements Rawls's reflective equilibrium in the balancing process seen in modern principlism.

Griffith (1998, 2003, 2005) developed a narrative model to help guide ethical behavior in forensic work. His model is a way to determine what is ethical in a case by fleshing out details, motivation, and background with a cultural formulation. It includes an emphasis on cultural considerations and the special problems faced by nondominant groups. Norko (2005) advocated for compassion to be part of the narrative of an ethical forensic assessment, even if the evaluation leads to an opinion not helping the person evaluated.

Narrative clearly plays an important role in ethics analysis when no conflicting obligations exist. But when faced with conflicting duty considerations in forensic work (e.g., answering the legal question, showing respect for persons, consideration of cultural factors, societal discrimination, biomedical

ethics principles related to the evaluee), narrative alone does not necessarily guide decision making, because it is not clear what considerations take primacy in the forensic context. To address this issue, Griffith (2016) endorsed an integrative approach of applying principlism to his narrative model in order to better resolve these types of complex dilemmas, a strategy similar to dialectical principlism.

DIALECTICAL PRINCIPLISM

Dialectical principlism is our method of laying out, prioritizing, and balancing conflicting ethics considerations to help practitioners act most ethically (Weinstock 2015). This model builds from and encompasses all the aforementioned ethics models, theories, and guidelines. For example, narrative is an essential component of this ethics analysis. It is the starting point from which to ascertain the relevant role and is used to assign weights to the principles based on contextual factors and the practitioner's unique personal ethics and values. Appelbaum's principlism is paramount to defining the "primary duty principles" for the role of forensic expert. Robust professionalism highlights the importance of ethics considerations outside a narrowly defined forensic role, what dialectical principlism refers to as "secondary duty principles." The balancing process of our model is essentially Rawls's reflective equilibrium and has similarities to Dworkin's (1986) model of legal interpretivism.

Although incorporating other models, dialectical principlism differs by establishing a hierarchy of ethics considerations prioritized according to the role of the practitioner. We distinguish primary from secondary duties based on professional role and then weigh the relevant principles accordingly in the reflective equilibrium-like balancing process. The conflicting considerations could be conflicting ethics guidelines, theories, or models.

PRINCIPLISM UNDER THE MODEL OF DIALECTICAL PRINCIPLISM

Under the dialectical-principlism model, "principlism" refers to the emphasis on principles in the broadest sense of the term. Principles include meeting the duties as prioritized for a specific role and context; principles of professional ethics, which may be influenced by organizational guidelines; principles of

personal ethics and values that may be shaped by various ethics theories; societal expectations for the specific professional role; and culturally based principles distinctive to individual practitioners and set by their unique personal and professional narrative.

THREE FACTORS DETERMINING WEIGHT OF PRINCIPLES IN DIALECTICAL PRINCIPLISM

Dialectical principlism assigns weighted values to principles based on the practitioner's professional role, the specific context of the situation, and the unique set of personal, cultural, and societal values created from an individual's unique narrative.

Dialectical principlism demarcates primary versus secondary duties dependent on the practitioner's role. In the treatment setting, primary duty principles differ from that of other roles such as forensic, research, or the managed-care reviewer.

Under the dialectical-principlism model, treating clinicians have a primary duty centered on patient welfare (following Beauchamp and Childress's principles of autonomy, beneficence, and nonmaleficence) and secondary duties to public welfare, society, hospitals, and the Beauchamp and Childress principle of distributive justice, among others. Forensic practitioners, on the other hand, have Appelbaum's primary duties to answer legal questions truthfully and honestly while showing respect for persons to achieve legal justice. In our model, they also have secondary duties to the person being evaluated, to the retaining attorney, and to the practitioner's personal ethics and values. Researchers have conflicting duties: the primary duty of advancing their studies and the secondary duties of safety for their research participants; they also face the risks of patients overly trusting them. Managed-care reviewers have a realistic primary duty to save money with secondary duties to patient welfare (despite contrary claims).

The principles most relevant to the primary duty as defined by the practitioner's specific role are given special weight in the balancing process, leading them to outweigh all other principles most of the time. Thus, this distinction between primary and secondary duty principles aids practitioners in ethical decision making when multiple principles conflict.

Dialectical principlism is not rigid in the sense that role, while very significant, is not the only factor weighting the principles against one another. The

context of the situation is also a relevant component. Unusually strong secondary duty principles occasionally can outweigh primary ones and become determinative of what we consider our most ethical action. This is not unique to forensic contexts. For example, in the treatment setting, the primary duty principles related to patient welfare can be outweighed by secondary duties to protect third parties. Examples are child- and elder-abuse reporting to protect the most vulnerable in our society or when the Tarasoff requirement to protect another's safety is triggered by the credible threat of imminent violence.

A third component that affects the weight assigned to each principle is the unique narrative of the practitioner, which defines his set of personal and cultural values and beliefs regarding societal expectations of his professional role. It is permissible under the model for forensic professionals to disagree on the ultimate solution to an ethics dilemma as a result of weighing the considerations differently based on unique reactions to an evaluee's narrative. Forensic experts may also disagree as a result of one practitioner's considering an aspect relevant, while another ignores this aspect completely. This third factor is consistent with what Griffith (2016) asserted under his narrative model.

DIALECTICS IN DIALECTICAL PRINCIPLISM

"Dialectics" refers to the balancing of competing principles to arrive at a synthesis of these considerations in order to direct action. This is akin to the reflective-equilibrium model of Rawls (1971).

HYPOTHETICAL CASE

The following case illustrates how dialectical principlism can guide a forensic professional's most ethical action regarding whether to remind an evaluee of his or her professional role and purpose in a forensic evaluation when there is evidence that the original explanation was not fully understood.

A forensic psychiatrist hired by the prosecution is evaluating the defendant male in a capital-murder trial. She initially describes her role and purpose at the outset of the interview, including that she was hired by the prosecution. Later in the interview process, the evaluee demonstrates a lack of understanding of this advisement. The

"CONTINUED"

defendant comments, "I know that you are trying to help me, Doc, so let me tell you what happened." The defendant pauses to take a breath, and before he continues, the forensic psychiatrist has the opportunity to clarify the professional's role and the purpose of the interview and to correct any misunderstanding.

Would you as the forensic psychiatrist actively at this point try to clarify your role, or would you passively allow the defendant, who likely has confusion about your role, incriminate himself? Would allowing the misled defendant to continue uninterrupted accomplish the end of fostering legal justice?

APPLYING DIALECTICAL PRINCIPLISM TO THE HYPOTHETICAL

PRESUMPTIVE PRIMARY DUTIES AND RELEVANT SECONDARY DUTIES

It follows in dialectical principlism that the forensic psychiatrist in this hypothetical would start with the specific context to determine her primary duties as well as any relevant secondary ones. The role is a forensic one in this scenario. Under dialectical principlism, Appelbaum's model of fostering legal justice is applied and is the forensic psychiatrist's relevant primary duty in this situation. Secondary duties are related to the retaining attorney, the person being evaluated, and the individual psychiatrist's own personal ethics, values, and societal expectations of physicians. The principles related to primary duties are generally given more weight than secondary ones in the balancing process. But a strong secondary duty can override a weaker primary one in certain contexts.

EXTRACT ETHICS PRINCIPLES PRIORITIZED BY PRIMARY VERSUS SECONDARY DUTIES

Next, the relevant ethics principles are extracted from the narrative of the situation and prioritized based on primary versus secondary duties. In this example, the principles related to the primary duty that would guide the psychiatrist's action would be to meet duties specific to the forensic role and abide by professional forensic-ethics guidelines. That is, significant weight would be given to the professional-ethics principles related to the primary forensic duty of fostering justice and answering legal questions truthfully. AAPL's organizational-ethics guidelines of being honest and striving for objectivity give guidance, as does the AAFS's guideline of not distorting data. Additionally, the primary principle of respect for persons is pertinent to not purposely or intentionally

mislead the evaluee into erroneously believing that the forensic psychiatrist's role here is to help him.

Biomedical-ethics principles related to the person being evaluated are secondary in the forensic role under the dialectical-principlism model. In this example, the relevant Beauchamp and Childress biomedical-ethics principles related to the psychiatrist's secondary forensic duty to the person being evaluated include autonomy, beneficence, and nonmaleficence. Dialectical principlism holds that the forensic psychiatrist in pursuit of fostering legal justice can violate principles of beneficence and nonmaleficence as it relates to the evaluee because sometimes answering the legal question honestly means that the evaluee will suffer punitive consequences—an intrinsic part of the forensic role. But this does not mean that there is an absolute relinquishing of these other principles in the forensic role. Dialectical principlism would designate these medical-ethics principles as secondary and thus less likely to be determinative of the most ethical action most of the time, except for certain scenarios where they can be overriding. Even when these secondary duties are outweighed by the primary one, they may nevertheless exert some influence. Therefore, they are still important to consider in the balancing process.

Autonomy refers to an individual's right to make decisions without coercion. It emphasizes the importance of respect for persons (Beauchamp and Childress 2013). It overlaps with the primary duty principle of Appelbaum's respect for persons—important in our analysis. Autonomy is relevant because the evaluee confuses the role of the forensic psychiatrist, saying that she is "on my side" when in fact she was hired by the prosecution. In order for the defendant to have true autonomy, the forensic psychiatrist would have to reinform him of her role as a forensic psychiatrist hired by the other side and emphasize that she is not his personal physician in a treatment capacity. It is important to explore and clarify the misunderstanding of the initial advisement. The secondary duty principles of beneficence (doing good) and nonmaleficence (not doing harm) would also favor clarifying the forensic role before the defendant has the opportunity to incriminate himself because he misunderstands the forensic psychiatrist's role.

WEIGH AND BALANCE COMPETING AND CONFLICTING PRINCIPLES

The argument for not interrupting to clarify the forensic role again is that legal justice is arguably best served that way. The evaluee's mistaken belief that she is there to help him may result in a more honest and less skewed interview than

if he was reminded again of her true role. Thus, this action of allowing the evaluee to continue might place the forensic psychiatrist in the best position to foster justice by answering the legal question most honestly; it also satisfies a secondary professional duty to the prosecuting attorney who hired her.

But by not correcting the role confusion, the forensic psychiatrist would violate the primary duty principle of respect for persons. She would also not be acting in conformance with societal expectations of her professional role as a physician—a secondary ethics duty in this context. Other secondary duty principles to the person evaluated regarding autonomy, beneficence, and nonmaleficence also go in favor of addressing the slippage of the original advisement.

In Appelbaum's principlism, the question of what to do when answering the legal question honestly conflicts with showing respect for persons is only partially addressed. He clarified (1997) that an initial warning is required by respect for persons but does not guide on how to act when encountering evidence that the initial warning was not fully understood. AAPL ethics guidelines also require such disclosure at the outset, but the most recent version is silent about the issue our hypothetical raises (American Academy of Psychiatry and the Law 2005). This example highlights the dilemma for the forensic psychiatrist in determining which principles take precedence. Applying dialectical principlism to this hypothetical, we would assign equal weight to the primary duty principles of answering the legal question honestly and showing respect for persons so that they in effect cancel each other out.

In this case, we weigh the primary duty principles equally for several reasons, underscoring how situational context is crucial in determining the weights of each principle. It is clear from the description that the evaluee has not registered or did not understand the forensic psychiatrist's initial advisement. Although the forensic psychiatrist did not purposely deceive or mislead the defendant, we assert that not interrupting and clarifying her role now, given the clear confusion, would be as unethical as not initially giving the advisement, regardless of what is legally or professionally acceptable.

We do not universally endorse stopping all evaluees from incriminating themselves, but specifically in this context it is a direct result of role confusion. If it were unlikely role confusion had occurred, or if the defendant was doing this for another reason, we might weigh the relative cost of not showing respect for persons as less than the benefit of fostering justice by answering the legal question with the most truthful information.

This consideration would also be very different if you were in the role of police detective or prosecuting attorney, as you would not have the same societal expectations of your profession and would not be bound by the same stringent professional-ethics duties of honesty, striving for objectivity, and not distorting data as a forensic psychiatrist. A police-officer role does not mandate a second Miranda warning to a person arrested, even if it became clear that the person did not fully comprehend the initial warning. In fact, some police officers might even give a Miranda warning in a rote way, hoping it will not be understood, so as to foster the possibility for self-incrimination. Forensic psychiatrists, by having the title of physician and given the societal expectations of physicians doing good through helping people with medical ailments, risk a defendant's or jury's mistaking or confusing their roles much more than would police officers or prosecuting attorneys. For this reason, we argue that forensic psychiatrists should be more mindful and sensitive to this possibility of role confusion and that they have an ethical responsibility to correct this misunderstanding.

We further assert that it would not be sound ethical reasoning to argue against having such responsibility because a forensic psychiatrist is no longer a "physician" but a "forensicist" with a narrowly defined role. As much as forensic psychiatrists may attempt to remove themselves from the implications of a physician's title, this does not change society's expectations, many potential evaluees' understanding of their role, and the high risk for confusion.

APPLY WEIGHTED CRITERIA TO DETERMINE THE MOST ETHICAL ACTION

It is consistent within the model of dialectical principlism that forensic experts may come to either solution depending on their own unique narrative and set of values and subsequently how they determine which aspects of the specific situation to be most pertinent. This is largely due to how experts weigh the principles differently based on their unique reaction to the narrative of the evaluee. We would balance the competing ethics considerations outlined above to side in favor of reclarifying the forensic role and purpose of the evaluation, including a reminder of being hired by the prosecution. This strikes the best possible balance for us between the conflicting ethics principles.

The primary duty principle of showing respect for persons is maintained, and we do not lose the ability to answer the legal question to foster justice or

fail in fulfilling our duty to the prosecution, despite risking the evaluee's becoming less forthcoming. Because of our secondary medical duties, forensic psychiatrists may come into more conflict with prosecutors than defense attorneys in this regard. Societal expectations of physicians should preclude misleading evaluees, since we would compromise our personal and professional integrity and betray trust in physicians. Thus, another advisement of the purpose of the evaluation is warranted. Although forensic psychologists do not have secondary medical duties, they still possess a duty to show respect for persons and secondary duties to consider a client's welfare, and these duties may lead to the same conclusion in this case.

CONCLUSION

In this chapter, we reviewed the various guidelines, ethics theories, and models that forensic psychiatrists and psychologists may implement when faced with ethics challenges inherent to the field. We illustrated how our method of dialectical principlism can guide ethical decision making in the hypothetical dilemma involving role confusion.

Although we cannot prescribe what to do for all possible dilemmas that may arise for forensic practitioners, dialectical principlism enables professionals to lay out the criteria that should be considered in an ethics analysis and frames how to weigh the relative significance of the criteria based on role, situational context, and the practitioner's personal narrative. Dialectical principlism as a methodology guides forensic experts to identify, prioritize, and balance competing ethics considerations in order to determine the most ethical action in situations without a general consensus. The goal is not merely to avoid professional or legal consequences but to go beyond that with a systematic approach to find the best ways to resolve ethics dilemmas. It is consistent with dialectical principlism that practitioners may come to distinct conclusions on what is most ethical based on individual differences in how they identify, prioritize, and weigh conflicting ethics considerations.

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2

FEMINISM AND FORENSIC ETHICS

Navneet Sidhu and Philip Candilis

"IT WOULD BE IMPLAUSIBLE to maintain that medicine is somehow exempt from broader social dynamics." The words of the bioethicist Susan M. Wolf (1996, 294) describe how societal changes are integral to the practice of medicine, especially in women's health. History provides ample evidence of women's oppression across almost all cultures: the lack of equality, limitation of rights, and prioritization of care-giving roles. Feminism as a social and political movement has consequently been instrumental in bringing change to the lives of many women, from legislation on voting rights and inheritance to case law controlling their reproduction. Certainly, historical oppression of women has been moving toward empowerment, but challenges remain for medical and forensic practitioners and for citizens in general.

The medical field has frequently advocated for empowerment, such as when it weighed in on the criminalization of substance use in pregnancy in states including South Carolina—which applied child-abuse and -endangerment statues to fetuses (ACOG 2011). At other times, medical practitioners have had to match their practice to the whims of the law—such as when mandatory informed-consent laws for those seeking abortions require doctors to provide specific information (Guttmacher Institute 2017). It may be clear that forensic practitioners—affected by risk-assessment and consent practices—are not immune to these pressures.

It is within this tension of empowerment and control that feminist ethics developed as a field and continues to influence medical and forensic practice: it is a tension that requires sensitivity to issues of gender, race, personal narrative, and recognized forms of societal oppression.

BACKGROUND

Traditional ethical approaches, such as the principlism of Beauchamp and Childress in *The Principles of Biomedical Ethics* (2013), have been the guiding approaches in medicine for decades. The classic principles of autonomy, beneficence, nonmaleficence, and justice pervade the culture of medical ethics. Associated values include truth telling, especially as it applies to informed consent; patient-physician privilege and its claims on confidentiality; and respect for persons and its presence in human rights. However, while practitioners use these common frameworks, concerns specific to women and other traditionally oppressed communities such as persons of color or those with disabilities may be overlooked. For example, how does a professional or an agency apportion medical resources between a single pregnant woman and an elderly man? Whose need is greatest? Is there even a valid calculus for this question, or is it a question of values? Or consider the physician describing the risks and benefits of treatment who fails to appreciate the personal, financial, or psychological limitations of the patient. A single mother may refuse or defer treatment because she has no childcare—a scarce resource in many U.S. communities. As noted by feminist writers, such analyses must move beyond existing ethics frameworks to incorporate the history and personal narratives of women and other nondominant groups.

As practitioners, medical and forensic professionals are not isolated from these developments in ethical thinking. For example, physicians are bound to honor the principle of justice, which in medicine can be applied to the fair distribution of finite resources. Yet until the Civil Rights Act, especially Title VI (1964), African American patients were admitted to segregated wards or hospitals, where they received substandard care. Similarly, before the 1973 Supreme Court decision in *Roe v. Wade*, women had little access to reproductive choices. Currently, the uncertainty over the future of the Affordable Care Act has far-reaching implications for the capacity of the medical profession to provide healthcare to poor people.

In forensic practice, legislative changes have an even more direct impact on professional practice. Forensic practitioners are bound by legal statutes in ways that are more specific—forensic specialists must answer specific questions of risk, capacity, and agency posed by the law. The public outcry and legislative reform following the 1982 acquittal of John Hinckley is the cardinal example of regulatory change and its impact on forensic examiners

conducting insanity evaluations (JAAPL 2014). As we shall see, landmark case judgments involving women's rights continue to influence medical and forensic practice—for good or for ill. *Roe v. Wade* is one famous example, but many others, such as *Coker v. Georgia* (1977), which deemed the death penalty to be cruel and unusual punishment for a rapist, have shaped women's rights and forensic practice as well.

SOME RECENT CHALLENGES FOR WOMEN

There are notable civil-commitment cases that afford protection to a fetus when commitment criteria would never be met if the woman were not pregnant. In a seminal 1979 article, Soloff, Jewell, and Roth highlighted the case of a twenty-year-old woman diagnosed with schizophrenia whose civil commitment was ordered until delivery to prevent harm to the fetus. States such as Wisconsin, South Dakota, and Minnesota have authored statutes permitting the civil commitment of a pregnant woman due to the woman's alcohol and drug use (Guttmacher Institute 2000). These are stark examples of *parens patriae* power being exercised over competent adults.

The now overturned conviction of Purvi Patel in 2015 for a feticide based on an old Indiana law sent shockwaves across the globe. Patel bought an abortifacient online (an illegal practice in Indiana) and was initially convicted of feticide (*Purvi Patel v. State of Indiana*). Similarly, child-abuse prosecutions of pregnant women with addictions (Burge 1999) are intrusions into a competent adult's autonomy: they pit the rights of a fetus directly against those of the woman. Legal actions such as these affect the physician-patient relationship because patients may be unwilling to express their concerns and may avoid prenatal care altogether. The professional ethics of practitioners may make adherence to community standards and law difficult, especially in assessments of defendants charged with crimes against a fetus. A physician's primary responsibility to the patient—underscored in decades of pronouncements by professional organizations such as the American Medical Association and American Psychiatric Association—is hindered by this kind of legal climate.

A physician who is required by state law to inform women seeking abortion of the potential risks prioritizes the state mandate over the information that carrying a pregnancy to term carries a much greater mortality risk (8.8 versus 0.6 deaths per 100,000 live births; Raymond and Grimes 2012). Such trends

affecting informed consent ignore the studies that capture the effects of unintended pregnancies. In unwanted pregnancies, mothers are less likely to obtain prenatal care, may expose the fetus to harmful substances, and create greater risks of low birth weight, of dying in the first year of life, of being abused, and of not receiving sufficient resources for healthy development (Hagen 1997). These are extraordinary burdens to place on a child, a parent, a family, and a community, and they contradict vitalist notions that any life is better than no life at all.

Incarcerated women face similar challenges. Women inmates have a higher incidence of trauma and mental illness compared to men (Messina et al. 2003) and more than 60 percent of women in state prisons have a child under the age of eighteen (Lewis 2006). As forensic specialists are aware, the fewer number of federal prisons for women lead to their being incarcerated farther from home, creating an even greater impact on their children and families (Glaze and Maruschak 2008). It may be clear that practices that countermand women's autonomy in reproductive matters or that prioritize potential life over the woman's life have considerable negative consequences. They are consequences that seriously undermine the ethics of fairness and personhood that usually govern medical and forensic practice.

Beyond mental-health and legal systems, women continue to face economic and social disparities that resonate in healthcare. Women in leadership positions lag significantly compared to men, with the popular magazine *Fortune* reporting that, in 2016, only 4 percent of chief executive officers in the United States were women (Zarya 2016). In 2015, women earned 80 cents on the dollar for similar work as men (Hegeswisch and DuMonthier 2016). In *Medicine*, a 2016 study by Jena, Olenski, and Blumenthal noted that annual salaries of female physicians in academic settings were substantially lower than those of male physicians.

Rape culture persists on campuses around the country, as evidenced by the infamous Brock Turner case in California, where the twenty-year-old Turner was sentenced to a lenient sentence of six months for raping an unconscious woman: the judge considered the perpetrator's alcohol use to be a mitigating factor (Koren 2016). Modern feminism also reacts to inequities that are more keenly felt among minority groups. African American women and nondominant groups such as immigrants remain at an even greater disadvantage in their ability to access healthcare.

Such social themes occur against the established historical backdrop that brought feminism to life in the first place. Consequently, a culture that

devalues women affects forensic practice. In the same way that Ezra Griffith (1998) encouraged a closer look at nondominant groups in the judicial system, forensic professionalism must now consider a broader vision of what it means to work in a biased environment. Ironically, authors such as Hatters-Friedman and Hall (2013) find a positive element to society's inherent bias—milder sentences may be meted out to women who commit similar crimes as men. So, considerations of fairness and feminism may cut both ways: ascribing greater inherent morality to women in order to punish them less may be sacrificed if a greater balance is found in how they are treated. Certainly, the application of equal rights does not occur merely by increasing the focus on discriminatory practice. Biases tend to be more ingrained, implicit, and subtle. An articulation of the feminist perspective is therefore only the beginning. Ultimately, the feminist perspective asks that practitioners look at issues concerning women from their viewpoint and history, giving them voice and agency in society.

For forensic practice, the already expanding view that forensic evaluees, as participants in a moral relationship (Norko 2005, Candilis and Martinez 2006, Ward 2014, Buchanan 2015), are owed respect and dignity requires a stronger ethical vision if society's gender inequality is to be overcome. This approach provides a feminist perspective that can guide forensic experts as they evaluate defendants entangled in the politics and biases of modern times. Recent legal decisions advancing fetal rights and restricting access to abortion are only the most overt challenges to a forensic professionalism that strives to recognize the various perspectives present in the work.

FEMINIST THEMES RELEVANT TO FORENSIC PROFESSIONALISM

The evolution of all social movements carries with it the mark of the times, the development of curious alliances, and contributions from unlikely sources. For example, the work of some early feminists, such as Catherine Beecher (1869), who advocated a "self-denying benevolence," is now viewed as quaint and even oppressive. Judging women by higher standards of morality and virtue, as Beecher did, robs an entire segment of the population of the freedom and agency to act in the manner they choose. In fact, the so-called first wave of feminism from the late 1800s and early part of the twentieth century was limiting, too: it was a movement largely focused on and driven by white women

of the upper classes (Dubois 1975). It focused on issues of inheritance and property rights and women's suffrage. In general, it did not include minorities or other oppressed communities.

Although the early suffragettes Elizabeth Cady Stanton and Susan B. Anthony (1853) raised the issue of marital rape in their correspondence, issues from the personal world of women such as contraception and abortion were not widely addressed until the second feminist wave of the 1960s. This wave coincided with the Civil Rights Movement and began to recognize the disadvantages faced by black women who sought rights on the frontiers of race as well as gender. Third-wave feminism, beginning in the 1990s, now seeks to incorporate an "intersectionality" of issues and believes that women are a diverse group with diverse identities. It formally includes issues of race, sexual orientation, socioeconomic status, and the varying personal narratives of all women; it is inclusive of all differences.

Intersectional feminism, a term coined by the law professor Kimberlee Crenshaw in 1989, seeks to highlight how oppression is not the same for all women. An African American woman from an inner city may have to overcome the limitations of poverty, housing, and lack of community medical resources before she can receive healthcare or legal recourse. A new immigrant may not be able to afford healthcare or legal advocacy for years. A college-age rape victim may choose to stay silent in a culture of victim shaming and victim blaming. Even a woman executive in a steady job may lag significantly in pay raises and promotions as her employer gauges her family obligations differently from a man's.

An impediment to advancing feminism in society is that traditional ethics has focused on the so-called masculine values of autonomy, free will, justice, and rights. These frameworks make strong claims on society to provide certain basic requirements for individual moral actors, among them safety, permission to pursue individual goals, and freedom from interference. One's right to something demands another's obligation to provide it. Much of the debate concerning women has been framed in these terms and, to an extent, correctly so. In asking for self-determination and independence—especially in promoting roles for women outside traditional settings—feminist thinkers as early as the suffragettes recognized the language of rights, including the imperatives of equality and justice. This led to major victories for women in voting, working, inheriting, and having children.

However, the language of rights, while providing a starting point, does not incorporate the entire extent and subtlety of inherent bias. This is where an

individual's personal experience, relationships, narrative, and intersectionality enter the picture. Feminist ethics often focuses instead on interdependence, community, and the forces that connect people. Alison Jaggar, in her seminal work *Feminist Ethics* (1992), noted that traditional ethics shows less concern for women's issues and interests, trivializing the moral issues that arise in the so-called private world—the realm in which women do housework and take care of children, the infirm, and the elderly. Jaggar is among those who believe that traditional ethics overrates culturally masculine traits such as "independence, autonomy, intellect, [and] will" and "underrates culturally feminine traits such as "interdependence, community, connection, sharing, emotion, body, trust, absence of hierarchy, nature, immanence, process, joy, peace, and life." She critiques traditional ethics for favoring "male" ways of moral reasoning that emphasize rules, rights, universality, and impartiality over "female" ways of moral reasoning that emphasize relationships, responsibilities, particularity, and partiality. Since Jaggar's critique, the new societal conversation about work-life balance may be viewed as a movement engaging the feminist ethics of interdependence, community, and connection.

While the traditional concept of an ethics rooted in autonomy suggests an independence of the agent from the surrounding context, interdependence may be the core of feminist ethics. Many feminists consequently view autonomy-driven arguments with suspicion. This is because women may participate in autonomous decisions that may cause them physical or psychological harm: genital mutilation remains a heart-rending example. In Western society, a focus on thinness and "body shaming" affects the self-esteem of girls and leads to unhealthy choices such as food restriction and illnesses such as eating disorders. Since some choices are often made willingly, the women exercising them may certainly be considered autonomous. They are nonetheless influenced by powerful and illegitimate external factors. The objectification of women in popular culture is an example of how women make seemingly autonomous choices while remaining tied to harmful views of body image and beauty. The rise of eating and anxiety disorders is among those trends linked to inherent social biases. One recent study found an alarming association between the use of social-media use and eating concerns in young adults of both sexes (Sidani et al. 2016).

A combination of oppressive forces can consequently lead to ambivalence or to a divided sense of self in which preferences pull in competing directions. These are the outcomes that highlight the limitations of autonomy and rights-based thinking. Elster's classic description of "adaptive preference

formation" (1983) is that of Aesop's fox who adapts his preference when he finds the grapes are out of reach and probably sour anyway. Martha Nussbaum (2001) has described poor working women in India as "accepting their lot" when they choose to remain in abusive marriages. The women were financially dependent and made the "choice" to remain. This resonates with many abusive situations where adaptive preferences or "false needs" (Nussbaum 2001) may result from the internalization of an oppressive ideology. Andrea Westlund (2003) has advanced what she calls a "formal and constitutively relational position" in which interpersonal conditions are included in the definition of autonomy. It is one important attempt at infusing moral and personal relationships into classic ethical thinking.

The idea that women may interact or think differently than men remains evident among feminist authors. Drawing from nineteenth-century proponents of the higher moral virtues of women, authors including Nel Noddings (1984) and Carol Gilligan (1982) do focus on a care-giving theme. They point out ways in which girls solve problems differently than boys, using communal solutions to keep their groups intact. Women have a distinct moral voice in this view—one that speaks a language of care, emphasizing relationships and responsibilities.

However, many feminist writers have sought to move away from casting women as virtuous caregivers because it may discourage women moving into nontraditional roles. For these writers, an ethics of care may be inherently sexist. Sandra Lee Bartky, in *Femininity and Domination* (1990), has distinguished the subjective feelings of empowerment in care giving from genuine empowerment. Bartky refers to women's care of men as "a collective genuflection by women to men, an affirmation of male importance that is unreciprocated."

U.S. women, along with other historically oppressed communities such as nonwhites and persons with disabilities, have similarly been at a disadvantage in exercising their agency. This has been noted in historical examples such as the lack of voting rights as well as the present-day disregard for women's reproductive choices. According to Diana Meyers (1987), this lack of agency is directly attributable to a socialization of women into roles that rob them of autonomy.

To apply present-day feminist ethics to forensic practice, professionals must take into account the social and intellectual changes of the past decades. Self-determination and economic independence, roles outside traditional settings, and equality of pay and opportunity may consequently require a focus on values that emphasize intersection and interconnectivity. When forensic evaluators take a closer look at the impediments facing women in

child-endangerment cases or in civil commitments while pregnant, they may find the laws and culture inadequate to a fair and just outcome. The moral relationships within society, cited as a fundamental ethical principle by a number of forensic commentators, only strengthen the call for more legislation to address the historic inequalities of agency and opportunity.

Liberal feminists (often called "equal-rights" feminists) are chief among those who maintain that the primary cause of women's subordination in society is the lack of laws that support advancement. Even when nondiscrimination rules are codified, their application may be weak or ineffectual. Persistent pay gaps and leadership vacuums are evidence of this. Authors such as Susan Sherwin and Carolyn McLeod (2000) have critiqued this absence of female agency in society and underscore female invisibility in making decisions that affect their lives. The continued passage of laws pertaining to reproductive rights by male-dominated legislatures has been the exemplar of this absence of agency since classic work by Susan Brownmiller (*Against Our Will*, 1975).

Disability-rights activists adopted the "Nothing About Us Without Us!" slogan from Eastern European political traditions in the 1990s to advocate for their agency and presence in legislation and policy decisions involving them. This should resonate for a feminist movement that has consistently demanded equality and representation. In medicine, as in psychiatry, the similar move away from the parentalistic model of treatment to the collaborative, even patient-first, model is exemplary of rights trends that have found traction and may presage advances for women.

Recent populist political movements underscore that changing cultural norms for women change norms for men as well. These role changes alter power differentials and frame new grounds for contention and political backlash, all shaping society and the influences on forensic professionals. The pro-life movement, for example, often led by religious and conservative advocates, has attempted to walk back access to reproductive freedom. *Roe v. Wade* has been under persistent pressure since its passing. The 1992 U.S. Supreme Court case of *Casey v. Planned Parenthood* (1992), for example, significantly weakened the access to abortion afforded by *Roe*. *Casey* allowed various states to devise regulations that mandate waiting periods before the procedure, require that minors obtain parental consent, and insist that doctors read specific information to patients. In 2012, Virginia passed the now overturned mandatory transvaginal ultrasound for women seeking abortion, effectively requiring women to have a device inserted into their bodies. This law was heavily criticized by some as a penetration akin to rape (Green 2013).

APPLYING FEMINIST ETHICS TO FORENSIC PRACTICE

One way to advance medicine's understanding of women's historical perspective is by incorporating feminism into its professional ethics. In her book *Radical Feminism: Feminist Activism in Movement*, Finn Mackay stresses that classifying individuals by their birth sex alone ignores the intersecting forces contributing to their oppression and thus their perspective and position. This "positionality" is already recognizable in the work of forensic authors such as Griffith (1998) and Candilis and Martinez (2006), indicating that both fields already value the perspective (or position) of the parties involved in the clinical or forensic encounter.

Using the cultural formulation in forensic psychiatry likewise leads to accepting the intersectionality of all groups who are not treated equally in the courts. Being more thorough in cases that raise oppressive themes, defaulting in favor of the individual who is in control of a social institution like a court or prison, and striving for objectivity and self-reflection when faced with cases that challenge firmly held personal beliefs are all tools that incorporate feminism into forensic psychiatry. As writers in forensic psychiatry have commented, a robust professionalism is one that is inclusive and incorporates perspectives from all quarters.

APPLYING THE FEMINIST LENS

VIGNETTE 1: IN DETENTION

Anna is a young black woman arrested for shoplifting and simple assault while shopping with her child. Anna was loud, agitated, and hit the cashier. Later, her blood tested positive for cocaine. This was her third charge, the previous two being for similar drug-related offenses. Anna is composed during the screening psychiatric examination requested by the arraigning judge. She says that she had been "high" and "hallucinating" at the time of arrest. She is worried that her daughter, who is currently with her grandmother, might be removed from her custody. Her two older children have already been removed. She also expresses concern that she is facing a prison sentence. She has no documented history of mental illness but outlines a history of physical abuse since childhood. In her jurisdiction, there is no government assistance available for her children because she has been convicted of previous drug offenses.

Feminist ethics requires familiarity with studies that show that 75 percent of women in correctional facilities are the primary and at times sole caretakers of their children prior to their arrest. This often leads to their children's entrance into the foster-care system (Margolies and Kraft-Stolar, 2006). The social and economic impact on families and communities cannot be underestimated. Another consideration for court evaluations and experts is the high rate of lifetime sexual and physical abuse among women inmates.

Under these circumstances, the introduction of feminist ethics addresses a conflict between the principles of justice and the interdependence of factors leading to the current crisis. Justice dictates that Anna face the consequences of her crime, whereas the positionality advocated by feminist ethics encourages an approach that restores Anna's agency. This recognizes the intersectionality between factors such as her race, poverty, and lack of access to resources. Should a person who has these limitations be judged by the same parameters as a person who does not?

Anna's addiction to drugs can be managed in a rehabilitative rather than punitive manner. Had her history of victimization been addressed earlier, it is even possible that her addiction would have been treated earlier, thus mitigating or preventing subsequent consequences. These factors, viewed through a feminist lens, can be alleviated to decrease the likelihood of conviction, incarceration, and loss of custody.

Finally, cultural expectations of how mothers should act will underemphasize Anna's trauma or the barriers of her race and socioeconomic status. These can be overcome by a more self-reflective and culturally sensitive approach by forensic evaluators.

Overall, acknowledging the individual's narrative (position or perspective) may lead a treater or examiner to incorporate these factors into a treatment plan, diversion or placement recommendation, or report on parental fitness. It would be consistent with feminist ethics (and other schools of thought) to recommend treatment for substance abuse and trauma. Moreover, identifying mitigating factors, describing community resources, and favoring treatment over punishment can be among other options already available to a forensic professional.

VIGNETTE 2: BEFORE THE COMMITMENT HEARING

Theresa is a thirty-nine-year-old woman diagnosed with schizophrenia. She is pregnant, likely in her second trimester, and has been homeless for several years.

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Her last hospitalization was over ten years ago, and she is well known to homeless outreach teams. Theresa is delusional, thinking she is married to a famous rap artist. She wanders through music venues, where she is often removed by police. She is not violent or suicidal and has no medical concerns. On this occasion she is involuntarily hospitalized after outreach workers note her obvious pregnancy and worry about her capacity to care for herself and her pregnancy. Theresa has a civil-commitment hearing tomorrow and is clearly upset about being hospitalized against her wishes.

According to the National Advocates for Pregnant Women study by Paltrow and Flavin (2013), roughly 413 pregnant women in forty-four states were forced into some sort of treatment through criminal laws or civil commitment between 1973 and 2005. These actions echo the move in society that pitches the woman's rights and her concerns for herself and her family against those of the fetus and the state's interest. For most analysts, the fetus is not an individual as long as it is a part of the female body.

The potential for life and life are two distinct concepts, ideas that are often coalesced or conflated by pro-life activists. It is telling that the state's interest in life does not always consider the woman's. Where a woman is the prime concern, as advocated by feminist ethics, then her wishes and desires and the realities of balancing her interests with those of her interest in having a family is also a state interest. This is not inconsistent with the state's interest in life. Life is more than mere existence. And as we have seen, women are more than merely potential mothers. Further evidence of society's bias for traditional roles for women comes from the lack of pro-life legislation for in vitro fertilization (IVF), where unimplanted embryos are discarded after the procedure. IVF offers much to individuals who struggle with fertility. However, an embryo is often unregulated, betraying an unusual inconsistency in conservative thinking. Similarly, conservatives and liberals alike who advocate the adoption of unwanted pregnancies advocate for carrying a fetus to term, downplaying or disregarding the emotional and physical changes a woman may have to endure.

Here, countermanding a woman's agency and control over her body is not part of the feminist ethic. Adopting a feminist ethic instead allows Theresa's inability to care for herself and her pregnancy to be addressed as a collaborative venture. Involving her in a plan that puts her desires and wishes first, including those about the fetus, would give her a proper voice in her care. If the pregnancy is primary, as it is now in some jurisdictions, the patient's intent for the pregnancy becomes secondary to others' views of her health. Her best interests do not govern the discussion.

Judith Jarvis Thomson, in *A Defense of Abortion* (1971), offered the famous thought experiment of an unconscious violinist who needs another person's body to survive his comatose state. Who would society ever commit to such an unwanted union, she asks. Feminism empowers women to have control over their lives and bodies, a right that can be undermined in modern-day clinical and forensic evaluations.

VIGNETTE 3: THE INSANITY EVALUATION

Mary has a documented IQ of 75 and a history of depression with psychotic features. She is accused of infanticide in the drowning death of her two-day-old child, whose body was found in a dumpster. Mary's boyfriend abandoned her as soon as he discovered her pregnancy. Her family is religious and was unwilling to pay for an abortion. She feels helpless, alone, and depressed. Her single prenatal-care visit at six months' gestation revealed that the fetus had Down syndrome.

Mary's narrative underscores several vulnerabilities: she has a mild intellectual disability, poor financial resources, limited social support, and found herself with an unwanted pregnancy. While a common societal view equates consent to sex as consent to pregnancy, this cannot be generalized among those with impaired reasoning and those who may not be able to insist that their partner use contraception. As we noted earlier, while the state's interest in some jurisdictions may now tilt toward the life of the fetus, the state also has an interest in protecting its female citizens. Punishment under a feminist ethic will take these intersectional matters into account not simply as a matter of diminished capacity but for the numerous events preceding it. Mary's incapacity to give voice to her competent wishes throughout her narrative is grounds for the use of intersectionality and consideration of the multiple vulnerabilities that affected her actions. Courts and forensic professionals involved in such cases conduct a more informed, thorough, and compassionate analysis, one taking these elements into account.

CONCLUSION: THE ROLE OF PROFESSIONALS

Both forensics and medicine can be enriched by the perspective of feminist ethics. Completing a well-informed evaluation, acknowledging historical inequities, and recognizing bias can only advance a professional ethics that

aspires to fairness and objectivity. Positionality, intersectionality, and equal representation are among the tools already recognized by forensic thinkers who advocate narrative approaches, the cultural formulation, human rights, and compassion for the evaluee. Any community that has lagged because of marginalization lays claim to these considerations, but it is women who are the largest and most affected constituency.

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3

ETHICS CHALLENGES FOR FORENSIC PRACTICE IN A CONTEXT OF LIMITED RESOURCES

Maisha Emmanuel and Michael Campbell

THIS CHAPTER DISCUSSES CURRENT ethical dilemmas encountered in forensic psychiatry practice in a small society where socioeconomic and professional resources are limited. The discussion also considers relevant culture-specific factors that affect approaches to resolving ethics problems. The discussion is of import to the practice of ethics-based forensic and general psychiatry in similarly distinctive geographic settings, particularly those in small developing societies with limited financial and human resources.

Barbados is an independent island in the southern Caribbean. The island covers an area of 166 square miles and is relatively flat. Its population is estimated at 284,000, making the island one of the most densely populated countries in the world. Public medical care is provided free at the point of delivery at the lone general hospital (which includes a twelve-bed psychiatric unit) (Evans 1999), a psychiatric hospital, eight polyclinics (primary-care facilities that provide a number of services, including outpatient medical treatment, immunization, mental-health treatment, and health screening/education), and three satellite clinics (PAHO 2007, 2012).

The psychiatric hospital is a 537-bed hospital. There are seventy beds allocated for male forensic patients. Female forensic patients are admitted to the general wards. Outpatient clinics are held daily. Weekly mental-health clinics are held at the polyclinics, satellite clinics, and general hospital. One clinic is held fortnightly at the prison (WHO 2009).

Of the 610 registered physicians (BMC 2016a) in Barbados, eighteen are psychiatrists (BMC 2016b). This ratio of 6:100,000 population is lower than that found in Europe (10:100,000) and the United States of America (16:100,000) (Tasman 2015).

EVOLUTION OF ETHICS COMMITTEES

Training of medical students at the University of the West Indies (UWI) began in 1967 in Barbados (Walrond 2001). At that time, little attention was paid to medical and research ethics, and there was no formal teaching of students on the subject. E. R. Walrond, professor of surgery, returned to the island in 1974 and was instrumental in establishing the first research ethics review panel, along with a representative from the Ministry of Health (MoH) and the Queen Elizabeth Hospital (QEH).

At that time, the reflection on and analysis of ethics dilemmas within the practice of forensic psychiatry and psychology remained in their infancy. There were (and still are) glaring ethics problems within the island's Mental Health Act (Government of Barbados 1985), which, for example, allows a person on trial before the High Court who is found unfit to plead, not guilty by reason of insanity, or guilty but suffering from diminished responsibility to be detained in a mental hospital until Her Majesty's pleasure is known. This has led to the continued incarceration of such individuals for decades without trial. In 2001, the Caribbean Court of Justice (CCJ) replaced the London-based Privy Council as the final Court of Appeal for Barbados and has ruled that such sentences were unconstitutional. Definitive verdicts were therefore required.

By 1993, Walrond had established a separate interdisciplinary ethics advisory committee for the medical faculty of UWI. This was composed of doctors, a lawyer, a priest, and a member of the lay public. The QEH committee was formed a few years later (around 1998), and this initially had a broad ethical remit, including research proposals that involved the hospital.

As the faculty expanded and more research was being conducted, the UWI signed a formal memorandum of understanding with the MoH to form what is now known as the Institutional Review Board (IRB), also termed the Research Ethics Committee (REC). The IRB is responsible for the assessment of research proposals generated on the Cave Hill, Barbados, campus as well as in the Barbados MoH. Each faculty, the MoH, scientists, and laypersons are all represented (UWI 2017).

Barbados is represented on the REC of the Caribbean Public Health Agency (CARPHA) for multicountry/regional projects proposed in the Caribbean Community (CARICOM). The IRB is also registered with Federal Wide Assurance in the United States. However, meeting the standards

of registration is a constant challenge, given the paucity of funding and the relatively small pool of persons from which to draw committee members. Other nations in the region experience similar or greater challenges, and Barbados sustains one of the most active IRBs in the Caribbean community.

TEACHING OF ETHICS TO MEDICAL STUDENTS

Formal teaching of ethics to medical students began in 1991 (Aaron 1999) but was delivered in a didactic setting more than practically applied. In 2001, Professor H. Fraser introduced a four-week ethics and humanities clerkship for medical students. The clerkship has now evolved into eight weeks and is taught together with psychiatry (UWI 2016). Fraser, together with Walrond, Professor H. Moseley, and Dr. G. Mahy, prioritized the teaching of medical and research ethics. Currently, from their first year, students are introduced to the principles of medical ethics, research ethics, and bioethics and are exposed to ethical dilemmas that arise in clinical encounters. In addition, the UWI and the QEH jointly host a monthly ethics conference. A clinical case is presented, and the ethical dilemmas arising from the case are discussed. The audience (primarily medical students, clinicians, and nurses) is given an opportunity to pose questions and share opinions. The lead discussant then presents his views, based on his clinical experience and a review of relevant clinical and ethics literature (Walrond et al. 2006). These conferences have been successful in taking ethical issues out of the textbook and into real-world settings for both medical students and physicians alike. The discussions are centered on local laws, cultural practices, and socially acceptable standards of behavior. It offers a unique opportunity for participants to understand medical ethics germane to the local Barbados setting.

VIGNETTES OF ETHICS DILEMMAS

The boxed vignettes represent composites of different ethics dilemmas discussed at the ethics conference over the past nine years. The stories were formulated to illustrate the typical ethics quandaries encountered in the Barbados cultural context. The subjects are not real patients.

A young woman was charged with the murder of her estranged husband. The accused was being seen by a psychiatrist because of complaints triggered by long-standing marital problems. She told the police about being under the care of a psychiatrist, and the police made a verbal request for her clinical file from the psychiatrist's secretary, who reported feeling pressured to release the file. There was no written consent from the accused or her attorney to release her medical records to the police. Nor was there a court order for the release of her records. Should the psychiatrist release the record, given that the patient voluntarily disclosed the information about seeing a psychiatrist to the police?

To answer the question, the perspectives of the main people involved—patient, police, and psychiatrist—need be considered. The police have an investigation to complete and therefore are trying to gather as much evidence as possible. The police may well feel justified in approaching the psychiatrist because the accused voluntarily disclosed that she was being seen by one. However, confidentiality is fundamental to every doctor/patient relationship. Detention or a criminal charge does not eliminate the importance of abiding by this basic ethical principle.

The psychiatrist might have contemplated not acknowledging whether the person was known or under his care. However, this seemed unnecessary, as the secretary had already confirmed the person's status during the conversation with the police.

The Barbados Medical Council Code of Conduct (BMC 2015) states that information obtained while treating a patient cannot be divulged without the explicit consent of the patient or as a result of a court order. It further states that medical practitioners are obliged to ensure that their staff has an obligation to maintain the patient's confidentiality. This discussion with staff is important in establishing best ethical practice because the physician may not be present when such requests are made. This may be of greater importance in small societies, in which the real or perceived pressure exerted by law-enforcement authorities is often magnified; that is, the detailed knowledge and close interpersonal networks in such societies present barriers to challenging orthodoxy.

The American Medical Association (AMA) Code of Ethics (2016, 5) on this issue reads:

> Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive

> personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient.

Disclosure of patient information without consent is justifiable if it is likely to protect the public from serious harm or crime, that is, in the public interest (GMC 2013). In this situation, the accused was already in police custody and posed no immediate threat to others. The psychiatrist did not release the records to the police because there was neither written authorization by the accused or her lawyer nor a court order. Some practitioners (Zur 2016) consider a request from the lawyer as legally the same as a request from the client, but the present authors believe such requests must come from the client and must be accompanied by written consent.

The psychiatrist was also concerned about the content of the clinical notes because the accused had discussed her relationships with named family members, including minors and previous sexual partners. The notes therefore provided intimate details of her relationships not necessarily relevant to the current investigation. Such information may have needed to be redacted before release.

The defendant's lawyer later requested that the treating psychiatrist also conduct a forensic evaluation for the defense. A dual role for psychiatrists as both therapist and forensic examiner is fraught with ethical dilemmas because the psychiatrist is being asked to perform conflicting functions. Both the American Psychiatric Association (2015) and the American Academy of Psychiatry and the Law (2005) have stated why these dual roles are best avoided. As the therapist, the psychiatrist acts in the patient's best interest, respecting his autonomy and keeping his confidence. The forensic psychiatrist performs an evaluation for legal purposes, and there is usually no therapeutic relationship established; there should be no expectation of maintenance of confidence or preservation of beneficence or autonomy (Schouten and Brendel 2016). The psychiatrist discussed these concerns with the attorney, who agreed it was best to avoid this predicament by requesting an independent assessment by an expert witness. In societies with a scale that makes dual-role conflicts more common, frank discussion of the conflict to the extent allowed by confidentiality standards is critically important to avoid subsequent ethical problems.

The parents of a preterm baby refused prenatal and postnatal testing of mother/baby for HIV based on their religious beliefs, their history of a monogamous relationship, and the belief that they were HIV negative. The treating clinicians believed HIV testing was indicated as part of the investigation for causes of preterm labor. The parents were adamant, despite repeated counseling, that the child should not be tested. The court was petitioned to allow for testing of the child, but the presiding judge denied the request.

Parents' right to make decisions (autonomy) on behalf of their children is guaranteed in article 5 of the UN Convention on the Rights of the Child (UNCRC 1989): Government must respect the rights and responsibilities of the parents and caregivers to provide guidance and direction to their child as they grow, so that they fully enjoy those rights. Article 18 of the Universal Declaration of Human Rights (1948) guarantees the individual's right of freedom of thought, conscience, and religion and the right to manifest his religion in practice and observance. The parents asserted these fundamental human rights in making their decision not to be tested.

The UNCRC (1989) also guarantees that every child has the right to life (article 6) and the right to best possible health (article 24) and states that the best interest of the child must be a top priority in all decisions and actions that affect children (article 3). The clinicians were of the view that in denying the child the HIV test, the child's right to life and best possible health was not being ensured. The clinicians relied on medical evidence to justify their conclusion and were convinced they were acting in the child's best interest (that is, they were following the principle of beneficence).

The prevalence of HIV infection in pregnancy in Barbados has been estimated at 0.6 to 0.8 percent (Kumar et al. 2003). There are about twenty-four babies born each year to HIV-infected mothers (St. John, Denny, and Babb 2015). Since 2007, there has been no case of mother-to-child transmission of HIV (St John et al. 2011). Antenatal screening for HIV is offered to all pregnant women. All persons who screen positive for HIV receive Highly Active Anti-Retroviral Therapy (HAART). Newborns of HIV-positive mothers are also treated prophylactically.

There is no local legislation for the regulation of HIV testing of pregnant women or their newborns. This process remains voluntary, and thus far, over 95 percent of women agree to be tested. A woman who refuses to be tested or

to have her newborn tested increases the risk of vertical transmission of HIV by not being appropriately managed herself and denying the child the opportunity to access treatment. Some jurisdictions, such as New York State, require all newborns to be tested for HIV, regardless of parental consent (Schleiter 2009), to promote early diagnosis and treatment of exposed newborns.

In 2006, the Center for Disease Control (CDC) in the United States revised its recommendations for HIV testing of adults, adolescents, and pregnant women in healthcare settings (Branson et al. 2006). This recommendation came after it was recognized that a specific number of factors led to the reduction in the incidence of pediatric HIV/AIDS via mother-to-child transmission to less than 2 percent: universal screening of pregnant women (CDC 1999), prophylactic administration of antiretrovirals (Cooper et al. 2002), scheduled Caesarian section when indicated (ACOG 2000), and avoidance of breast feeding (WHO 2003). The CDC also made changes to their guidelines based on the cost effectiveness of routine testing for HIV (Branson et al. 2006). Paltiel (2006) provided strong evidence that routine testing of HIV was cost effective even in populations for which the prevalence of undiagnosed HIV was 0.2 percent.

The judge agreed with counsel that the clinicians did not provide strong, positive evidence that the child may have been infected or was at significant risk of contracting HIV, given that there was no evidence that either parent or siblings or others in the child's environment were HIV infected. The clinicians needed to demonstrate that there was a clear benefit to testing this child because of the risk. Further refusal of the parents to allow testing could not be used as evidence of risk. The court did not have jurisdiction to intervene in speculative or hypothetical situations.

Judgment was made without oral evidence being given by any clinician involved in the care of this child. Cross-examination of the clinician may have been critical for the understanding of the rationale for testing the child and thus convincing the court.

A national discussion to inform the populace of the advantages and disadvantages of opt-in or opt-out options for HIV testing in pregnant women and/or mandatory testing of newborns is timely. This is especially important as Barbados strives to maintain its record of zero transmission of HIV from mother to child, a goal that has been achieved without mandatory testing. Compulsory testing protects the health of the child and is in its best interest, but the results reveal the status of the mother and therefore potentially violate her right to autonomy and confidentiality. Ultimately, clinicians, ethicists, and policy makers should decide which argument is more persuasive for our present society.

An elderly man presented to a psychiatrist because his wife sent him for "help." As the psychiatrist was explaining that there were limits to confidentiality in the doctor/patient relationship and started to describe some possible exceptions to blanket confidentiality, such as the ethically, if not legally, required disclosure to the relevant authority if the patient was physically, sexually, or verbally abusing a child, the patient said, "Doc, I'm one of them."

He explained that he was having oral sex with a twelve-year-old boy (with his "consent") but had had no further contact with the child after he told his mother what was happening. At the time this patient presented, there were no laws requiring mandatory reporting of child abuse in Barbados. The psychiatrist sought legal counsel and was advised not to report because there was no law obligating disclosure. The lawyer advised encouraging the patient to remain engaged in treatment. The psychiatrist ultimately decided to disclose to the child-protection agency.

The priority was to ensure that the child was in fact safe and not experiencing ongoing abuse. The perpetrator's wife confirmed that the child's mother (her sister) was aware of the situation and that there was no further contact between her husband and the child. Even in the absence of abuse, how was the child coping with the revelation? Was he receiving appropriate psychological support? The wife was angry with her husband and called him a "monster." However, she remained in the marital home and worked with him every day. How was this development affecting the relationship between the man and his wife? Was the wife also angry with the child for disclosing? What was the relationship between the wife and her sister like now?

The child's mother declined to speak with the psychiatrist and did not want this matter referred to the police. Why was this so? Historically, some cases like this one have been "settled" by the alleged perpetrator paying an agreed sum of money to the victim's family. Did this happen in this case? If so, what were the psychological consequences to the child if he was aware that his abuse had not been fully addressed because of monetary inducement?

After the initial visit, the man made a follow-up appointment, but he did not return. In fact, he seemed to be avoiding calls from the psychiatrist's office. The Medical Profession Act (2010), CAP (23 (1–3)) requires that a medical specialist not engage in behavior that is contrary to medical ethics. Such behaviors include but are not limited to a willful or reckless betrayal of a professional confidence (Government of Barbados 2010).

Confidentiality is thus central to the doctor/patient relationship, but it is not absolute. Schouten and Brendel (2016) described the ethical and legal

responsibilities of psychiatrists to maintain confidentiality with patient disclosures but recognized that there would be exceptions in which the psychiatrist must decide whether to breach his responsibility to the patient or allow the harm of any third parties to continue. These exceptions fall under two categories: ethical and legal. The former represents calls based on his or her own judgment, and the latter is based on the laws and statutes in the practicing jurisdiction. In Barbados law, any disclosure that is legally justifiable or required for the treatment of a patient is not deemed a willful betrayal of confidence.

The Sexual Offences Act (1992), CAP 154 (4(1)) states:

> Where a person has sexual intercourse with another who is not the other's spouse and who is under the age of 14, that person is guilty of an offence whether the other person consented to the intercourse and whether at the time of the intercourse the person believed the other to be over 14 years of age, and is liable on conviction on indictment to imprisonment for life.
>
> (GOVERNMENT OF BARBADOS 2002)

The people involved were choosing not to engage with the psychiatrist, and there were many unknowns. Although there was no legal requirement to report either known or suspected child abuse or neglect, the psychiatrist was of the view that there was an ethical responsibility to protect the current victim and any potential victims from harm. The psychiatrist therefore chose to inform child-protection services, recognizing that there were times in which the standards for ethical behavior superseded legal requirements. A mandatory-reporting protocol has since been drafted and is awaiting statutory implementation. This protocol will include guidelines for reporting different types of abuse, detail categories of people mandated to report, and explain reporting procedure (Marshall-Harris 2014).

One interesting observation has been the experience of England, where abuse/neglect mandatory-reporting laws do not exist. In a recent consultation on reporting and acting on child abuse and neglect (HM Government 2016), there was consideration of the introduction of mandatory reporting, as is required in the United States, Australia, and Canada; or "duty to act," which would require certain practitioners or organizations to take appropriate action, which could include reporting.

In spite of the obvious benefits of mandatory-reporting laws (increased awareness of reporting, more cases identified at an earlier time), the report

cited the possible risks of such a system to include an increase in unsubstantiated referrals, with the resultant diversion of resources for actual cases into assessment and investigation; a focus on reporting but not on improving the quality of interventions needed; and an undermining of confidentiality for those contemplating disclosure of abuse. In England, the referral rate is 54.8 per thousand children (Cossar et al. 2013), which is higher than in the United States, at 47.1 per thousand (USDHHS 2015), and 37.8 per thousand, in Australia (AIHW 2015)—both with mandatory-reporting systems.

Mandatory-reporting protocols do not necessarily solve ethical dilemmas and may create new ones. Careful consideration of all the factors involved in each individual case will need to be completed before a decision on the way forward is taken. Once this law is enacted, Barbados has to evaluate the effectiveness and usefulness of this new reporting system.

A young adolescent presented to hospital with superficial lacerations to her wrist and daily thoughts of hanging herself. Her history was significant for sexual abuse by her father and neglect that led to her being cared for by an aunt. She reported that she was having sex with her aunt's adult boyfriend and had terminated two pregnancies. There was no other family member who could offer care. A psychologist assessed her as having a full-scale IQ of 51, equivalent to a child of eight years. The treating psychiatrist recommended that this young lady be made a ward of the court: the psychiatrist opined that despite her chronological age she was not competent to make decisions about her well-being and would be at risk for continuing harm if she lived on her own. She required a safe and predictable home environment, which could only be provided for by child-protection services.

She was made a ward of the court and placed in a children's home, where she remained until her eighteenth birthday, when she was discharged. The patient returned to her aunt's house, and sexual contact with the same boyfriend resumed. She presented to psychiatric services with increasing suicidal ideation and was readmitted to hospital.

The Minors Act (chap. 215, sec. 3 (1)) defines the age of majority as eighteen years. However, the legal minimum age at which an individual may give sexual consent is sixteen years, as stated in the Sexual Offences Act 1992 (sect. 11 (2)) (UNCRC 1997). The age of sixteen is generally considered to be the age of sufficient understanding and intelligence to permit individual decisions, although a sixteen-year-old is still a minor.

The law assumes that individuals at the relevant ages are competent to make decisions unless proven otherwise. Evidence obtained during clinical interviews and formal IQ testing were the bases for the conclusion that this young lady was not competent to make decisions to manage her own affairs. She did not understand the consequences of a "relationship" with her aunt's partner and the ongoing exploitation she was facing. She was, in effect, a minor who required the protection of state agencies to ensure that her abusive experiences were not repeated.

By making her a ward of the court, the court was exercising its fundamental authority in common law and acting in her best interest. The Crown was offering protection as *parens patriae*. The concept of the best interest of the child is also stated in the Juvenile Offenders Act (chap. 138), the Adoption Act (chap. 212), and the Child Care Board Act (chap. 381) (UNCRC 1997).

Unfortunately, the decision to discharge her on her eighteenth birthday was made based purely on her chronological age: the Child Care Board is responsible for the care and protection of any child under the age of eighteen. In spite of being an adult chronologically, she functioned as a minor and so needed to continue to be protected as a minor.

Her readmission to an acute psychiatric ward was protracted because there is no system in place to provide adequately for young adults who have lived in children's homes: they are required to leave even without alternative social support. Limited residential care is provided for persons with severe/profound intellectual disability, which was unsuitable for this young woman. After discharge she eventually lived with a family who was very understanding of her plight.

This case highlighted, among other things, deficiencies within our system regarding appropriate housing options. There was no structured system in place that addressed the level of housing needed by people living with mental illness/disability or for persons who are transitioning out of residential care. The availability of supported housing that was safe and affordable was critical in maximizing her quality of life.

The promotion of a standard of care, the allocation of sufficient resources, and the development of a robust national policy supporting the care of young adults post discharge from residential care is crucial. This is needed most acutely for persons whose mental capacity creates vulnerability to exploitation and abuse. Specifically, this policy needs to include access to secure, stable, and affordable housing options, which may range from fully supervised group homes to independent living.

A thirty-five-year-old woman presents with a one-week history of "strange behavior" that included preaching loudly and quickly with the belief that God was talking to her about healing the sick and feeding the hungry. She was previously diagnosed with a bipolar disorder and had been noncompliant with her medication. She did not believe the diagnosis. Some of her family members also disagreed with the diagnosis because they believed that her interactions with God were in keeping with her religious beliefs. Others believed she was possessed and requested to have a priest cast out her demons while she was admitted. They all agreed that her current symptoms were not in keeping with her usual behavior. The patient when well was an active member of her church.

The 2000 census reports that 95 percent of Barbadians are considered Christian, with the top five religious groups being Anglican, Seventh-Day Adventist, Roman Catholics, Pentecostal, and Methodists (USDS 2008). Religion/religious beliefs remain central and important within the social fabric of the wider community. The etiology of mental illness for some is understood in terms of spiritual warfare between good/evil and demon possession. Psychiatrists are often faced with the arduous task of differentiating religious delusions from normal beliefs. A delusion is more likely if the beliefs are associated with other psychotic symptoms, are strongly held, seem improbable, and are distressing.

The psychiatrist's approach to the management of the patient (and the family) was to develop a better understanding of her belief systems and use this to explain the interface between psychiatry and religion. This was also useful in encouraging compliance and augured well for the long-term relationship between the medical and familial teams. Koenig (2007) proposed five approaches that psychiatrists can take in addressing religion with their patients: taking a spiritual history, respecting and supporting beliefs, challenging beliefs, praying (if/when appropriate), and referral to clergy.

There is anecdotal evidence to suggest that psychiatrists have gone beyond these approaches and are involved in the actual process of casting out demons. This raises serious ethical issues related to acting in the patient's best interest while doing no harm. Whereas it is appropriate to support patients and their relatives seeking guidance from their religious/spiritual leaders, the authors opine that it is not appropriate for mental-health professionals to be involved directly in the facilitation of nonmedical practices that have not been proven as valid by evidence-based medicine.

The participation of mental-health practitioners in these rituals further perpetuates the strongly held beliefs of some that the practice of psychiatry remains steeped in mystery and is less scientific than other specialties in medicine. On the other hand, it is recognized that physicians themselves hold a wide spectrum of religious beliefs, and some promote the integration of medicine and other folk practices. We wish to urge that this type of integration be done in a thoughtful manner that recognizes the advantages and conflicts that can be presented by such an approach.

CONCLUSION

These cases underscore the diverse range of ethical problems that can present in clinical practice. Over the past forty-five years Barbados has developed culture-specific approaches to managing these problems in the context of limited legislation and inadequate general knowledge about medical, psychiatric, and forensic ethics. These deficits emphasize the need, on both local and national levels, for public and professional education about fundamental human rights, including the rights of children; doctor/patient confidentiality and its limitations; and the critical principle of acting in the best interest of people who are not competent (for whatever reason) to make their own decisions. Equally important is training of police officers and other relevant stakeholders (for example, officials responsible for ensuring the safety and protection of children) on human rights, law, and ethics. Finally, the implementation of mandatory-reporting protocols and the possibility of mandatory antenatal/postnatal testing of HIV present important new developments in forensic practice and consultation. Evaluation of the necessity and the effectiveness of these laws will be instructive for both policy and practice.

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4

ON WEARING TWO HATS

Ethics Challenges and Role Conflicts in Forensic Practice

Rebecca Weintraub Brendel

SINCE THE EMERGENCE OF FORENSIC psychiatry and psychology as modern subspecialties, forensic specialists have faced inherent potential and actual conflicts in their roles, responsibilities, and obligations. Following the trial of John Hinckley Jr. and his acquittal by reason of insanity, forensic practitioners fell under particular scrutiny regarding their practice. In a 1984 commentary, the psychiatrist and law professor Alan Stone gave his rationale for being a student and scholar of law and psychiatry but not a forensic psychiatrist: it was because of "the intellectual and ethical boundaries of forensic psychiatry" (Stone 1984, 58). He identified four distinct boundary problems. First, he cited the epistemic question of whether forensic psychiatric knowledge and testimony could meet the standards of truth such that it could or should be considered by the courts. While this concern is important, it is beyond the scope of this chapter to unpack further.

Instead, let us direct our focus to the three additional boundary concerns Stone (1984) identified. He saw both the risk that forensic psychiatrists would go "too far and twist the rules of justice and fairness to help the patient" and also that, in the other direction, forensic psychiatrists would "deceive the patient in order to serve justice and fairness" (58). Finally, Stone identified the risk to the profession of becoming "prostitute[d]" through psychiatrists' participation in the adversarial system of the law. Now, more than three decades following publication of Stone's critique "from the Ivory Tower," these complex considerations remain front and center and continue to pose challenges for all forensic specialists from psychiatry and psychology (57). The challenges are encountered by those testifying in court and more generally for those working in traditionally forensic settings, such as correctional institutions. The forensic specialist also confronts these challenges while carrying out disability

evaluations; while working in the increasingly complex systems of healthcare delivery, payment, and regulation; and in navigating multiple administrative, legal, and societal demands.

This statement is not to say that substantial work has not occurred regarding ethics in forensic psychiatry and psychology but is instead meant to highlight the ever-critical task that is before forensic specialists, other clinical professionals, and physicians in general. Specifically, as the healthcare system in the United States continues to evolve and our society continues to become more diverse and complex, how are mental-health professionals to reconcile competing considerations of patients, institutions, and, more broadly, justice? This question is merely a restatement of Stone's concerns about forensic psychiatry. As a general matter, how does the forensic specialist maintain fidelity of roles when patients, institutions, and justice are all at stake? And how to do that while safeguarding the integrity of one's profession?

HISTORICAL DEVELOPMENT

The debate over forensic ethics has benefitted from the contributions of multiple voices and perspectives. On the twenty-fifth anniversary of Stone's 1982 original presentation of many of these concepts at the annual meeting of the American Academy of Psychiatry and the Law (AAPL), AAPL and its journal convened a revisiting of forensic ethics and a discussion of the evolution of its thought. By that time (2008), AAPL had published multiple versions of its own Ethics Guidelines for the Practice of Forensic Psychiatry, culminating in the current iteration (AAPL 2005), and, following Appelbaum (1997b), had identified different ethical responsibilities and guidelines for forensic psychiatrists serving in forensic and clinical roles. Appelbaum (1997b, 236) had proposed that the ethics of a particular profession, in this case forensic psychiatry, ought to be based in general ethical obligations of persons in addition to the "values that society desires the profession to promote." For Appelbaum, forensic roles and clinical roles are different and require different ethical guideposts. Simply put, for treating clinicians, the primary obligation is to the doctor-patient relationship and thereby the patient's interest (invoking principles of beneficence and nonmaleficence), whereas for the forensic psychiatrist, the underlying values relate not to the patient but to the justice system (1997a, 1997b). Specifically, Appelbaum (1997b) identified the value of the forensic psychiatrist to society based in the forensic psychiatrist's ability to advance fair adjudication and

the interests of justice. This forensic role, rather than primacy of patient interests rooted in the therapeutic alliance, instead ought to be guided by truth telling and respect for persons.

That same year, a now classic article by Strasburger, Gutheil, and Brodsky (1997) was published, specifically identifying the potential for conflict when a treating psychotherapist also serves as an expert witness. As opposed to the type of dual relationships generally prohibited by professional codes of ethics up to that time (professional and nonprofessional conduct), the notion that role conflict could occur *between* professional roles within the same profession (for example, treatment and other roles) emerged as central. Strasburger, Gutheil, and Brodsky concluded that the problematic nature of role duality supported its avoidance and cautioned that therapists who attempted to combine roles faced "especially treacherous waters" (454).

The explicit identification of dual (or even multiple) agency in professional roles was critical to extend the debate in forensic ethics. Multiple roles, after all, had become more commonplace in forensic practice, where the primary therapeutic duty to the patient came into tension with third-party obligations such as safety to the community, relationships with payers, advancement of research, and responsibilities to other care providers (Robertson and Walter 2008). While role identification and clarity could assist the forensic professional in elucidating responsibilities and allegiances, multiplicity of role was but an early chapter. Since that time, prominent voices in forensic ethics have argued that critical elements are missing from this "Standard Position" (Appelbaum 2008, Miller 2008).

Griffith (1998) came to the debate in response to Stone and Appelbaum to question the relevance of their frameworks to nondominant groups, with a particular emphasis on race. The essence of Griffith's normative claim is that a "culture-free" theory of ethics is insufficient; instead, sociopolitical considerations are critical to the work of forensic specialists and its ethics. A robust notion of ethics requires incorporating the narrative of the personal alongside the professional: for Griffith (2005), there must be concern both about commitment to professional values and responsibility to others in one's community. The personal and the professional are not so easily delineated. Instead, they inform each other. The forensic professional should not distort justice but must not forget compassion for the less fortunate (Griffith 2005, Norko 2005).

This expansion beyond role ethics as central to the forensic psychiatric enterprise to include the importance of narrative continued with contributions based both in professional ethics and in traditional medical ethics, particularly

principlism. First, avoiding dual roles was more easily said than done in many forensic contexts, and, second, the dual-role approach lacked the undergirding of a professional ethos (Candilis, Martinez, and Dording 2001; Martinez and Candilis 2005). As a result, an ethics for forensic psychiatry, for example, requires incorporation of elements of personal and historical notions of medical professionalism in order to avoid harm (Candilis, Martinez, and Dording 2001; Martinez and Candilis 2005). Professional integrity is deeper than role identification, performance, and ethics on this view and must resonate both with the individual values of integrity and professionalism of the forensic specialist as well as with the narrative history of both medicine and the evolving field of forensic psychiatry (Candilis, Martinez, and Dording 2001; Martinez and Candilis 2005). This conception of an expanded forensic ethics has also benefitted from an incorporation of pluralistic theory and methods, which strive to identify context, apply often competing ethical considerations derived from a common morality, and engage the tension in coming to a resolution (Beauchamp and Childress 2009, Timmons 2013, Weinstock 2015).

DEFINING THE CONTEMPORARY CHALLENGE

When Stone first embarked on his challenge to the ethics of forensic psychiatry, his principal focus was on the role of the forensic psychiatrist offering testimony in courts (Stone 1984). Appelbaum's (1997b) proposal also focused on forensic psychiatrists in the legal system, with roles in the courts as prominent. Yet today, there are few psychiatrists practicing in isolation from systems of care. The evolution of the healthcare system has necessitated that psychiatrists attend not just to the patient but also, for example, to public safety, through mandated reporting and protective actions; payment systems; administrative entities (both public and private); and integrated-care systems. In navigating these many systems, how do psychiatrists reconcile responsibility to individual patients and to third parties? And, even more, what are the responsibilities of psychiatrists beyond their responsibilities to the individual patient? Are there values that psychiatrists ought to recognize by virtue of the profession? And are there other cultural or moral norms that should be considered, even in the absence of a treatment role? Competing considerations are now common across psychiatry, in which the psychiatrist must answer, in whole or in part, to both patient and third party. This is not just specific to forensic psychiatry but more broadly occurs, for example, in psychosomatic medicine

(consultation liaison psychiatry), child psychiatry, community psychiatry, psychiatric research, and psychiatric publication (Robertson and Walter 2008).

One often-cited example of ethical conflict, which has been the subject of significant attention, is the role of psychiatrists in the current system of managed care and insurance benefits. There are several ways in which challenges of the payer system may lead to ethical tensions between the patient, on one hand, and third parties, on the other. Treating psychiatrists, viewing most prominently the individual patient before them, may feel justified in actions that promote the well-being of their individual patients over systemic limits that appear unjust. Examples might include writing prescriptions for more frequent administration of a medication than the patient actually takes, to "assist" the patient in avoiding a high monthly copay. The psychiatrist, as the treater, feels justified out of obligation to the patient, who otherwise would struggle to pay for medication or, even worse, be unable to afford monthly medication copays were the psychiatrist to prescribe the medication as taken. In using this example to teach medical students about ethics, there is the inevitable and positive impulse to help patients in the interest of patient primacy and beneficence. After all, insurance and pharmaceutical companies make a lot of money, and this is one vulnerable patient before one individual physician. On its face, this dilemma is of Stone's first type: twisting the rules of the game, so to speak, to help the patient. The practice might help the individual patient but also raises questions about the individual psychiatrist's responsibility to honesty, nonparticipation in fraud, and his or her professional duties. As Stone suggested, these ends-justifies-the-means activities on behalf of individual patients could compromise the integrity of the profession, even if we assume that the psychiatrist acted in good faith and with beneficent motives in writing the prescription. Identification of role identity as treater of the patient does nothing to help resolve this tension.

At the opposite end of the payer spectrum is the psychiatrist who serves in an insurance or managed care–reviewer role. That psychiatrist does not treat the patient who is the subject of the review. Instead, the reviewer's job is to determine whether the care requested or being delivered meets the contractual terms such that it will be paid for, in full or in part, by the managed-care company. Treating psychiatrists often view, justifiably or unjustifiably matters not, the managed-care reviewer as an obstacle to the individual patient's care, a so-called hatchet person, an individual with no conscience and merely concerned about dollars and cents. Treating psychiatrists direct venom at reviewing psychiatrists when individual patients do not get the care that the treating

psychiatrists believe the patients should receive insurance reimbursement for, given the clinical presentation. No doubt there are challenges and obstacles within the current U.S. healthcare-financing structure. And, no doubt, the psychiatrist acting in an insurance-reviewer capacity cannot wholly ignore the needs of the individual patient and may not deny care that patients ought to be entitled to, based on professional norms and standards as well as insurance-contract provisions. The reviewer who serves the interest of the managed-care company by wrongly or unfairly denying benefits or by enforcing denials of care that is medically necessary in the interest of profit is clearly running afoul of Stone's second concern: that the individual is deceived or mistreated in the interest of the system. Note, however, that if the reviewer acting in good faith and according to sound judgment and criteria does what the treating psychiatrist wants and authorizes treatment out of compassion that is not contractually covered, the reviewing psychiatrist runs afoul of Stone's first concern: twisting the rules of the system to help the patient.

There is no question that the treating psychiatrist has a fiduciary obligation to the patient's treatment. There is also no question that some managed-care companies have engaged in overly restrictive practices that led to treatment denials for patients in need or at risk or that could potentially violate parity-law requirements (Plakun 2017). The first point of these countervailing examples is to show that once psychiatrists are engaged in a system of care of any kind—a payer system, a public-health system, a hospital system—competing responsibilities are likely, if not guaranteed, to occur, and any course of action must be engaged with careful consideration of the many values and considerations that are in tension. The second point is that the values assumptions that factor into action guidance need to be explicit. It is easy to say, or more problematically feel but not explicitly identify, that the patient is good and the managed-care company is bad in addressing the tension between the two. It is true that psychiatrists must think of patient interests centrally and prominently. But it is also true that psychiatrists cannot ignore or abdicate other responsibilities in the name of individual patient interest.

It is perhaps easy, at least for some, to discount the competing claim of the managed-care company, especially in a context of aggressive denials of care. But substituting a public-health system for a managed-care company, for example, still leads to the same core dilemma about how to make allocations from a system to individuals and how to reconcile the individual with the finite pot of resources in the system budget, a budget approved by representatives of the individual's constituency. The point remains that the tension between the

individual patient and the greater good of society is upon us as a profession. It cannot be ignored. Furthermore, while the parsing of roles to determine responsibilities of the individual psychiatrist actor in each situation is both practically necessary and helpful in guiding the psychiatrist actor in identifying responsibilities and obligations, it is not sufficient to resolve ethical tensions and conflicts. The managed-care reviewer can no more discount the well-being of individual patients whole cloth based on the role of reviewer any more than the treating psychiatrist can ignore reimbursement requirements and prescription-writing regulations in the role of clinician. To do so, as Stone warned more than three decades ago, would compromise the integrity of the profession. An ethically satisfactory approach in a system of care requires an explicit identification and acknowledgment of the inherent tensions, and even conflicts, before the psychiatrist as healer, researcher, and administrator in an increasingly complex system can preserve the integrity of the profession and the well-being of our patients. But how?

APPROACHING THE CHALLENGE

In early 2015, American Psychiatric Association President-Elect Renee Binder convened an ad hoc workgroup to revise the APA Ethics Annotations. This group worked alongside the APA Ethics Committee to compile the APA Commentary on Ethics in Practice (APA 2015). The purpose of this commentary was to provide useful tools for psychiatrists to engage the everyday ethical challenges that emerge in the contemporary practice of psychiatry. The goal was not for the commentary to provide answers in specific situations but to make explicit the ethical tensions that are likely to arise in practice and to provide education, guidance, and tools to engage these tensions outright. Of note, colleagues from the realm of forensic psychiatric ethics were included in this project: Appelbaum, Griffith, and Candilis served as consultants to the workgroup, and Weinstock served as a member. In full disclosure, I chaired the workgroup. The APA Board of Trustees approved the commentary at its December 2015 meeting, and the document was made available online to members.

In addressing the challenges of systems of care, the APA Commentary on Ethics in Practice came to a balancing approach. It recognized that psychiatrists owed duties to third parties such as insurers but also to group and multispecialty practices, hospitals, government and military systems, and, increasingly, to accountable-care organizations (ACOs) (APA 2015, 9). In section 3.4.1 of the commentary, the workgroup recognized both the increased

complexity of these systems and the challenges to the primacy of patient care for psychiatrists in these systems but also the opportunity for innovation, research, integration, research, and collegiality. What guidance could the workgroup provide to colleagues given such muddy waters?

Ultimately, the workgroup adopted an equilibrium approach to the ethical tensions inherent in systems of care, recognizing obligations that psychiatrists may have to employers, ventures, and systems but explicitly stating that patient interests cannot be ignored. Specifically, the commentary addressed the responsibility of psychiatrists working in cost- and care-containing systems:

> Psychiatrists practicing within such systems must be honest about treatment restrictions, maintain the confidentiality of patient information, ensure reasonable access to care within the system, and help identify alternatives available outside of the system when the patient's psychiatric or medical well-being requires it.
>
> (APA 2015, 9)

The individual psychiatrist may have multiple masters, but the patient is always present in the calculus. The psychiatrist must carefully walk the line between the patient and the system without distorting the interests of either.

In the commentary, the workgroup departed from a strict role-definition hierarchical approach to these obligations and similarly departed from a hierarchical ordering of these competing interests. Instead, the document left open the possibility of a recognition of these tensions so as to allow for a pluralistic approach to their engagement, incorporating principles, narrative, compassion, and professionalism. One facet of this balancing approach is that, in a pluralistic society, it allows for individual psychiatrists to identify and apply their own values in engaging ethical tensions within the confines of the profession's ethics. On this reading, the possibility of a range of ethically permissible alternatives may be developed and discerned in coming to a course of action in an ethical dilemma. Yet this possibility may also raise challenges of lack of coherence, substantive rigor, and even moral relativism, at the extreme.

A moral pluralism is required to capture the richness of the profession and promote and protect its integrity. But, amid external pressures from ever more complex systems in an increasingly vibrant and innovative society, how can psychiatrists continue to foster a moral identity? In this respect, moral action in the individual case, identifying and making explicit the ethical tensions, and maintaining the integrity of the psychiatrist is necessary. But it is hardly sufficient. The commentary acknowledges this point in its recognition that

psychiatrists have duties in the particular but also to "maintain[ing] commitment to promoting organizational ethics supportive of individual patient care and care of patients more generally" (APA 2015, 9). This commitment is a broader call to action. Psychiatrists are uniquely positioned to influence the system by making explicit—not just in individual cases but more broadly in practice and policy—the ethical considerations that ought to be incorporated in the provision of psychiatric (and medical) care. However, there are also the values that as citizens we ought to share in understanding and defining the scope of our responsibility to one another as both professionals and as citizens.

Individuals may engage this challenge through advocacy of their own. On this view, however, the roles of organized psychiatry and medicine take on particular significance in fostering the moral norms that ought to guide healthcare in our society. These roles are particularly important in the liberal political state. Liberal here refers not to politically liberal but rather to a society that identifies the responsibilities of its citizens based on choice (right) rather than a predefined notion of the good to which society strives (Sandel 2009). Without collectively calibrating our moral compass in developing a vision of the good, divisiveness and a lack both of engaged citizenry and compassion ensue (Sandel 2009). The effects of the liberal view of the state and institutions are particularly relevant to the realm of healthcare. As Annemarie Mol (2006) described in her monograph, the guiding force in healthcare similarly rests on a logic of choice. But actually to care for and take care of our patients (and one another), healthcare should instead engage a logic of care (Mol 2006). How does this occur? For Mol, the logic of care occurs when moral and values judgments occur in the performance of practical activities. Ethics, and the determination of good, better, and, for that matter worse, occur in the doing (Mol 2006, 75). For Mol, defining the good is a critical part of practice. This call to action has the potential to reinvigorate the ethics of the profession at a critical point in time, one in which societal pressures both financial and political seem poised to challenge and dismantle the very foundations of ethics the profession was built upon.

CONCLUSION

There remains an ongoing tension in forensic practice between responsibility to the individual patient and to other roles and obligations. Psychiatrists

cannot manage these tensions through role separation alone. Instead, ethical tensions are inherent in psychiatric practice, increasingly so, given our ever more complex systems of care. To navigate these waters, forensic professionals benefit from making the tensions explicit; engaging them from a broad ethical perspective incorporating principles, professionalism, narrative, and compassion; and effecting a balancing of competing values in coming to a course of action among ethically permissible alternatives.

However, engaging the particular is not enough. Forensic practitioners also have the important responsibilities of engaging in organizational and societal debates about what core values matter and are at stake and to advocate for the creation of systems, policies, and law that serve the core mission of care. Through this advocacy, psychiatrists and psychologists can influence care for patients but can also strengthen the integrity of the profession.

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5

OBJECTIVITY AND BOUNDARIES OF COMPETENCE AS ETHICAL ISSUES IN FORENSIC ASSESSMENTS

Jennifer Cox and Stanley L. Brodsky

WHEN ALBERT FINK, a forensic psychologist from Bloomington, Indiana, intentionally drove his BMW into a tree in August 2016, he told the investigating state trooper something startling. He said he was afraid that it would be discovered that he had falsified his competency-to-stand-trial report for a case scheduled to be heard the following day. The eighty-three-year-old Fink subsequently admitted to having falsified other reports, and, indeed, jail records showed he had never been present at times he indicated he had completed evaluations. Fink was later charged with obstruction of justice, charges that are pending as of this writing (Del Monico 2016, Fater 2016).

In a parallel example, Joseph Franzetti, an Arizona psychiatrist, is under investigation by the Maricopa County Sherriff's Department for sexually inappropriate behavior with a detained forensic evaluee (Rubin 2009). But Franzetti's allegedly unethical behavior began years before that reported incident. According to Paul Rubin of the *Phoenix New Times* (Rubin 2009), Franzetti has a history of submitting competency evaluations after meeting with defendants for only fifteen minutes. Subjects of these interviews reported that his "evaluation" consisted of a single question. Many of these reports include identical "quotes" from the defendant, and in each case Franzetti opined that the defendant was incompetent yet restorable. At the time of this writing, Franzetti continues to receive referrals from the Maricopa juvenile court.

Fink's and Franzetti's professional misdeeds are compelling instances of blatant unethical behaviors in forensic evaluations. However, few cases of unethical behaviors lend themselves to such clear black-and-white interpretations. Most unethical actions are more nuanced and less obvious.

Ethical forensic assessors are committed to maintaining clear objectivity and competence in evaluations of defendants and litigants. Objectivity may

be compromised in a variety of ways. In this chapter, we discuss explicit identification with the retaining or referring party as well as implicit processes in which diminution of objectivity is outside the awareness of the mental-health expert assessor. In a process known as adversarial allegiance, the expert acts in a covert but compelling manner to influence the direction of even purportedly standardized measures toward the retaining party.

A second compromise of ethical professional behaviors occurs when forensic mental-health experts practice outside the boundaries of their competence. Although this principle is widely understood and accepted, the actual nature of these boundaries has not been fully explored. In this chapter, ethics will be examined that are associated with occasional and crossover assessment areas, with what may be termed dilettante practice, including practicing in an area new to the assessing expert.

For both of these topics, the chapter starts with a delineation of the ethical dilemmas. Then case examples will be presented. Finally, possible paths to prevent or resolve the ethical conundrums will be identified.

ADVERSARIAL ALLEGIANCE

First labeled as such by Murrie et al. (2008), "adversarial allegiance" is the psychological phenomenon that describes a tendency for forensic experts to reach conclusions more favorable to the retaining side. Not a new concept, adversarial allegiance is rooted in decades of psychological theory, including social-identity theory (Tajfel 1982) and cognitive-dissonance theory (Festinger 1957). Brodsky (1991) applied this phenomenon to the courtroom and opined about a "pull to affiliate." He cited an old German proverb that illustrates this phenomenon: "Whose bread I eat, his song I sing." Indeed, courts and court officers have lamented that experts sometimes may sacrifice objectivity for advocacy (Boccaccini and Brodsky 2002, Edens et al. 2012, Mossman 1999, *U.S. v. Fell* 2005).

A number of field studies supported the likelihood of adversarial allegiance (Murrie et al. 2008, Murrie et al. 2009). When examining the prosecution- and defense-retained experts' scores on a measure often used for assessing violence risk, the Psychopathy Checklist-Revised (Hare 2003), in a sexually violent predator civil-commitment context, Murrie and colleagues (2009) found less than half of the variance in defendant score could be attributed to a defendant's true level of psychopathy. Instead, in this adversarial context, the average PCL-R

score given by the prosecution was 24, compared to the average defense score of 18 (Cohen's $d = .78$). This difference is especially striking considering the dozens of studies that have documented that the PCL-R is able to be scored reliably in research and nonadversarial settings (Gacono and Hutton 1994, Hare 2003). The Murrie et al. findings suggest there is something about the context of the adversarial legal process that influences the clinician's ability to score this measure reliably. These field studies evoke adversarial allegiance, in that prosecution-retained experts rated a defendant higher on the risk measure compared to the defense-retained experts.

Field studies are further supported by case-law research. In reviewing published and unpublished case-law decisions, researchers have made inferences about the evidence the court considered when rendering appellate decisions. Two studies in U.S. (DeMatteo et al. 2014) and Canadian (Edens et al. 2015) case law have reported that opposing experts' PCL-R scores favor the retaining side. However, these differences are not limited to the PCL-R. When reviewing Canadian case law, researchers found that an actuarial measure, the Violence Risk Appraisal Guide (Quinsey et al. 1998), may also be susceptible to adversarial allegiance (Edens et al. 2016).

Only tentative conclusions can be drawn from these data. It is possible the attorneys chose experts they anticipated would be sympathetic to their side or that experts hired by one side were better trained than the opposing evaluators. For these reasons, a controlled laboratory study was necessary to eliminate error and control for extraneous variables.

Murrie and colleagues (2013) published such a study. Researchers recruited over one hundred doctoral-level forensic clinicians and trained them on the PCL-R as well as the Static-99R (Helmus et al. 2012), an actuarial measure of sexual-violence risk. All participants attended the same formal two-day training and then returned three weeks later to complete the case ratings. During this portion of the study, participants were randomly assigned to the prosecution-retained or defense-retained conditions. Participants met with the same "attorney" (confederate), who acted as a representative for either a public defender's service or a prosecution unit. Participants then read through the same four cases, which included court, criminal, and correctional records, and rated each defendant on the PCL-R and Static-99R.

The results were striking. In three of the four cases, expert ratings showed a clear pattern of adversarial allegiance, with effect sizes in the medium to large range. The pattern emerged for both the PCL-R and the more structured Static-99, although the differences in ratings for the Static-99 only reached

significance for one case. The researchers asserted that their manipulation was likely weaker than actual judgments seen in the field. Participants only spent fifteen minutes with the retaining attorney and received the same case information across conditions. In real cases, experts are likely to spend considerably more time with the retaining attorney and elicit different information from collateral sources. These data raise serious concerns about the objectivity of forensic mental-health experts working in the adversarial context.

AN (EXTREME) EXAMPLE OF ADVERSARIAL ALLEGIANCE

Data from field studies, case-law reviews, and experimental manipulations suggest adversarial allegiance is real and may affect an evaluator's decision. Anecdotal accounts provide rich details of the phenomenon. According to Mike Tolson, of the *Houston Chronicle* (2004), an extreme example of adversarial allegiance comes from Dr. James Grigson, a forensic psychiatrist practicing in Texas in the 1970s, '80s, and '90s. Grigson testified as an expert witness for the prosecution in over 160 cases. In more than one hundred of these cases, he opined that the defendant would pose a continuing threat to society if not given a sentence of death. The base rates of violent crime for inmates sentenced to life in prison are low (Cunningham, Reidy, and Sorensen 2008; Reidy, Cunningham, and Sorensen 2001; Sorensen and Cunningham 2010), and empirical data suggest life-term inmates are less likely to engage in violent behavior compared to inmates with lesser sentences (Sorensen and Cunningham 2010). Indeed, the low base rates of violent behavior during incarceration directly conflict with Grigson's frequent assertion that the defendant would not only pose a continuing threat to society but would "absolutely," "beyond any doubt," and "without question" murder again (Marquart, Ekland-Olson, and Sorensen 1989). Offering an opinion with such certainty is atypical and not supported by the empirical literature on violence-risk assessment. This reputation earned him media attention on the national level as well as the nickname "Dr. Death." In 1995, Grigson was expelled from the American Psychiatric Association, and he subsequently tapered down his clinical work in death-penalty cases (Tolson 2004). However, he remained active conducting competency evaluations (always retained by the prosecution) until his retirement eight years later.

Some lawyers have argued that Grigson's long-term impact was to fuel distrust for mental-health testimony and provide evidence that forensic experts

are only "hired guns" (Mossman 1999). In 1997, the Texas Defender Service stated, "Grigson, while outlandish and notorious, is not the only 'expert' upon whom the state of Texas relies to convince juries of the need to put a defendant to death. Other 'killer shrinks' have followed Grigson's lead" (Texas Defender Service 2004, 19). This pejorative view of mental-health experts may bear out in the courtroom. In a 2012 review of case law, Edens et al. examined allegations of bias in mental-health testimony. When a mental-health expert's neutrality was questioned, allegations most typically involved questions about the expert's willingness to bias their opinion or advocate for one side.

Dr. Death is an extreme example. However, the totality of Murrie and Boccaccini's work suggests that all forensic clinicians may be susceptible to this cognitive bias. Consciously or unconsciously, they are more likely to side with the attorneys paying their fees.

AVOIDING THE PULL TO AFFILIATE

The pull to affiliate may be too strong to eliminate completely. However, if we connect adversarial allegiance with its presumed theoretical ancestor, social-identity theory, methods of ameliorating its effects become more obvious. Educating evaluators about adversarial allegiance may result in more informed, less biased, opinions. Further, increased attention to nonsupportive data when forming an opinion may eliminate the extent to which the evaluator places undue weight on any opinion-confirming data points. Ethical evaluators may choose to consider perspectives such as "What would the opposing attorney want to see?" "What data dispute my hypotheses?" and "Does this report language accurately reflect my level of confidence in my opinion, or am I trying to 'sell' my opinion too much?" which could help reorient the evaluator to reflect his or her opinion more accurately.

Evaluators may also benefit from seeking peer supervision and consultation from a colleague unaffiliated with the case (Grisso, Heilbrun, and Goldstein 2009). The value of good supervision cannot be overstated. If used correctly, this practice can help the evaluator organize and synthesize case information and simultaneously explore contextual characteristics influencing the evaluator's conceptualization. In addition, forensic mental-health professionals might consider accepting referrals from both prosecutors and defense attorneys. This "playing-for-both-teams" approach could also result in increased credibility in the eyes of attorneys, jury members, and judges.

Systematic changes may be helpful, although they are unlikely to be implemented. For example, jurisdictions could require that each referral include two experts, one for each side, or that all expert witnesses be court appointed. Although some jurisdictions do regularly employ such a strategy, particularly for highly sensitive cases (for example, juvenile-competency evaluations and child-custody evaluations), this practice is far from the norm in most criminal cases. Legislators are unlikely to allocate funds for this service, and attorneys may not need, or even want, a forensic evaluator to support their legal strategy.

The available research suggests a second expert may not help the court reach a more valid decision. For example, Edens et al. (2014) examined the differences in PCL-R scores between court-appointed, defense-retained, or crown-retained (prosecution) experts in Canadian criminal proceedings. To explore this question, Edens and colleagues identified all published cases that included at least two experts, categorized the expert based on the retaining party, and then compared each expert's score with the other expert's within the same case. Across almost all possible pairings, the level of agreement was low, with interclass correlation coefficients ranging from .20 to .79. However, the pairing with the lowest level of agreement was the two court-appointed experts, suggesting a more complex reliability problem that cannot be attributed to adversarial allegiance alone.

Levett and Kovera (2008) explored the impact of opposing expert witnesses from a different angle. In this study, researchers presented mock jurors with a defense-retained expert who testified regarding psychological research. Participants then read either an opposing expert who challenged the relevance of the research, an expert who challenged the relevance of the research and the quality of the research methodology, or no opposing expert. Data suggest that the presence of an opposing expert, regardless of the content of the expert's testimony, resulted in jurors who were more skeptical of all expert testimony. The addition of an opposing expert also did not help jurors distinguish between flawed and valid scientific testimony. Although informative, these studies undoubtedly require replication and expansion to understand what and how contextual factors mediate these relationships.

In summary, research supporting the phenomenon of adversarial allegiance is mounting. We offer suggestions for how evaluators may attenuate the impact of this effect on the quality of their opinion, although more research is needed to understand better how clinician- and case-specific variables influence, and are influenced by, this effect.

ATTRIBUTIONS OF INCOMPETENCE

When we addressed adversarial allegiance, our attention was focused on real differences in tests and associated conclusions between forensic examiners retained by opposing sides. A related phenomenon is the perception of compromised objectivity, in which experts perceive other forensic experts with substantially different conclusions as biased and bought. This perception is common. We hear state-employed forensic assessors sometimes disparaging independent evaluations, finding pathology or incompetence where none exists. In the same sense, we sometimes hear independent evaluators labeling state-employed assessors as knee-jerk tools of prosecutors.

Our perspective is that caution is in order about the stimulus pull to label experts "on the other side" as incompetent. Forensic professionals tend to be invested in their training, their methods, and their conclusions. When other evaluators have reached contradicting conclusions, some evaluators inappropriately rush to fill the causal space with attributions of incompetence. We see this process as possibly reflecting a first cousin of adversarial commitment as well as a form of narcissistic thinking that "I am right and therefore the slovenly and slippery other evaluator is unethical and wrong."

Many forensic assessors fall into this trap. What to do to avoid it? The responsible position is to speak only of one's own findings. When we are on the stand and asked about a differing conclusion or expert, we usually try to respond with a statement that we cannot speak for what anybody else has done but can only describe what we have done and what conclusions we have formed.

At the same time, a modest confession is in order. Every now and then we do privately think pejorative thoughts about other examiners and their conclusions. However, we try not to be caught up in such thoughts and never communicate them in our reports or when on the stand.

BOUNDARIES OF COMPETENCE

The Ethics Code of the American Psychological Association concretely mandates that psychologists should not engage in clinical practice outside their boundaries of competence (APA 2010). The aspirational Specialty Guidelines for Forensic Psychology (APA 2013) specify that forensic psychologists should consider a number of factors when determining their personal level of

competence, including their training, experiences, preparation, opportunities for consultation, and complexity of the referral question. Five areas of knowledge are specified:

1. Knowledge of the legal system and the legal rights of individuals
2. Knowledge of the scientific foundations for opinions and testimony
3. Knowledge of scientific foundations for teaching and research
4. Appreciating the impact of personal beliefs and experiences
5. Appreciating individual and group differences

Other organizations, including the Federal Bureau of Prisons and the American Bar Association, also outline education and training criteria that must be met before a clinician can qualify as "expert." The American Academy of Psychiatry and the Law in its 2005 two-page set of ethical guidelines similarly declared, "expertise may be appropriately claimed only in areas of actual knowledge, skill, training and experience" (AAPL 2005). In the fifty-page revised 2015 guidelines (Glancy et al. 2015), the assertion is again made that knowledge, skill, and expertise is needed before accepting a case, but this time a substantive and detailed case is made that cultural understandings and formulations are core elements of professional competence.

In every field, forensic mental-health professionals are mandated to obtain and maintain competence. This mandate raises the question of what really is competence.

THE NATURE OF COMPETENCE

Forensic mental-health professionals routinely evaluate the competency of litigants and defendants. They examine competency to stand trial, competency to act pro se, competency to understand Miranda warnings, competency to make a will, and many other criminal and civil competencies (Glancy et al. 2015). Forensic professionals are sometimes better at thinking about the competencies of others than they are about their own professional competencies. It is not far-fetched to generate the concept of metacompetence in this context: the competence to assess competence.

Consider as an element of professional competence the nature of experience in conducting forensic mental-health assessments. If examiners have never conducted an assessment related to a particular topic or population, does

such inexperience place them outside the boundaries of competence? Despite the inclusion of experience as one of the five criteria in the Federal Rules of Evidence ("Testimony by Expert Witness," *Fed. R. Evid.* 702) for admission of persons as experts, we argue that experience by itself neither validates nor invalidates the competence of examiners to perform specific tasks. Indeed, Faust (2012) has argued that experience is unrelated to competence. In his chapter on experts' experience and diagnostic accuracy (131–146), Faust observes that there are few differences in performance between experts with much and little experience, in part because of the unstructured and impressionist methods used.

We agree here with Faust that the essential question is what examiners know and what they have learned in their assessment experiences. Every forensic expert has a starting point in his or her career, in which a first evaluation on a specific topic is undertaken (see Cox, Stinar, and Foster 2017 for a discussion of novice forensic evaluators). Furthermore, one may reasonably posit that there are aspects of every evaluation that are in some ways different from all others, in terms of culture, background, legal issues, and functioning of the examinee.

A colleague told of the first time he assessed a Native American woman who was suing the university that had employed her, with allegations of racial discrimination. Instead of assuming that he knew what it meant to grow up on a Lakota community in South Dakota, he asked this well-informed woman what he should read to understand the culture in which she was raised. She gave him a list of books, four of which he read. When he eventually conducted the assessment, he was more informed about her cultural heritage and assumptions. Was he incompetent to conduct the assessment before he read the books? That is hard to judge. However, it is reasonable to conclude that he was more prepared after reading them.

In the book *The Portable Mentor*, Trimble (2013) points out that much research and practice in psychology has been carried out in a cultural vacuum. It is seductive for forensic mental-health examiners to proceed in a manner that is stimulus-bound by the psycholegal tasks to be addressed. Furthermore, related issues may be raised about the depth and nature of the knowledge base on which assessors rely. For the moment, let us accept such professional myopia as a reasonable possibility for some examiners. Then how do examiners become aware of their limitations, and how do they become more informed and more broadly competent? These are not simple questions.

We do know something about the cultural competence of forensic mental-health examiners. Kois and Chauhan (2017) surveyed one hundred forensic

evaluators about five domains of cultural competence, including communication issues and topics such as alternative healing practices. The demographic characteristics of the forensic evaluators differed substantially from the examinees, and there were many approaches to becoming culturally competent. Evaluators often did not meet practice guidelines for cultural competence, but the more varied the examinees in terms of race and language, the more likely evaluators were to be culturally sensitive.

The detailed findings from Kois and Chauhan revealed that most of their forensic examiners saw themselves as culturally sensitive and competent. It is reasonable to ask how much of this affirmative responding is part of a socially desirable response set. For example, 72 percent of the respondents usually or always considered how the examinees' perceptions of the examiners' racial or ethnic background may have influenced their response style. Although we have no data on the topics, our own observations and discussions with other examiners have led us to infer that this, in fact, is an infrequent consideration. Indeed, the authors of the study concluded that "Most notably, a number of evaluators reported that they *infrequently* or *never* ask evaluatees about their evaluation expectations, religious beliefs, or use of alternative healing practices, which are all important practices to pursue" (Kois and Chauhan 2017, 8). The authors conclude, and we agree, that forensic evaluators are ethically obliged to get the experience, skills, background, and perspectives to practice in culturally competent ways.

As an example of such complexities, we consider that forensic examiners and their work rarely fall into clear taxonomies of "competent" or "not competent." Despite the reports of almost all examiners that they know practitioners who are profoundly and unethically incompetent, we see competence as a skill that must be understood in context. Is the examiner competent in assessing psychological aspects and causal links of personal injuries? Can she or he sort out the extent to which specific events were influential in leading to impairments? Does the examiner appreciate nuances of the legal issues on which the examination is built? Are there blind spots in the examiner's work because of personal or idiosyncratic training experiences? Are the examination methods explicit and appropriate? Are examiners overly reluctant or have insufficiently high thresholds in reaching inferences related to MSO pleas?

These questions do not necessarily lend themselves to straightforward resolution. The last question, about thresholds for mental-health conclusions related to pleas of not guilty by reason of insanity, is illustrative. Some examiners are fiercely hard-nosed about reaching conclusions supportive of NRGI pleas; others consider that a straightforward history of severe mental disorders

and similar current disorders are sufficient. Is the difference in conclusions a matter of competence? A matter of training? A matter of knowledge? A matter of preexisting bias against (or toward) such evaluations supporting such pleas? We are inclined to agree with the last assertion.

CLINICAL EXPERTISE IS NOT NECESSARILY FORENSIC EXPERTISE

In their 1997 and 2007 articles, Greenberg and Shuman drew bright lines in the sand between what practicing mental professionals do and what forensic mental-health professionals do. The distance between the roles is indicated by the drama of the article titles used by Greenberg and Shuman: "irreconcilable differences" was used in the 1997 article and "when worlds collide" in the 2007 follow-up article. The nonforensic professional was described as committed to a helping role in which the objective is the promotion of the therapeutic relationship. As a helper, the therapist is typically supportive and accepts with little scrutiny what is presented by the client. In contrast, the forensic professional is engaged in critical scrutiny for the purposes of addressing a mental-health/legal issue being adjudicated in an adversarial context.

Nonforensic practitioners get dragged into litigation for a variety of reasons. Sometimes they are the only practitioners in sparsely populated rural areas. Sometimes clinical therapy clients are charged with offenses, are caught up in custody battles, or are participants in personal injury or civil actions. When subpoenaed, the pull to offer an opinion can be strong. They want to help their clients. They think they know a great deal about the psychological makeup of their clients. And as much as they find the legal context scary and unfamiliar, when they are dragged into depositions of court and asked to offer opinions, they offer opinions.

It is not enough just to dislike being in this legal setting. Unless the practitioners have substantial forensic knowledge, they are practicing beyond the limits of their knowledge. Ethical practitioners stay intensely and closely within the bounds of what they have done and what they know. That boundary usually encompasses saying "I don't know" over and over again when asked about parenting abilities, proximate causes, and mental states at times of offenses, issues about which they have not conducted an evaluation.

When our clinical colleagues have been in this position and ask for our advice, we inquire about the nature of the working relationship with the client. We address the difference between a therapy client and a forensic examinee.

These practitioners often do not want to be testifying about their clients, but they tend not to have the clarity of knowledge about the differences between what they have done and what forensic examiners do.

There is one more ethical boundary problem that is first cousin to that of the treating mental-health professional. This occurs when professionals, distressed by the paperwork, Health Information Portability and Accountability Act (HIPPA) constraints, and financial limits of therapy practice try to add an element of forensic work to their activities. Such a forensic practice on the side is not automatically unethical. That depends on how much practitioners supplement their assessment skills, learn about the legal issues, and shift from clinician to forensic examiner. It is not easy, but it is doable.

Many such practice jumpers do not supplement their skills enough. A few CEU workshops rarely suffice. Given the availability of systematic academic training, internships, residencies, postdoctoral fellowships, and other advanced study, it is a formidable task to bring oneself up to a practice level of sound competence.

COMPETENCE IS DYNAMIC

The notion that competence is not fixed may be obvious to some readers. However, we argue that it is easy for forensic evaluators to become complacent with respect to their personal competency, potentially rendering themselves incompetent. The foundations of scholarly and professional knowledge are constantly evolving. When evaluators practice without being well tuned to the field's understanding of effective evaluations, by not staying abreast of current practices or the most recent useful tools, they are diminishing their commitment to ethical practice.

All jurisdictions require licensed mental-health experts to complete a certain number of continuing-education hours yearly. Presumably, these continuing-education requirements result in professionals who are reasonably abreast with up-to-date literature and knowledgeable about trends in the field. Realistically, however, these CEU requirements fall short of ensuring competent experts. Jurisdictions do not mandate training within forensic assessment. Assessment measures are often updated, and understandings of the biological and sociocultural factors that affect behavior are evolving. Over the past decade, a significant push has been made from within the scientific community to scrutinize our own research, encourage more stringent methodology

and open access to data, and limit the implications that are drawn from any single study (Kidwell et al. 2016, McKiernan et al. 2016, Open Science Collaboration 2015). It is impossible and undoubtedly unrealistic for forensic experts to digest and critically evaluate every newly published study that may, in some way, relate to their forensic practices. Instead, experts are tasked with selectively identifying the literature they believe is most pertinent to their work and turning the science into application.

EXPANDING THE BOUNDARY OF COMPETENCE

One obvious method of working toward competence is continuing to be a student of the field. CEUs are meant to work in this capacity, but one must commit to be a lifelong learner to make real strides toward competence. This includes paying attention to and digesting empirical literature, attending training workshops to familiarize oneself with the best of assessment tools, and challenging oneself to explore new areas of interest.

In this regard, we would encourage the motivated clinician to accept referrals for new and different cases, a choice that calls for putting in the work required to complete the evaluation competently. Indeed, if every clinician focused solely on cases in which she or he felt completely competent, the field would be overflowing with assessors conducting personnel or competency evaluations. Instead, a reasonable amount of consultation and supervision, coupled with research on the more recent empirical findings, may move one well along the path to be a competent evaluator.

CONCLUSION

Ethical forensic evaluators are committed to maintaining objectivity and professional competence in every area of their work. Although aspirational, a high bar of competence is necessary to improve the quality and ensure the integrity of our work. Adversarial allegiance is just one phenomenon that may affect this integrity. Although compelling, research on this phenomenon is in its infancy, and more work is necessary to understand the full scope of its effects and how forensic evaluators can minimize the impact on their opinions.

The principle of competency is long standing and widely accepted throughout the field of psychology. Yet "competency" itself is an ambiguous construct,

and, despite efforts to operationally define and measure competency in the form of licensing tests and continuing-education training, it remains subjective. We have addressed the ambiguity of the construct, including how competency is shaped by context and professional and state definitions.

We have also offered suggestions on how to decrease adversarial and other bias perspectives and increase competency. We have not covered every possibility. Instead, this discourse has sought to encourage forensic evaluators to examine their own practices to come closer to reaching aspirational goals of forensic competency.

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6

MINORS' AUTONOMY IN FORENSIC CHILD AND ADOLESCENT PRACTICE

Peter Ash

FORENSIC EVALUATIONS OF CHILDREN and adolescents differ from forensic evaluations of adults in several ways. With adults, respect for persons requires that, with limited exceptions, the informed consent of the evaluee be obtained. In those situations where informed consent is not required, then appropriate notification about the nature of the evaluation must be provided. From an ethical standpoint, one of the most significant differences in child forensic work is that children are generally, but not always, legally deemed not competent to give informed consent for themselves, so such decisions are made by a substitute decision maker. Parents are the most common substituted decision maker, but sometimes guardians, state agencies who have custody, or courts provide consent. Substitute decision makers are generally expected to make decisions in the best interests of the child. The child or adolescent is due appropriate notification about the evaluation, and their assent may be solicited. Appropriate notification and the weight given to a child's assent depend to a large degree on the developmental maturity of the child. A number of problems may arise as a consequence of this approach, including:

1. How is the decision maker to ascertain the minor's best interests?
2. What happens when decision makers have conflicts of their own that undermine their motivation to act in the best interest of the minor?
3. In what situation is an alternate decision maker not appropriate and the minor's consent required?
4. How much explanation about the evaluation and its purposes needs to be given to the minor?
5. What weight is to be given to the autonomous choice of the minor to assent (or not), especially when it conflicts with the choice of the legally designated decision maker?

6. Particularly in situations in which the child does not assent, how is the clinician to proceed in a way that protects the child's developing autonomy and promotes self-esteem?

The dilemmas discussed in this chapter will have as a central theme the exploration of the questions just enumerated.

The general principle that minors cannot legally consent for medical procedures, which would include forensic evaluations, has exceptions. For example, emancipated minors, typically defined as those who are married, in the military, or are living separately and self-supporting, legally function as adults. Adolescents can consent to treatment of sexually transmitted diseases and substance-abuse problems on their own. If a pregnant girl wants to obtain an abortion without notifying her parent, she can go to the juvenile court, where the judge will make a determination as to whether the girl is a mature minor, in which case she alone can consent, or, if she is found not mature, whether an abortion is in her best interest. If a minor is capable of giving assent, the child's assent is necessary for participation in any research that is not of direct benefit to the minor. Some states allow "mature minors" to consent to medical treatment. In some jurisdictions, a minor who can understand what a do-not-resuscitate order means must assent before such an order is written. Youth waived to adult criminal jurisdiction can provide consent for most forensic evaluations. The justifications for these exceptions provide pointers to ethical principles that are relevant in other ethically complex situations.

The law typically distinguishes between consent and assent. Consent is what is legally required for an evaluation to proceed, and assent refers to the agreement of the minor. Assent is taken into consideration but is not binding on the legal decision maker or the evaluator. With regard to medical treatment, there is a growing consensus among pediatricians that the child's refusal to assent should carry considerable weight when the treatment is not essential or can be delayed without substantial risk (American Academy of Pediatrics Committee on Bioethics 1995, De Lourdes Levy et al. 2007).

PROFESSIONAL CODES OF ETHICS

Professional codes of ethics give relatively little direct guidance regarding problems related to the autonomy of children and adolescents in forensic evaluations. The ethics code of the American Academy of Psychiatry and the Law (2005) has no discussion of the differences between evaluating a child and

evaluating an adult. The ethics code of the American Psychiatric Association (2010) has several references to including families in the treatment of minors and a reference to confidentiality but does not discuss autonomy issues of minors. The ethics code of the American Academy of Child and Adolescent Psychiatry is centered on the Belmont Principles, which include respect for persons, beneficence, and justice (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978) and states:

> Children and adolescents, however, should play a role in determining the services they receive and their participation in treatments to the extent of their capacities to understand options and act rationally. . . . Child and adolescent psychiatrists are strongly advised to proceed with great caution regarding the performance of forensic evaluations on patients with whom therapeutic relationships are contemplated or previously exist, inasmuch as such situations are likely to pose conflicts of interest.
>
> (AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY 2014)

The forensic guidelines of the American Psychological Association (2013) discuss the issue of consent with minors in guideline 6.03.03: Persons Lacking Capacity to Provide Informed Consent:

> For examinees adjudicated or presumed by law to lack the capacity to provide informed consent for the anticipated forensic service, the forensic practitioner nevertheless provides an appropriate explanation, seeks the examinee's assent, and obtains appropriate permission from a legally authorized person, as permitted or required by law.
>
> (EPPCC STANDARDS 3.10, 9.03)

The question of what constitutes "appropriate explanation" will be discussed below.

DILEMMA 1: AUTONOMY IN THE CONTEXT OF POSSIBLE SELF-INCRIMINATION

A father brings his thirteen-year-old son for treatment because he suspects his son has sexually molested his sixteen-month-old nonverbal baby sister. The clinician realizes that if he learns enough from the boy reasonably to suspect that he is abusing his sister, he is legally required to make a report to Child Protective Services (CPS), which has a significant likelihood of resulting in the boy's arrest.

Psychiatrists are generally advised to avoid the dual roles of being both a forensic evaluator and a treating psychiatrist in the same case. Mandatory-reporting laws, however, add to mental-health clinicians the role of having a duty to the state in any case where unreported child abuse or neglect is suspected. Most often, the evidence for abuse comes from the child victim, but clinicians sometimes obtain incriminating information from a suspected child perpetrator.

In the above example, the clinician is being asked by the parent to take the role of treater. But before treatment for sexual abuse can commence, the clinician (or someone) needs to determine whether sexual abuse actually took place. While such a determination by the consulted clinician is not being done primarily to provide information to a court, the fact that a positive finding of sexual abuse requires reporting to CPS gives such evaluations a strong forensic aspect. Thus, if the clinician proceeds to see the boy, it is hard to avoid taking on the roles of treater, forensic evaluator, and investigator for the state.

Since the clinician is initially being asked to provide treatment, the default beginning position is for the clinician to see his or her role as having a duty to care for the patient. In this example, a potential constraint on the duty to maintain confidentiality is the mandatory reporting of suspected abuse. A reasonable first step is to see the parent alone and, before obtaining any information, to inform the parent of the clinician's duty to report suspected abuse. As a matter of law, the parent is the person legally charged with making the decisions as to whether the clinician should conduct an evaluation of his son. Such laws are based on the premise that minors are legally incompetent to give consent in most situations, and the law presumes that parents will act in the best interests of their child and so can provide consent for them. In this case, however, the parent has mixed allegiances: in addition to wanting help for his son, he wants to protect his baby daughter, possibly at the expense of his son. Further complicating the parent's decision is that it is unclear what will happen if a report to CPS is made.

A report might trigger a criminal prosecution of the son. However, the benefits of treating the son may outweigh the risks of his being involved in the legal system, especially if the clinician can help guide the case toward mental-health interventions as opposed to criminal sanctions. Juvenile-court judges are often more likely to let young perpetrators who are actively involved in treatment proceed with treatment without removing them from the home than they are if the case first comes to attention through legal processes, such as complaints by a victim. How the legal system approaches a young offender

varies widely depending on the jurisdiction, the age of the offender, whether the problem comes to the attention of the authorities from a therapist for the offender or from the victims, and the particular views of the case worker assigned to the case, as well as the nature of the abuse. There are also jurisdictional differences as to whether reports to a therapist are admissible in court to prove guilt. Further, since the main clinical issue is that if abuse is occurring, the most important thing is to prevent further abuse from occurring, both for the sake of the victim as well as for the sake of the perpetrator, who will likely only face more severe sanctions if abuse continues. A strong argument can be made that it is in the boy's interest to obtain treatment as rapidly as possible.

In speaking to the parent, the clinician faces the dilemma of how to advise the parent on the pros and cons of communicating anything about his son. If the clinician has had experience with CPS in the local jurisdiction, the clinician could inform the parent of how they might respond. He could then lay out the father's options, which include consulting an attorney by the father and the boy for advice on how to proceed or to proceed with the father's telling the clinician what underlies his concern. While referral to an attorney has the attraction of helping safeguard the boy's rights, the reality is that while the attorney could interview the boy without having to make a report, few attorneys are skilled at conducting such an evaluation, and even if they were, if abuse has taken place it is likely that the need to protect the baby sister will require some intervention with the boy.

Whether or not the father decides to consult an attorney or retain one for his son, at some point the father will likely discuss with the clinician his grounds for concern about his son. As a result of that discussion, the clinician may have enough information to form a reasonable suspicion of abuse such that the clinician is required to make a report to CPS. Making a report based on limited information, prior to seeing the boy, has certain advantages. It avoids the problem of the boy's incriminating himself in a context where the clinician must make a report. In most jurisdictions, once a report is made, the clinician does not have an obligation to provide further details if more information becomes available. While this may seem like finessing the system, the principle behind mandated reporting is that clinicians sound the alarm but do not have the duty of further investigation. Further investigation is the job of CPS, and the boy does not have to answer any questions they might pose (a right he should certainly be informed of and encouraged to utilize).

Another possibility is that the information provided by the parent does not lead the clinician reasonably to suspect abuse.

With the parent's informed consent, the clinician could legally proceed to evaluate the boy by conducting a diagnostic evaluation that may be a prelude to treatment. What is his ethical duty toward the boy with respect to explaining the clinician's role, the nature of confidentiality, and possible outcomes? Answering this question requires weighing the conflicting duties of promoting the best interests of the boy, maintaining the boy's confidentiality, protecting his sister, and fulfilling legally mandated reporting requirements.

If a report has already been made to CPS, the clinician needs to ascertain whether he has an independent obligation to make a further report. If so, the clinician may want to obtain only as much information as is necessary to make a report. After a report is made, the clinician cannot promise the boy to keep additional material confidential, but it is less likely that he will have to make further disclosures to CPS, and the clinician can likely revert to a role of evaluating for treatment.

If no report to CPS has been made, the situation is more complicated. The evaluation then takes on aspects of a forensic evaluation, and it may not be appropriate for the clinician to continue later as a treating clinician. The clinician faces the issue of what to tell the boy about the interview. Is a *Miranda*-type warning required, something along the lines of "If you tell me you molested your sister, I will have to report this to CPS, and you could get in serious trouble"? Does the clinician need to advise the youth that he does not have to answer any of the clinician's questions? If one views the situation as an investigation into a possible criminal offense, where a possible outcome is criminal prosecution, then it would seem to follow that a warning against self-incrimination is necessary. The obvious downside to this approach is that such a warning is likely to lessen the likelihood of the clinician's obtaining information needed for effective treatment. Respect for the autonomy of the boy, however, probably requires that he be informed about what's at stake and that he has a right to refuse to answer questions.

Could the self-incrimination problem be sidestepped by utilizing an educational intervention, one in which no determination is made as to whether abuse occurred, but simply clarifying for the boy what behavior is not appropriate, essentially a "I don't know if you did it, but if you did, stop, and here's why" approach? While such an approach has the advantage of not having the boy incriminate himself, many parents and therapists might see this as a half-hearted approach to a serious problem.

There are no clear-cut answers to these dilemmas. The clinician has a clear duty to care for the patient, but this duty is constrained by the limited confidentiality inherent in mandatory-reporting statutes. In the author's experience,

actively advocating for the adolescent by developing a good treatment plan and actively engaging with CPS, the courts, and the youth's attorney has usually succeeded in diverting the adolescent into the mental-health system and forestalled punitive sanctions. Whether the evaluating clinician continues as the treating clinician is a decision that needs to be made with the clinician, parents, and adolescent and often results in a decision to engage another clinician for ongoing treatment.

DILEMMA 2: ADOLESCENT PROVIDING HIS OWN CONSENT

A fifteen-year-old boy has been arrested on a murder charge, and he has been waived to adult criminal jurisdiction. A court-ordered evaluation on competency to stand trial and criminal responsibility has been ordered. The boy's attorney has agreed with the need for an evaluation on criminal responsibility but not on competency.

Court-ordered competency evaluations do not require the consent of the evaluee, but criminal-responsibility evaluations, since they involve waiving Fifth Amendment rights against self-incrimination, do (*Estelle v. Smith* 1981). In most jurisdictions, fourteen-year-olds are legally incompetent to make decisions about their medical care, but minors who are criminal defendants in adult court are empowered to consent to make decisions about their case, plea bargains, and criminal-responsibility evaluations. The reason for this appears to be largely practical: No one else is deemed in a better position to provide consent, in large part because no one else knows the precise details of the crime or will bear the punishment. This, too, is a situation where the law is clear, but ethical problems remain: Can one get informed consent from a minor in a meaningful sense, not just in a legally permitted sense, and if so, how is that to be done?

Although minors are presumed not legally competent for most decisions, research on the cognitive capacities of adolescents generally supports the finding that for adolescents of normal intelligence age fifteen and up, for decisions made with reflection (as opposed to decisions quickly or impulsively made in stressful situations), adolescents make decisions similar to those of adults. This conclusion has been researched in situations involving waiving *Miranda* rights following arrest (Grisso 1981), decisions about consenting to health care (Lewis et al. 1977, Weithorn and Campbell 1982), preferences about custody in hypothetical divorce situations (Garrison 1991), and decisions about

psychoeducational interventions (Taylor, Adelman, and Kaser-Boyd 1985). Other studies have found that normal adolescents age fourteen and up are typically competent to stand trial (McGaha et al. 2001, Savitsky and Karras 1984, McKee and Shea 1999, Grisso 2013). This research was used in professional associations' amici briefs to the U.S. Supreme Court in the 1980s and early 1990s to support the view that pregnant adolescent girls seeking abortion without notifying their parents should be able to do so (see, for example, American Psychological Association 1990). On the other hand, studies on adolescent decision making under stress, used in arguments to reduce adolescent culpability for crime, generally find that stress, peer pressure, and threat disrupt rational decision making, leading adolescents in those situations to overweight immediate rewards as opposed to long-term consequences (Ash 2012).

As with adult defendants, respect for the youth's autonomy requires that a youth who undergoes a court-ordered evaluation for proceedings in adult criminal court should be given notice of lack of confidentiality and notice of how the information will be shared. This information needs to be conveyed in a manner suitable for the developmental stage of the juvenile defendant, which will often require more detailed explanation than is needed for an adult. Presumably the youth has had an attorney appointed—if not, the evaluation should probably be deferred until an attorney has been appointed—and so has had an opportunity to discuss the evaluation with the attorney. In addition, if the attorney has concerns about the evaluation, the attorney has had an opportunity to object formally to the evaluation being conducted. If the evaluation includes an evaluation for criminal responsibility, the consent of the evaluee is required. Some states have statutes that spell out minimum requirements for notice, which may vary depending on the nature of the proceeding, as juvenile courts may have different standards from criminal courts (Barnum, Silverberg, and Nied 1987). As a practical matter, the defendants who require more detailed explanation, and whose understanding needs to be more carefully tested, are those under age fifteen or those who have some degree of intellectual disability.

DILEMMA 3: APPROPRIATE NOTIFICATION

A ten-year-old girl has been removed from her home following a finding that she was kept locked in a basement room by her parents for six months. She very much wants to be returned to her family, but CPS is strongly against reunification, and

"CONTINUED"

the parents are being prosecuted on criminal charges. A forensic psychiatric evaluation of the girl is requested by the prosecutor to ascertain the effects of the abuse, as conviction of the parents legally requires a finding that the girl suffered from the abuse. Legal custody is currently with CPS, which has consented to the evaluation.

This example raises the questions of what type of notification is due the girl and whether it is ethical for the evaluating psychiatrist to use his or her skill in forming relationships with children to obtain information from the child that will likely be used to support nonreunification and criminal conviction of the parents, outcomes the girl strongly opposes and finds terrifying.

The AAPL ethics guidelines (2005) state that "at the outset of a face-to-face evaluation, notice should be given to the evaluee of the nature and purpose of the evaluation and the limits of its confidentiality. The informed consent of the person undergoing the forensic evaluation should be obtained when necessary and feasible." There are at least two separate issues here. The first has to do with consent in forensic evaluations, and the second has to do with what notice is necessary, whether it's seeking consent, assent, or simply providing information so that the evaluee can understand what is going on. With regard to the consent/assent distinction, in this situation consent from the girl is not legally required, as legal consent has been given by CPS, which has custody. However, in most situations, it is not clear that the type of notice given should be different, depending on whether assent or consent is being sought. The underlying idea is that respect for the evaluee's autonomy dictates that people understand the situation they are in, regardless of whether the situation calls for consent, assent, or simply maximizing the child's understanding.

"Notice" in the AAPL guidelines appears to mean that the evaluee is told the evaluation is for the purpose of determining the girl's views, that the evaluator is not providing treatment to the child, and of the limits on confidentiality (that the evaluator will be writing a report and may testify). Such notice essentially describes the process of the evaluation. The second sentence quoted above could be read as implying that such notice represents the "informed" part of informed consent.

What is absent in this notice is any discussion of the likely outcomes of the evaluation (that the girl will not be reunited with her parents). Further, it does not include any statement that the girl does not have to participate, nor that she does not need to answer any questions. Yet in a medical context, actual potential outcomes, such as the likelihood of improvement, side effects, and risks of no treatment, are considered required elements of the informed-consent

process. Why should informed consent for a forensic evaluation be different? First, with adult evaluees, the outcomes are generally understood by the examinee. Most evaluees understand that if the evaluation is for disability benefits, the possible outcomes are that they get benefits or not; for an insanity plea, they receive an insanity acquittal or not, etc. However, when the outcomes are not obvious, then it would seem that the informed-consent process should include informing evaluees of the potential outcomes. Leaving out such a discussion suggests that the process is actually notification of the process of evaluation and not informed consent. On this reading, use of the term "informed consent" would appear to be an ethical gloss rather than a correct use of the term. A second possible reason for not including discussion of potential outcomes is that the outcomes turn on legal processes (trial outcomes, plea negotiations, settlement discussions), and a mental-health clinician might disclaim expertise in predicting the outcome of legal processes, although for an expert forensic examiner such an argument appears disingenuous.

The most likely reason that discussion of the possible outcomes is omitted is that discussing the outcomes may subvert the advancement of justice, which is the main goal of the evaluation. Such a discussion might encourage evaluees to bias their answers toward their preferred outcome, thus frustrating the aims of justice. Nevertheless, there is a strong argument to be made that respect for persons implies that if the potential outcomes are unclear to the evaluee, they should be spelled out as part of an informed-consent process, especially when the person being evaluated is not a party to the case and has no obligation to participate in the evaluation at all.

One counterargument potentially applicable to child evaluees is that whatever adult provides formal consent is more able than the child to ascertain the best interests of the child and to act in the child's behalf. However, particularly when a child is in state custody, there are instances in which considerations other than the child's interest are paramount, such as when prosecuting a parent. (Best-interest considerations are more relevant in determinations about reunification or termination of parental rights.) A forensic evaluator might take the position, "Well, I have legal consent, and it's not my role to determine whether such consent is actually in the child's best interest." This, however, does not obviate the problem of what information should ethically be provided for informed assent and what weight is to be given to the child's assent or lack thereof. Respect for persons would weigh on the side of providing information about possible outcomes for those who have limited knowledge of the legal system. Standardized protocols for sexual-abuse evaluations

of suspected victims do not generally contain discussions of the child's right to refuse to answer or the possible consequences to the perpetrator (see, for example, National Institute of Child Health and Human Development 2007). A further downside for the child is that if a child does provide information after being told that it may lead to an outcome the child doesn't want, the child may feel responsible for the outcome.

In a treatment context, if a treater has parental consent but the child does not assent, the treater can (generally) administer treatment over the child's objection (hospitalize, administer medications, conduct a procedure, etc.). In an interviewing context, however, a child's refusal to assent can be determinative. There is no obvious way of forcing a child to reveal information the child is determined not to give. As a consequence, the practice of child forensic psychiatry tends to emphasize providing notice of the process of the evaluation, which serves the interest of the justice system but typically does not provide full information that would bolster the child's autonomous decision making when doing so runs a serious risk of the child's withholding information.

The issue here is akin to the use of the *Miranda* warning in police interrogations. The police are obligated to tell the defendant that what he says "will be used against him," but just what that means is not spelled out, and the context of the interrogation is structured to encourage a defendant not to take that warning seriously. There are few instances in which it is good judgment to waive *Miranda* rights, which is why attorneys almost always advise their clients not to do so. Yet society is comfortable giving the notice but then going ahead with interrogations of defendants who do not use good judgment. Children, whose knowledge of legal processes and whose maturity of judgment are generally considerably less mature than adults, are in a comparable situation.

A related problem to what notification should be given for a forensic evaluation is what techniques are ethically appropriate in obtaining information. In forensic evaluations, it is generally considered unethical to lie to the evaluee, unlike in police interrogations, where such techniques are commonly employed (for example, "Your friend has already confessed that you both robbed the store, so why don't you just tell me about it . . ."). Children especially defer more to authority figures, and they tend to be more compliant with adult requests to answer questions. It is also clear that suggestive questioning of children is much more likely to lead to inaccurate information than using such questions with adults (Ceci and Bruck 1993). What is less clear is the extent to which using interviewing techniques that build rapport with children, and so encourage them to provide information that is possibly contrary

to either their wishes or their best interest, is ethical. Children do not have the judgment and autonomy of adults, so to what extent does an evaluator need to protect a child from the consequences of the child's immaturity? There is no clear answer to this question, but in practice, the interest of the justice system in obtaining relevant and accurate information gives forensic evaluators wide latitude in utilizing noncoercive and nonsuggestive techniques and outweighs the need of informing the child of the possible consequences of providing information.

CONCLUSION

In civil cases involving forensic interviews of children and adolescents, legal consent for the evaluation is typically provided by an adult substitute decision maker. This can lead to ethical dilemmas when the person consenting has interests other than the best interests of the child or when he makes errors in assessing the best interest. Respect for the autonomy of the child requires that the forensic evaluator consider this possibility and may, depending on the situation, need to advocate for the child's interest and not exploit the child's vulnerability.

Most forensic evaluations, both civil and criminal, have as their primary duty furthering the interest of justice. The ethical duty to respect the evaluee's autonomy comes up particularly in the evaluator's discussion of the nature of the evaluation and obtaining consent or assent from the evaluee. This discussion is more complex with children and adolescents, given their immature developmental status. Using the terms "informed consent" or "informed assent" with regard to forensic evaluations of children and adolescents (and likely even of adults in many instances) appears to be a somewhat misleading use of the term. In a medical context, "informed" includes identifying potential outcomes. Forensic evaluators of children and adolescents rarely discuss potential outcomes that are likely to result from the evaluations (go to prison for twenty years, go to a mental hospital if found insane, have one's parent removed from the home, etc.), even though children especially are often unaware of the legal implications of the information they convey. Rather, evaluators restrict the information provided to notice of the process of the evaluation (lack of confidentiality, no treatment relationship, distribution of the report, etc.). "Notice" would appear to be a more appropriate term than "informed consent" or "informed assent." Promoting justice appears to outweigh providing full information, which respect for persons might suggest.

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7

ETHICS DILEMMAS IN CORRECTIONAL INSTITUTIONS

Graham D. Glancy and Alexander Simpson

PRACTICING CLINICAL PSYCHIATRY in circumstances of high security presents particular challenges. Psychiatrists owe patients the same ethical duty that any treating psychiatrist would, but the circumstances of security, whether in a correctional facility or a maximum-security hospital context, necessarily complicates the treating relationship. Issues of high risk to self and others are generally present, and institutional rules and accountabilities require the psychiatrist to work with the security apparatus of the institution in its day-to-day management. Progress is frequently governed by institutional or criminal-code review boards or parole boards that may require the treating psychiatrist to report on aspects of clinical progress, thus highlighting problems of dual agency: where the professional's commitment to a patient is at odds with the competing demands of the institution. Often the ethical paradigms of beneficence/nonmaleficence and security/justice are in competition (Adshead and Sarkar 2005).

Various regulatory and professional associations publish information on practice ethics that govern the behavior of psychiatrists working in correctional institutions. Organizations such as the American Medical Association (AMA), the American Psychiatric Association (APA), and their equivalents in various jurisdictions, such as the Canadian Medical Association (CMA) and the Canadian Psychiatric Association (CPA), publish ethics codes, which give broad guidance. These principles are clearly applicable to the clinical practice of psychiatry, including in the correctional and high-secure contexts. However, in the particular situation of correctional forensic psychiatry, there are supplementary guidelines coming from relevant specialist organizations, such as the American Academy of Psychiatry and the Law (AAPL) and its Canadian equivalent, the Canadian Academy of Psychiatry and the Law (CAPL).

The traditional medical-ethics codes are derived from the Hippocratic Oath. The practitioner in each subspecialty has to translate and apply these traditional ethical guidelines into practical everyday use. This is not always an easy task. Correctional psychiatrists often work in isolated areas, in a very different institutional structure from that found in a healthcare organization, and under considerable work pressure, and they have to deal with particularly difficult ethical questions. The published ethics guidelines are useful as reference documents, but in practice, they provide little clear guidance. The individual practitioner has to make decisions based upon a number of factors, which include institutional values and norms, broader societal norms, legal rights and duties, and other factors (Ward and Syverson 2009). The individual psychiatrist has to apply core ethical terms such as justice, beneficence, nonmaleficence, honesty, dignity, and autonomy and then contextualize these in a broader ethical model.

Clinical correctional psychiatry must be bounded by the standard ethical practices that apply to all clinical contexts. Multiple statements of human rights and domestic legislation require that prison inmates are entitled to the same standard of healthcare to which they are entitled in the community. That includes an expectation of the same ethical standards from their attending physician. Correctional and forensic psychiatrists are also confronted by a variety of ethical complexities. What is one's duty to work with correctional authorities around the safe care of a person presenting serious risk to others? How does one respond to a requirement to report to parole, probation, or institutional review boards as a treating doctor? And what if one's clinical opinion results in longer detention or impairment of liberty for one's patient? These are examples of when the competing paradigm of justice can affect the clinical duty of beneficence/welfare.

The distinction between the ethical obligations of a treating psychiatrist and a forensic psychiatrist providing a report to a lawyer or review board has been discussed at length by Appelbaum (1997). He argued that the general medical approach, focused on the psychiatrist's obligation to the patient, provides limited ethical guidance to the forensic psychiatrist. He proposed specific principles to guide forensic psychiatry that could be likened to the single code primacy–criminal justice approach discussed earlier. He proposed two principles to guide forensic and correctional practice: "truth telling" and "respect for persons." This approach recognized that the psychiatrist is serving an instrumental role on behalf of the justice system (Wolgast 1992). Glaser (2002, 2010) proposed that psychiatric intervention in a correctional treatment setting may be constrained by general norms of human rights and dignity

applicable to our patients, particularly prisoners. Correctional psychiatrists must attempt to retain a strong focus on values such as autonomy and respect for patient's dominions (Brathwaite and Petit 1993), including significant attention to human-rights misuse (Birgden and Perlin 2008). However, this approach has been criticized, with Levenson and D'Amora (2005) noting that simple treatment in correctional facilities should be differentiated from assessments for the court or for correctional authorities and that it is the latter functions that complicate the role of the correctional psychiatrist.

It can also be argued that some interventions are more ethically coherent if understood as forms of punishment that may prioritize social benefits over individual benefits (Glaser 2010). Ward (2010) suggested that the potentially harmful nature of interventions undertaken in the name of justice should not be considered punishment because they are justified by the absence of an intention to inflict suffering, a position supported by Day and colleagues (2004), who pointed to the overall benefits of rehabilitation to the client as well as to society in general.

The practitioner frequently has to walk a fine line between the mental-health and criminal-justice aspects in determining what ethical practice is. Monahan (1980) asserted that psychiatrists working closely within the legal system are obligated to balance an individualistic orientation to the patient against the collectivistic orientation to social welfare. He noted that the collectivistic orientation in the end carries more weight. Other commentators have proposed a schema focused on balancing the value of the patient's welfare against societal justice (Adshead and Sarkar 2005). Another way of looking at this is proposed by Allan (2013), who identified six criteria to consider in the balancing equation. These factors are individual autonomy, human rights, law, public morality, organizational norms, and professional norms.

Commentary included in the various ethics guidelines noted above may provide the practitioner with some help in balancing the various conflicting values. It is necessary to look further in order to resolve specific situations. For example, Candilis and Neal (2014) described a notion of "ethical exceptionalism," defining this as the special obligation of psychiatry to justice and public safety, an obligation that may justify research and interventions that might be unethical for other types of physicians. One of these authors also offered an approach that he described as "robust professionalism," which advised psychiatrists to engage evaluees, patients, and other persons associated with the case as parties to relationships with narratives that the psychiatrist must understand in order to act ethically (Candilis et al. 2001). Included in this concept are core principles such as sensitivity to vulnerable evaluees, sensitivity to role

problems, awareness of personal biases, honesty, and competence. This acknowledges that multiple values of the various parties require consideration when faced with an ethical dilemma.

Four general ways in which correctional psychiatrists can navigate these ethical complexities include single code primacy–mental health professional; single code primacy–criminal justice; balancing approaches; and hybrid approaches (Ward 2013).

The *single code primacy–mental health* approach reflects the traditional theoretical orientation that correctional forensic psychiatrists are physicians first and that their obligations to the patient include treatment within a medical model. From this perspective, ethical obligations to the court, to correctional institutions, and to third parties should be secondary to the interests of the patient (to the extent possible, given the law and relevant regulations of practice within a jurisdiction). One example of this approach is to extend the popular "four principles + scope" approach (Beauchamp and Childress 1979) to correctional psychiatry. This approach invites physicians to consider autonomy, justice, beneficence, and nonmaleficence as they relate to the patient, then subsequently to consider this in light of the scope of their obligations to parties other than the patient (Beauchamp and Childress 1979).

The traditional primacy of mental health as an overarching ethical theory in psychiatric practice has been challenged by the increasing demands for psychiatric expertise in making risk-management and classification decisions in corrections or in assessing violent-recidivism risks elsewhere in the justice system. Each of those examples appears to challenge the psychiatrist's typical patient-centered values of consent, beneficence, nonmaleficence, and confidentiality. This is the classic dual-role problem in correctional and forensic psychiatry, defined by Ward (2013) as "a quandary in which a psychiatrist faces the dilemma of conflicting expectations or responsibilities between the therapeutic relationship on the one hand and the interests of third parties on the other." Discomfort with the apparent poor fit of mental-health norms to these societal objectives has animated a great deal of discussion in the field.

ETHICS PROPOSALS

Weinstock (2015) proposed an elegant approach to prioritizing and balancing the various conflicting principles, duties, and personal and societal values. He proposed a method based on what he called "dialectical principlism,"

involving synthesizing contradictory and competing considerations into a coherent whole in order to guide one's actions. He described this as a way of balancing primary duties to the patient and secondary duties to other parties such as the criminal-justice system. He asserted that this is a method whereby the psychiatrist can resolve ethical dilemmas within a dialectic, by asking oneself the questions and seeking the best answers—the Socratic approach.

On a daily basis, correctional psychiatrists repeatedly have to deal with ethical challenges in their application of the primary duties such as beneficence, nonmaleficence, respect for autonomy, and justice, with secondary duties to the criminal-justice system and to the institution. In the next section, we will frame these issues in the context of the core principles in the ethical guidelines of AAPL.

CONFIDENTIALITY

This principle is considered one of the major ethical principles in medicine and, in particular, psychiatry. Patients require reassurance that personal information will be protected in order that they will seek treatment and disclose personal details about themselves. This principle therefore promotes access to treatment and medical care, the utilitarian justification. Another way of looking at this is the deontological method, which requires physicians to refrain from disclosing information that they do not own (Green 1995). Traditionally psychiatrists have placed great emphasis on this ethical guideline. The ethics guidelines of the AAPL note that psychiatry should maintain confidentiality to the extent possible, given the legal context.

Psychiatrists must also take the correctional context into consideration. Variations on this ethical guideline apply to the psychiatrist in the correctional setting, who must give different warnings to a patient to whom he is administering treatment. This includes enunciating limitations to confidentiality for situations that may occur more commonly in correctional settings than in general psychiatry, such as the duty to warn or protect where there is a serious threat of imminent bodily harm to a third person or the duty to warn the authorities where there may be a child at risk. A common occurrence in corrections exists when a patient expresses suicidal intent; this triggers the duty to inform the administration that the patient may well be at risk for self-injury or suicide. Additionally, if the patient requires movement to a special unit or needs to be sent to a treatment facility for treatment of an acute psychiatric

episode, this requires the administration to take steps to facilitate or transfer the patient appropriately.

A further situation that arises in correctional settings is when the patient presents a significant risk of a threat to the security of the institution (APA 2016). The patient may give information that leads to the conclusion that there is a specific threat to the security of the institution. This may involve other individuals in the institution, such as specific threats to harm another inmate or correctional officer. A patient may also report that one of his peers is bringing in contraband. Psychiatrists must then balance the competing principles of confidentiality against the security of the institution and make a decision whether to inform the authorities. Another situation arises when the patient has been assaulted within the institution. In this situation, the patient may need to be moved to a different housing unit or receive other forms of protection. This may also involve initiating disciplinary proceedings against another inmate.

The duty to protect is precipitated when a patient tells a psychiatrist about an imminent threat of serious bodily harm to a third person. It is likely that this occurs more commonly in a correctional center than in the general population, so it is in the province of the correctional psychiatrist. The threat may be to another inmate, members of staff (including the psychiatrist), or to a person in the community. As in other circumstances, it is necessary to analyze the situation carefully (Chaimowitz and Glancy 2000). The first consideration is the severity of the threat and the nature of the threat. This includes a risk assessment based on all the information available. If it is concluded that the significant threat exists, then a process of negotiation takes place. The patient may agree to treatment or mitigation of the risk by various means, including involuntary admission to a psychiatric unit or facility if appropriate. If change is not effected by these means, then consideration should be given to whether there is an identifiable victim or group of victims. A special consideration in a correctional facility is the length of time that the patient will likely spend in the correctional facility and whether this restricts access to and therefore protects the intended victim. If at the end of this analysis there is still an intended victim at risk, steps should be taken to warn that victim or group. In a correctional facility, there is an additional threat to confidentiality in that it is necessary to inform the security authorities of the situation, since the patient will likely have to be moved to a different area or program.

An analogous situation applies where it is thought that a child may be at risk. An example might be when a patient confesses to pedophilic urges. Psychiatry should perform a similar analysis in this case, and the results of the

risk assessment would determine whether there is a duty to inform the appropriate authorities (Glancy, Regehr, and Bryant 1998).

The risk of suicide and self-harm is higher in prisons and jails than in the general population (Noonan and Ginder 2013). As a correctional psychiatrist, a considerable amount of time and effort is expended dealing with this issue. It is necessary to breach confidentiality in order to initiate a plan to prevent the eventuality of suicide. This plan may include housing options that allow for adequate or continuous monitoring and a plan to provide mental-health services and crisis intervention.

A common issue that confronts the correctional psychiatrist on a day-to-day basis is trying to treat and interview patients in private. The AAPL ethics guidelines (2005, 2) use the phrase "to the extent possible, given the legal context" when addressing the right to privacy and confidentiality. It is not uncommon that some psychiatric contact in corrections has to be done either in the presence of a correctional officer or at a cell door. The correctional psychiatrist has to balance the patient's need for access to care, in conditions of security as dictated by the security staff, with the requirement for privacy. The patient may refuse to come out of the cell to attend the clinic, or the security needs may dictate that the patient cannot attend without security officers present. In practice, this means that there may not be enough security staff and therefore that the patient will not have any access to treatment unless the clinician goes to the patient. The correctional clinician, therefore, has to use judgment in balancing these various needs (APA 2016). Team-based approaches have become increasingly common in correctional contacts, and therefore a wide range of staff may be present at interviews and treatment sessions. Patient's confidential information may also be exposed to possible breaches of their privacy given the increased use of health informatics and integration of health databases (Appelbaum 2002).

CONSENT

Informed consent is a principle at the heart of any discussion of medical ethics. Even though correctional institutions are to some extent punitive, in so far as they involve involuntary constraints on the freedom of the residents, nevertheless these dimensions do not mitigate the patient's moral and cognitive agency. It is therefore an ethical obligation upon clinicians in these institutions only to treat patients with their consent. At the commencement of any treatment, the clinician should assess the patient's capacity to consent and

ensure that he can give informed consent to the proposed treatment. The APA's *Principles of Medical Ethics with Connotations Especially Applicable to Psychiatry* (2013) remains the guiding document, even in a correctional setting. A statement about the limitations of the confidentiality of treatment records might include some of the issues discussed in the section above regarding confidentiality.

One of the special considerations in the structured environment of corrections arises when a patient, unknown to the treater, may expect benefits for participating in psychotherapeutic or pharmacological treatment. Dugosh and colleagues (2010) noted that patients believed that participating in groups may result in more favorable legal outcomes. Patients may also agree to participate in therapy or groups simply because they are feeling socially isolated, ignoring potential risks of treatment (Day, Tucker, and Howells 2004). It is even more important in the correctional context to be transparent about the nature of a proposed course of treatment because of the inherently coercive environment. Treatment programs aimed at criminogenic factors, for instance promoting prosocial skills and behavior by increasing the ability to manage anger and emotions, may promote accountability for past actions or expose the patient to emotional distress (Glaser 2010). Certain types of therapy promote prosocial attitudes and behavior, with the intention of helping the patient internalize social norms and thereby decrease their chances of recidivism (Day et al. 2004). These therapies may be considered a type of moral therapy and therefore ethically contentious (Day and Ward 2010). Others have argued that these psychoeducational aspects of treatment promote a sense of personal effectiveness (Levenson and D'Amora 2005).

As discussed above, forensic psychiatrists evaluating an individual are required to adopt a truth-telling function when dealing with the criminal-justice system. If the same psychiatrist is a correctional psychiatrist, performing both treatment and evaluation for the courts, with the same patient and in the same setting, this could confuse the evaluee, thereby eroding his ability to give informed consent to the treatment. In the function of an evaluator, the psychiatrist is obliged to give objective and honest opinions. The patient, on the other hand, may be under the impression that he should share his innermost secrets and that these will not leave the room. After all, in previous treatment sessions, and possibly in subsequent treatment sessions, this would be the rule. The AAPL ethics guidelines are quite clear in differentiating consent to treatment in criminal-justice settings, such as a jail or prison, from consent for a forensic evaluation. They also address this under the section entitled

"Honesty and Striving for Objectivity." They note that the psychiatrist's credibility may be undermined given the different and conflicting clinical and forensic roles. When moving from the treating role to an evaluating role, a psychiatrist no longer accepts what the patient is saying as a subjective truth but has to seek corroborative information and look at the case from an objective point of view. There is also a risk that the psychiatrist will bring information from previous treatment, which was governed by different rules of confidentiality, into a future assessment, therefore betraying the patient's trust.

It has become increasingly common for correctional psychiatrists to be involved in disciplinary matters within the institution. Although this raises questions about acting in a dual role, we would argue that it is important to take this opportunity to educate security staff about the effect of mental illness on the patient's ability to follow institutional rules. If a patient with active psychotic symptoms refuses a direct order to go into his cell, which he may believe is inhabited by the devil, it would seem to be the psychiatrist's role to explain that the patient should not be disciplined for this. In ideal circumstances, the psychiatrist should obtain informed consent from the patient and if possible not to be the treating psychiatrist (APA 2014). In practice, owing to the low staffing ratios in institutions and the immediacy of the situation, this may not be possible. Another issue is that even if the patient's mental disorder did not specifically contribute to the offense, the same mental disorder might be a contraindication for certain sanctions or punishments, such as segregation or removal of visits (Trestman 2014). It is clear that the psychiatrist should not be involved in recommending punishment, but it could be argued that suggesting mitigation for one patient but not for another is participation in the punishment process. The psychiatrist, therefore, is caught in an ethical dilemma, which would require a balancing of these competing principles.

COMPETENCE/QUALIFICATIONS

The AAPL ethics guidelines, and the CAPL guidelines (CAPL n.d.), which are under review, deal with the issue of whether the psychiatrist is competent or qualified to claim expertise. These guidelines make clear that knowledge, skills, training, and experience all go to whether a person is an expert. We argue that correctional psychiatrists also require expertise and that similar factors go to this expertise (Glancy 2015). There are five reasons why correctional psychiatrists should be forensic psychiatrists. First, forensic psychiatrists are

well positioned to deal with the ethical issues that are discussed above. Second, forensic psychiatrists have skills in maintaining boundaries, which is very useful in the correctional setting. Third, forensic psychiatrists have an intricate knowledge of the interaction between the correctional and forensic systems, which is vital in this role. Fourth, forensic psychiatrists are accustomed to dealing with the relationships between mental disorders, crime, and substance-use disorders. Last, a forensic psychiatrist is knowledgeable about the treatment of various disorders that are not in the province of the general psychiatrist. These disorders include dealing with patients with antisocial disorders, psychopathy, and the paraphilias. Management of these patients requires specialized knowledge. Administrators in the correctional institution should make every effort to employ forensic psychiatrists, rather than general psychiatrists, to administer treatment in correctional settings. This issue may not even be considered by some administrators. The professional skills of a correctional psychiatrist require an adequate knowledge of these specialized areas. The importance of these matters is emphasized by the fact that prisoners as a group are especially vulnerable, and once incarcerated, they also do not have any choice regarding their treating psychiatrist.

The Canadian Medical Association encourages all physicians to contribute to the development of the profession through research and advancement of clinical knowledge (Canadian Medical Association 2015). Correctional psychiatrists are no exception. Prisoners are a highly vulnerable group (Ward and Syverson 2009), and they may be considered underserviced (Konrad 2010). It would seem to make sense that extensive research on treatment of this population would be to their benefit and to the benefit of society. Prisoners have been exploited by the use of grievous research atrocities, such as those conducted by the Nazis during World War II (Pont 2008). In response to these atrocities, guidelines were developed that took the conservative approach to research involving prisoners (Overholser 1987). Trestman (2014) pointed out that although these guidelines were generated with excellent intentions, prisoners are now overprotected.

The International Covenant on Civil and Political Rights identified three core principles for ethical research that have been adopted in research regulations, such as the United States' "Common Rule" (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979): *respect for persons*, *beneficence*, and *justice*. Bradford et al. (2000) interpreted these three principles to support additional secondary or derivative ethical obligations, such as requiring informed consent (which respects the autonomy and self-determination of persons), the duty to do no harm (which

flows from the obligation of beneficence), and a duty to include the just and equitable distribution of research risks and benefits across society. Researchers must consider these guidelines, as well as other sources of regulation and guidance, but the level of ethical complexity is largely an effect of study design.

Some researchers and ethicists have suggested that a highly cautious and conservative application of these Common Rule principles has limited research that could be of benefit to prisoners and to society in general (Pont 2008). As a result, some jurisdictions have moved away from the general premise that prisoners are too vulnerable to participate in research without risking exploitation (Chwang 2010) or are unable to provide informed consent in light of correctional coercion (Day et al. 2004), in favor of a risk-benefit balancing approach (Institute of Medicine 2007). Elger (2008) argued that prisoners' *right to care* includes a *right to improvement in care*, rejecting the prevailing "paternalistic" approach. Chwang (2010), however, suggested that risk-benefit analysis is not necessarily a robust enough ethical heuristic to guide prison research and stated that a more specific set of principles may be required to be aware of the complex variety of risks and benefits at stake.

Correctional psychiatric research does have distinctive ethical risks, and an attention to the complex ethical context of practice is necessary to avoid "ethical blindness" (Ward and Syversen 2009) when evaluating these risks (and associated benefits). Many of these risks relate to decisional competence, understanding of the nature of the research, and the presence of potential coercion, pressure, or inducements to participate. These issues may be particularly pronounced in the correctional context, and so Overholser (1987) identified three main types of correctional research based on their relationship to prisoners as agents: *convenience research*, *prison research*, and *treatment research*. *Convenience research* is conducted with prison populations because they provide an accessible, captive participant group for administering and following up on studies that may not even benefit them. *Prison research* refers to studies of the effects and nature of prison on prisoners that may or may not be of eventual benefit to them. *Treatment research* is focused on interventions for the direct benefit of specific prisoners or prisoners as a group. This typology distinguishes among types of correctional research in part based on how it treats the autonomy and dignity of the individual: purely as an instrument for the greater good, partially as an object for understanding the institutional effects of incarceration, or as the subject of research that may directly benefit participants *and* contribute to the advancement of knowledge.

However, not all research conducted by correctional psychiatrists has the potential to benefit offenders. Some of it may be to improve the operation of

the justice system, which risks exposing offenders to longer incarceration or other consequences (Bradford et al. 2000). Munthe (2010) suggested that we can justify this fourth type of research by analogy to public-health research directed primarily toward the "societal handling of individual liberty, public safety and national economy" because research aimed at improving the justice system is a societal priority warranting a permissive approach to balancing risks and benefits.

Engaging in a nuanced analysis of risks and benefits in correctional research is an important part of ethical practice, but the effects of coercion on decisional capacity remains a live issue. A recent study of coercion in the context of consent to participate in research suggests that over half of participants were influenced by their subjective expectation that they would obtain a benefit by participation, while 15 percent felt that they could not say no to participation in research (Dugosh et al. 2010). The "therapeutic misconception" (Appelbaum, Lidz, and Grisso 2004) by participants that research is intended to produce treatment benefits is likewise a widespread issue that threatens informed consent (Christopher et al. 2011), and therefore special attention to transparency and honesty with participants is critical. Nonetheless, as Day et al. (2004) noted, the existence of subjective pressures and coercive dynamics does not necessarily reflect the objective reality of the prison environment, nor does the mere presence of potential pressure to participate negate individual offenders' decisional capacity per se. Consequently, Day et al. (2004) suggested that we liberalize our understanding of consent to participate, lest we reinforce the cautious conservatism that has limited correctional psychiatry research and left prisoners with lower-quality care. Trestman (2014) extended this argument to ask whether correctional psychiatrists have an ethical obligation actively to push for more research on correctional psychiatry.

CONCLUSIONS

Appelbaum (1997) has suggested that forensic psychiatry requires its own ethical framework, since forensic psychiatry may have different goals from those of general psychiatry. In this chapter, we argued that an extension of this argument is warranted, in that correctional psychiatry requires its own code of ethics. These ethics recognize that correctional psychiatrists have secondary duties to the criminal-justice system, which must be balanced against the primary duties to a patient in treatment. Psychiatrists in corrections will

repeatedly come across situations that reflect the ethical knife edge on which they must exist. Approaches such as Weinstock's dialectical principlism and Candilis's robust professionalism offer a mechanism for prioritizing and balancing the various conflicting principles with which correctional psychiatrists generally contend.

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8

FORENSIC ETHICS AND INVOLUNTARY OUTPATIENT COMMITMENT

Ezra E. H. Griffith and Daniel Papapietro

OVER ALMOST the last fifty years, involuntary outpatient commitment (IOC) has been a topic of intense discussion by mental-health professionals, policy makers, politicians, individuals utilizing mental-health services, and patient advocates. Useful early reviews of IOC and coercion have been carried out by Dennis and Monahan (1996) and Geller (2006). In this contentious conversation, observers and participants have referred differently to the phenomenon, calling it, besides IOC, assisted outpatient treatment, mandated community treatment, and community-treatment orders (American Psychiatric Association 2015).

The American Psychiatric Association (2015, 1) defined IOC as "a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration." In referring to New York State's statutory version of IOC, Dlugacz (2008/2009, 80) called it "a comprehensive statute establishing procedures for obtaining court orders mandating outpatient mental health treatment for those found by clear and convincing evidence to meet its criteria." The criteria referred to here are generally based on episodes of repeated nonadherence to treatment, which are followed by a deterioration of one's mental health and a tendency to refuse offered healthcare services. An important aspect of the debate over IOC has centered on whether it is ethical to compel individuals into mental-health treatment in an effort to prevent or mitigate an anticipated deterioration in their mental-health status.

IOC's significance was highlighted when the subject served as a distinguishing feature between proposals generated in the U.S. House of Representatives (HR 2646) and those developed in the Senate (S.1945) for the 2015 national political agenda to improve the mental-healthcare system. House politicians considered IOC important to have in their plan, but senators

declined to support it as a mandated feature of their proposals (Care for Your Mind 2015). This political wave at least in part catalyzed the American Psychiatric Association (APA) in late 2015 to refurbish both its position statement on IOC (American Psychiatric Association 2015) and the resource document (American Psychiatric Association 2015a) on the same subject. In its resource document, the APA noted that it had considered IOC in 1987 (Starrett et al. 1987) and in 1999 (Gerbasi, Bonnie, and Binder 2000) and reconfirmed support for IOC, stating "that involuntary outpatient commitment can be a useful intervention for a subset of patients with severe mental illness who 'revolve' in and out of psychiatric hospitals or the criminal justice system" (American Psychiatric Association 2015a, 2).

The American Psychological Association (2004) had passed a resolution on outpatient IOC as early as July 2004. In it, that association acknowledged the "disabilities associated with serious mental illness, and the competing values of personal liberty, public safety, and the public's interest in providing for those who cannot provide for themselves"; that "involuntary treatment raises special concerns about gender, ethnic or minority status . . . for the practitioner"; and that "it is never the role of any mental health practitioner . . . acting in the role of caregiver, to make decisions that infringe upon a person's right to consent to services." In asserting those claims, the American Psychological Association still advocated that psychologists stay involved in conducting research on forms of and alternatives to IOC and in professional training in the ethical, clinical, and legal considerations related to IOC.

The points enunciated by the two professional associations suggest a subtle disagreement between them concerning IOC, or at least some carefully drawn points of differentiated emphasis between them. Where the psychiatric group supported careful use of IOC as a clinical intervention, the psychological association more clearly stated that the autonomy of the patient remained paramount, though recognizing that IOC exists as a legal and social reality. Thus it expressly promoted the involvement of psychologists in advancing knowledge about IOC through participation in research, teaching, and clinical activity. These notable distinctions are a part of the historical development of IOC in the United States. Geller (2006) has documented scholarly commentary about IOC going back as early as 1967 (see Bleicher 1967) and has lucidly outlined developments in the debate between 1967 and 2006. Geller considered some commentaries balanced and others simply polarizing.

Little has changed since then in terms of the debate. In the face of clear support for IOC, Rowe (2013) has argued that there are other options for voluntarily engaging into care many patients suffering from severe psychiatric

illness. One such mechanism is the use of peer-engagement specialists. On the other hand, while the overall debate has persisted, the American Psychiatric Association (2015a, 2) has observed that IOC has been statutorily adopted by forty-five states and the District of Columbia. Thus, in the face of continuing objections to IOC, there has been significant support for it, contributing to its acceptance as an intervention both in the United States and abroad.

Consequently, we think it likely that forensic professionals will continue to be involved in carrying out assessments of patients being considered for IOC. The effective execution of such work will require knowledge about the IOC debate, clinical indications for posing such a recommendation, statutory and case law relative to the use of IOC, and the ethics-based considerations that apply to IOC. As it is the subject of ethics that concerns us here, we highlight for forensic practitioners that they will confront struggles to determine for themselves the rightness of choices and decisions concerning the use of IOC. Thus we present ethics principles that the forensic specialist should consider when engaged in clinical decision making about IOC; making recommendations to advocates, family members, and others about its use in specific cases; or contributing to the development of policies related to IOC. But as we shall see, ethics principles applied to any dilemma may at times be ambiguous or in conflict (Robers and Reich 2002), ultimately requiring what McCarthy (2003) calls "reflective equilibrium," or the flexible weighing and application of the relevant ethics principles (in our case, autonomy and beneficence), as we try to contemplate IOC. As a result, we caution against adherence to rigid principlism as we consider the complex ethics dilemmas evoked by IOC. Our point is not to join forces with either side of the debate. It is to make sure that forensic specialists are familiar with the ethics arguments relevant to the use of IOC.

GENERAL CONSIDERATIONS

Reitan (2016) noted that efficacy, legality, and ethics represent the three cornerstones of the IOC debate. Hence, while ethics as a subject is our primary concern here (particularly since the ethics-based arguments have been given relatively less attention in the literature), the clinical effectiveness of IOC has received substantial attention. Dawson (2016), a member of the Oxford Community Treatment Order Evaluation Trial group, recently raised questions about the clinical effectiveness of community-treatment orders. In so doing,

he recommended that the Canadian Psychiatric Association reconsider its claims concerning the positive treatment outcomes of such treatment orders. In light of these questions, Dawson (2016) expected that the orders would eventually face legal scrutiny in Canada.

Rowe (2013) has pointed out that there is disagreement about the treatment effectiveness of IOC, and he observed that more attention should be given to treatment alternatives. He described his experience with a peer-engagement specialist project that used persons with lived experience of mental illness to engage into treatment persons with serious mental illness who also had a history of lacking treatment adherence and demonstrated some history of being dangerous to self or others. The peers had considerable success in keeping these patients in treatment and helping them achieve improved clinical status and functioning. This outcome naturally begs for further research and confirmation.

The American Psychiatric Association's Resource Document (2015a, 2) stated unambiguously that there "was no broad consensus" about the effectiveness of IOC across jurisdictions. The document also added that research on IOC faced "substantial methodological problems" related particularly to separating "the effects of the court order" from those produced by improved access to care.

It is therefore a nonpartisan conclusion that the treatment effectiveness of IOC may hardly be considered robust enough for anyone to argue that its use as an involuntary intervention could be based solely on those grounds. Further, policy advocates should recognize that a more nuanced position is necessary, emphasizing the need for research on the potential treatment success of IOC as well as on alternative interventions to IOC. Nevertheless, none of this argumentation gets us past the traditional history of compulsory care. Reitan (2016) has noted that for a long time there has been worldwide concern about certain patients who are judged by the broad community authorities to need involuntary care for the protection of themselves and/or the community from physical, mental, or social harm. We will return to this point later.

We go back to the problem of treatment effectiveness of IOC to contemplate some novel and useful observations made by Kahan and colleagues (2010). They underlined the reality that neither side in the IOC debate about IOC's treatment effectiveness can point to conclusive empirical evidence to support its claims. They also raised an important question related to the connection between fact and culture in the formulation of public policy. Will many of us selectively interpret IOC treatment-effectiveness data in a way that

fits our preexisting values? The question is relevant because Kahan et al. demonstrated how two policy think tanks had clearly opposing views of IOC research. Thus, their theorizing leads to the complex idea that opposing cultural values may generate competing factual beliefs about IOC policy matters even within a single society. Our intent here, of course, is not to be diverted into a discussion of cultural cognition and public policy. But it is to make sure that conclusions about IOC now be related to certain aspects of the IOC discussion.

ETHICS PERSPECTIVES

In turning specifically at this point to considering certain ethics perspectives related to IOC practice or policy, we intend to strike a neutral tone. The point is to assemble ethics ideas to be found in the literature, keeping in mind the cautions advocated by McCarthy (2003) that we maintain our focus on some basic ethics principles that generally guide the work of the forensic professional, such as autonomy, beneficence, nonmaleficence, and justice. The expert should remember that any principle, while obligatory on first impression, may be overridden in certain contexts. And as mentioned earlier, the expert will evaluate the strengths and weaknesses of the principles in light of the dilemma being confronted. As McCarthy (2003) also advised, resorting to emphasizing ethics principles requires a flexibility in considering other matters, such as the narrative approach to ethics, which entails giving meaning to life stories of the individuals affected by the orientation taken in resolving the dilemma confronted.

An important final point to be understood is that substantial parts of the ethics ideas we will present should be understood as ideas flowing from philosophically derived argumentation. This is in contrast to the empirically derived reflections about the clinical effectiveness of IOC. As a result, it would be a mistake to conclude that the ethics ideas we present here are all linked to demonstrable science.

THE PROBLEM OF DISCRIMINATORY COERCION

Szmukler (2016, 125) has suggested that compelling patients to have treatment against their wishes is an unpleasant aspect of clinical practice for the clinician, and it may be humiliating for patients. It is generally conceded that some patients will express contentment at having been compelled into care. But

McNeil, Gormley, and Binder (2013) have raised questions about this claim, noting that patients' higher satisfaction with treatment was associated with lower perceived coercion and a better treatment alliance. But at this juncture, we are more concerned with Szmukler's (2016) substantive question: Why do we treat medical/surgical patients differently from the way we apply coercion to psychiatric patients?

Szmukler (2016, 127–130) explained that coercion is in play when pressures are applied at the level of threats (a clinician tells a patient that stopping medication will result in the patient's admission to hospital) or when pressure is applied at the level of compulsion (legally authorized pressures). Both of these levels of pressure are applied in the use of IOC. Szmukler (2016, 130–131) argued that generally speaking, we apply coercion to medical patients when we believe that the patient lacks decision-making capacity and wishes to do something that we judge inimical to the patient's interests. A common example is the senile patient, evidently confused and seeking to leave the hospital against medical advice. In this case, the intervention is justified by the patient's obvious lack of decision-making capacity, compounded by the potential risk of his wandering unattended in city traffic.

The other recognized example is the patient with diabetes who avoids exercise, consumes meals known to increase his blood sugar, and follows his doctor's medication instructions haphazardly. In the face of the patient's clear retention of decision-making capacity, and even taking note of the potential pernicious effects of persistently elevated blood-sugar levels, doctors and clinicians generally will go only as far as applying gentle efforts of persuasion, interpersonal leverage, and inducements of some kind to change this patient's behavior, stopping short of threats or compulsion (thus short of coercion).

So as Szmukler (2016, 127) put it, clinicians apply to medical patients these softer measures of treatment pressures, even though we recognize that the outcome is not in the patient's best interest. We appreciate the patient's capacity, and that trumps all. However, in the American Psychiatric Association's resource document on IOC (2015a, 5) we have already noted that a judge may order a person with severe mental illness but who retains decision-making capacity to adhere to an outpatient-treatment plan designed to prevent relapse and dangerous deterioration. IOC, then, is meant to prevent something from happening in the future, a preventive step we refrain from employing with the patient suffering from diabetes.

What can be the reasons for this differentiation in the legal regimes applicable to psychiatric patients, on the one hand, and medical-surgical patients, on the other? Szmukler (2016) suggested that the reasons for this difference in

treatment of the two classes of patients are based on two entrenched cultural stereotypes. The first stereotyped notion is that individuals with mental illness generally lack decision-making capacity because of their psychiatric illness. The second stereotype concerns the belief that patients with these illnesses are dangerous. Szmukler argued that we should find these stereotypes unacceptable, since we are aware that the brittle patient with repeated elevated blood sugars may at times have impaired decision-making capacity and be dangerous to self. Yet we avoid legal regimes that would interfere with their autonomy. Furthermore, the American Psychiatric Association's position statement (2015, 2) explicitly states that "the preventive form (of IOC) should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others." Szmukler considered this distinction between the two classes of patients to be a form of discrimination that may in turn produce an ethics dilemma demanding serious consideration.

What should we do to contend with this ethics problem of employing coercion in a discriminatory fashion? Szmukler (2016) recommended emphasizing a lack of decision-making capacity as a first order of consideration. As a general rule, we don't involuntarily treat medical patients who retain decision-making capacity and refuse medication. This first order of consideration would be applicable to all patients across the board. If the patient's decision-making capacity is impaired but dangerousness is present, then treatment is considered according to existing legal regulations. Szmukler pointed out that the cause of the impaired decision making should not be determinative. It is the impaired mental status itself that is important. If the patient retains decision-making capacity but is considered dangerous, then that patient is dealt with as the law prescribes for any individual who retains capacity and is threatening the safety of self or others.

We anticipate that clinicians will ask about the patient who is hospitalized in a psychiatric facility, retains decision-making capacity, and has a repeated history of acts dangerous to self or others. Such individuals may present special political and legal difficulties, since judges, legislators, and advocates may argue that this class of patients should be considered dangerous and lacking capacity simply because of their presence in a psychiatric hospital. The forensic professional should keep the ethics principles clearly in mind when discussing these local political matters. A similar situation will arise in the application of IOC when the patient is living in the community and periodically deteriorating after having stopped treatment for a period of time. Szmukler's position is that involuntary treatment must cease

once the patient is considered to have regained capacity. In other words, this class of individual suffering from a psychiatric illness should be treated like the medical patient who periodically deteriorates in the absence of care but improves and regains capacity once treated. The opposing argument will be that repeated episodes of deterioration should be avoided so as to protect the patient's long-term health, to protect self and others, and to protect health-care resources.

Stefan (2016, 495), in talking about the problem of suicide by psychiatric patients, raised her voice too in arguing against legal regimes and clinical approaches that prioritize discriminatory treatment of psychiatric patients. She argued that "there should be policies and laws that apply to everyone." She raised concerns about parallel tracks for society and a third rail for the individuals with psychiatric disabilities.

Forensic experts should be aware that, for example, Dlugacz (2008/2009, 95) suggested that the discriminatory use of coercion may attend IOC through the racial disparity seen in the application of IOC statutes. However, the authors of the American Psychiatric Association's resource document (2015a, 15) have argued that "the research on this issue is limited to a single jurisdiction." They noted that independent evaluation of IOC should be carried out regularly with regard to its possible effect on minority populations. Thus, there are currently no substantiated conclusions about the discriminatory use of IOC in minority groups, something the forensic specialist should remember.

LINGUISTIC OBFUSCATION

There are examples of "linguistic obfuscation" that merit examination at this juncture. These expressions, employed in presentations about IOC, may appear to some as an effort to frame the contextual structure of IOC in a more positive light than it deserves. Other observers may disagree and conclude that there may be a problem concerning the obligation of caregivers to deal honestly with patients and the public. The first example concerns the term "assisted outpatient treatment" referenced in the American Psychiatric Association's position statement on IOC (2015, 1), where it is acknowledged that some see the term as euphemistic. However, on the following page, the document argues that IOC "should be available to assist patients who . . . are unlikely to seek or voluntarily adhere to needed treatment" (2). The document consequently legitimizes the use of IOC as a mechanism of patient assistance, while others may argue that no such involuntary assistance is seen as necessary for the medical-surgical

patient. This use of "assist" or "assistance" may be intended to dilute and soften the use of coercion in IOC.

In the American Psychiatric Association's resource document (2015a, 13) there is explicit articulation of a response to the patient's nonadherence to the IOC treatment plan. The clinician should seek help from a special treatment-assistance team or from police officers to transport the patient to some place to undergo a forced clinical evaluation. Noteworthy here is that the sole basis for this forced evaluation may be just treatment nonadherence. In other words, the document authorizes this use of legal compulsion for a patient who, having capacity and simply being at odds with his treaters, is considered nonadherent with his treatment plan. It is hard to understand that treatment nonadherence may by itself be grounds for compulsory treatment, without further reliance on a medical justification. Presumably, calling it a lack of "adherence" to treatment minimizes the possibility that the patient may in effect be exercising the privilege of refusing a treatment plan, something that medical-surgical patients do all the time.

RECOVERY, CITIZENSHIP, AND COERCIVE CARE

We think it important to return now to the formidable task of treating individuals who suffer from mental illness the same way everyone else wants to be treated. Davidson, Rakfeldt, and Strauss (2010) have discussed the roots of the recovery movement in mental healthcare and pointed out that in the movement's early days, principles were emerging that highlighted the patient's freedom, autonomy, choice, and self-determination. It was the collective of such ideas that led to notions of collaborative relationships between caregivers and their patients and the belief that the humanity within psychiatric patients should be recognized.

As Davidson pointed out (2016), these developments emerged and were influenced by other manifestations of broad sociopolitical change: It became recognized that recovery from mental illness was possible for some individuals and that learning to live with psychiatric disabilities was an important way of approaching care of these patients, there was increased emphasis on restoring functioning for patients beyond just symptom reduction, and new ideas were established that emphasized how individuals with psychiatric disabilities could live in the community and fulfill normative adult roles even while suffering symptoms. This ran counter to the long-standing notions that many of the

illnesses represented progressive deterioration and that once diagnosed with a chronic and severe psychiatric illness, an individual could look forward with little hope for a reasonably normal life. Advocates have struggled against this morass of stigmatized abandonment and profound social discrimination.

Davidson (2016) also emphasized that the 1990 passage of the Americans with Disabilities Act helped smooth the path for many from mental illness to at least some form of recovery. The act redefined serious mental illnesses as disabilities, which extended rights and responsibilities of community living to individuals with mental illnesses, much as had been enjoyed by those with physical disabilities. This and other legal decisions were reinforced by significant advocacy efforts from mental-health professionals, consumers, and others. The aim was to combat practices that kept patients in hospitals inappropriately or in community living that was substandard and lacking supports.

Rowe (2012, 2015) emphasized that this notion of "a life in the community" went along with effective treatment to constitute a dual goal for all our efforts on behalf of patients doing their best to live with the problems of a mental illness. But this idea of living life in the community inevitably turns our thoughts to how these individuals should, in a practical way, participate in community living. How should they stand in relation to others in the community? Should their citizenship rights be merely substantive or thoroughly full? Rowe (2015, 12), advocating for patients' rights, reminded us of the different categories of these citizenship rights: legal rights, political rights (such as voting), social rights (that support economic subsistence, for example), and participation rights (in decision making among individuals and groups).

Rowe (2015, 24) has captured these notions in a collective definition of citizenship that is worth mention here: "Citizenship is a measure of the strength of the person's connection to the 5 Rs of rights, responsibilities, roles, resources, and relationships that society makes available to its members through public and social institutions and the associational life of neighborhoods and local communities." In light of this definition, some observers may contend that an important consideration rears its head: May coercion taint the label and tasks of citizenship? One could maintain that because the patient under IOC participates differently in the community, he may have some rights curtailed and certain preferences expressly ignored. For example, the patient under IOC may have his housing options curtailed or his free use of time diminished. Thus it may be suggested that IOC undermines the citizenship privileges of autonomy and dignity.

This problem concerning the possible deterioration of autonomy has been considered by Anderson and Honneth (2005, 131). They advanced the view that certain competencies that make up autonomy "require that one be able to sustain certain attitudes toward oneself (in particular, self-trust, self-respect, and self-esteem) and that these affectively laden self-conceptions . . . are dependent, in turn, on the sustaining attitudes of others." The authors theorized that these self-conceptions or this relation to self are not the matter of a solitary ego reflecting on itself. It is the "result of an ongoing intersubjective process, in which one's attitude toward oneself emerges in one's encounter with an other's attitude toward oneself" (131). The authors referred to this recognition of self in the interaction with others as "mutual recognition" and concluded that "one's autonomy is vulnerable to disruptions in one's relationship to others" (130). The authors called these disruptions "attitudes of denigration and humiliation" (131), which one might suggest could well refer to IOC. While these notions should be considered in any evaluation of potential IOC use, we remind forensic specialists that these views and this theorizing about IOC suffer from a lack of robust empirical support. Until the empirical scholarship is provided, forensic practitioners are constrained to be conservative about claims concerning IOC's impact on the individual patient's autonomy and sense of self.

In an effort to conceptualize more clearly what a patient may lose when subjected to IOC, it may well be instructive to ask what capabilities are lost to the individual with IOC status. It does not appear that IOC, for example, prevents one from exercising political capabilities such as voting. But it might deprive one of "the self-confidence to think and judge for oneself, freedom of thought and movement." One might also lose the "social conditions of being accepted by others," "the ability to appear in public without shame," and protection "from the scrutiny and intrusions of others" (Anderson 1999, 318). Of course, some may legitimately reply that some or even all of these losses may be attributable to the effects of mental illness and not IOC. They may also point out that studying these claims will be difficult because of the inherent complexity of disaggregating the effects of IOC from those of the underlying psychiatric illness.

THE CONCEPT OF THERAPEUTIC SPACES

The transfer of mental healthcare from hospital to the community is especially relevant to our understanding of IOC and to the task of finding solutions to problems appearing in the community approach to care. Sociologists,

anthropologists, and especially lawyers have turned eagerly to the study of the community as a locus of care. But now medical geographers have joined the march and are contributing significantly to theorizing about our work in the community. They are referring to the "changing geographies of care" (Williams 2002) and have noted with insightful perceptions how patients, formal and informal caregivers, and, by extension, advocates have been affected by this transformation in the locus of care. It is well known that the shifting of the locus of care from institution to community has resulted in transformations of political economy, payment mechanisms, functions and status of different care disciplines, and of course the status and contribution of the patient to the process of care giving and treatment planning.

We are most concerned with the evolution of the change in locus from hospital to community as a development with serious potential impact on the patient's identity and sense of self. It is in thinking of the architectural space where therapeutic work must occur that one begins to appreciate the complexity of the interactions that go on in the space. Indeed, the contradictions are persuasively laid bare in the study of the home as therapeutic space. The home may be seen by some as a haven, a place of freedom and independence. Others may experience it as a prison, a place of violence, a place of tyranny and oppression (Mallett 2004).

It is in recognizing the importance of the architectural shift from institution to community that some observers took an interest in visiting psychiatric patients recently discharged from hospital to the community in an effort to see where patients lived and how they spent their days. The results were sometimes disappointing, such as the case of one individual displaying the chair and table where he sat every day simply smoking cigarettes (See Davidson et al. 1995). Such an example diluted the notion of the community as effective therapeutic space. But it certainly clarified what Honneth (1992, 187) meant when he wrote of human dignity's being "ascertained indirectly by determining the forms of personal degradation and injury." Parenthetically, we emphasize again that such degradation may well be attributable simply to the corrosive effects of severe, chronic mental illness.

The implications of these developments are significant and deserve serious consideration from forensic experts contemplating the use of IOC. First, the movement from institution to community has been dramatic. The shift makes clear that the roles of patient, caregiver, and others have changed. Second, the shift to the community has required consideration of other stakeholders and their roles in the healing process (this includes individual professionals and institutions participating in the therapeutic interventions). Following

Honneth's arguments, caregivers now should understand that every therapeutic intervention should, where possible, in a spirit of beneficence, confirm the human dignity of and our respect for the patient. No clinical treatment action should be allowed in the usual course of things to weaken or dilute dignity or potentially provoke some version of humiliation.

At this point, however, we pause to acknowledge that with some patients, IOC may well be obligatory. In such cases, risking personal degradation of a patient by limiting control of his own body may be permissible. But such decisions should be clearly justified and come after having weighed other important factors, such as the decision-making capacity of the patient, his risk to self, and to the community.

Mol (2008) anticipated that, in the transfer of psychiatric care from institution to the community, we were bound to confront ethics-based struggles between what she called the "logic of care" and the "logic of choice." After all, it seems reasonable to expect that individuals who have savored life in the community might prefer to stay there, even if unable to cope with the vicissitudes of life in that landscape. Thus the conflict between the patient's wish for autonomy and caregivers' preoccupation with beneficence and nonmaleficence.

We take note of Mol's caution concerning rigid adherence to ethics principles as we seek solutions to ethics dilemmas such as this struggle between autonomy and beneficence. We recall her deceptively elementary story (Mol 2008) of a hospital patient who wished to stay in bed in the morning and refused caregivers' invitations to rise. Seeing no threat from the patient, some observers recommended that the patient be left alone. But then Mol asked what to do if the patient lacked decision-making capacity and if leaving the patient alone might lead to deterioration. Mol raised the possibility at that point that leaving the patient alone might be seen as a lack of care.

It is through this simple story that Mol introduced the struggle between the logic of care and the logic of choice. Concerning the patient's wish to stay in bed, the logic of choice may easily carry the day in one telling of the vignette. In another form, the logic of care suddenly becomes more prominent and demands consideration. Mol (2008, 85–87) explained that in the logic of choice, autonomy and equality are good elements, and oppression is bad. In the logic of care, attentiveness is good, and neglect is bad. The major task is for caregivers (those who naturally are preoccupied with the logic of care) to join with lawyers and advocates (generally preoccupied with the logic of choice) in jointly providing attentiveness, autonomy, and equality.

The interaction will of course produce friction from time to time. But its intensity may be managed through mechanisms such as ethics committees or

joint clinical rounds where leadership is exercised to persuade participants that discussing and debating ethics publicly are good things. Ultimately, the slippery but still attainable objective is to improve the lives of patients through collaborative care giving. In the context of focused and limited forensic consultation related to IOC, we recommend a thorough understanding of the ethics principles we have exposed here before the forensic expert unveils conclusions about IOC-based conflicts.

CONCLUSION

We recognize and we accept that, as a political matter and as a matter of ethics-based forensic practice, colleagues may have different views of when and why to employ IOC. However, we argue that contemplating the use of IOC requires serious advance exploration of the ethics matters that may accompany both implementing and withholding the intervention. Regardless of which side of this debate one finds attractive, it should be obvious that IOC is not a solution to be applied simplistically to the problematic task of dealing with severely and chronically ill patients who refuse the psychiatric care offered to them.

We have tried to argue here that IOC is a popular clinical and policy intervention that has often been recommended without thorough consideration of the implications that flow from its use. Some groups even support IOC while simultaneously being in favor of the recovery and citizenship movements. The latter movements have now taken steps to strengthen their basic philosophies by exploring a theory of recognition that fundamentally holds that "the constitution of human integrity is dependent on the experience of intersubjective recognition" (Honneth 1992, 188). That is to say that our patients' attitudes of self-trust, self-respect, and self-esteem may indeed be dependent on the sustaining attitudes of all caregivers. But in the spirit of neutrality, we state that IOC, with its potential for denigration and humiliation, requires more exploration and study if we are to conclude with certainty that the phenomenon may disrupt those attitudes in patients (Anderson and Honneth 2005, 131) and interfere with their clinical improvement.

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9

NEUROSCIENCE IN FORENSIC CONTEXTS

Ethical Concerns

Stephen J. Morse

THIS CHAPTER USES THE TERM "neuroscience" to refer to brain imaging in individual cases, especially using noninvasive techniques such as structural and functional magnetic-resonance imaging (MRI and fMRI, respectively), and to reliance on studies about the relation between the brain and behavior that use noninvasive imaging. The issue is whether the use of these newer techniques and the data from studies employing them raise new ethical issues for forensic psychiatrists and psychologists. The implicit thesis throughout is that if the legal questions, the limits of the new techniques, and the relevance of neuroscience to law are properly understood, no new ethical issues are raised. A major ethical lapse would occur if practitioners use neuroscience without the proper understanding.

Brain imaging and neuropsychological methods have always been admissible in personal injury or malpractice suits to answer questions about brain injuries and lesions that are typically medically well characterized. In such cases, the image or test data is directly relevant to the question of whether the plaintiff had an injury or lesion. This is the forensic use of the old neurology, neuropsychology, and neuroradiology, and this chapter does not address the ethical issues in such cases. (Neuroradiologists have published an analysis of the ethical issues for that specialty with recommendations based on a consensus conference held at Emory University in 2013 [Meltzer et al. 2014]. The author of this chapter was one of the participants at the conference.) Instead, this chapter addresses the question of the relevance of the newer techniques of brain imaging to forensic legal criteria that are behavioral, that is, that require evaluation of a subject's mental states and actions. For example, did a defendant charged with homicide kill the victim intentionally? Is the defendant competent to stand trial? In these cases, the imaging will be inferentially relevant.

I begin with a brief discussion of the legal standard for the admissibility of scientific and technical evidence. I then turn to the proper understanding of legal questions to guide forensic work. I will use examples from criminal law, but the analysis generalizes to behavioral criteria in civil law, such as whether a person is competent to contract or whether a decedent was competent to make a valid will. The next section considers the current state of cognitive, affective, and social neuroscience, which will be most relevant to law. I will assume in this section that the research design (where relevant) was appropriate, the image was acquired properly, and the analysis was sound. It is of course true that some expert testimony does not meet this standard, even if it is improperly admitted. Nonetheless, I shall ignore that problem and focus instead on what I consider the greater problem: the general limits of current neuroscience.

The third section uses the analysis of the preceding two sections to address the question of legal relevance. In short, the question is, "How, precisely, does the proffered scan or data based on scanning or other techniques answer the specific legal question it supposedly helps answer?" I term this the problem of "translation." I conclude that, at present, brain imaging has little relevance to behavioral legal criteria. The primary exception is cases in which the subject has a well-characterized brain abnormality, such as epilepsy, that may be probative of a legal question, such as whether a criminal defendant's harmful bodily movements were "acts" as the criminal law defines action. This section also reports the findings of five recent studies that investigated the reception of neuroscience in criminal cases in four countries. The conclusion addresses the ethical issues directly, takes note of the rampant disorder I call Brain Overclaim Syndrome, and offers a remedy.

BRIEF LEGAL PRELIMINARIES

Forensic practitioners understand that expert opinion and testimony are needed when the subject matter is beyond the ken of the ordinary layperson's understanding. Whether the testimony will be admissible will be decided according to the applicable rules for scientific and technical evidence in force in a jurisdiction. In general, testimony will be admissible if the scientific or technical methods and data being proffered are scientifically and technically valid and have been reliably applied to the facts of the case and if the testimony is legally relevant. Legal relevance is judged by whether the evidence makes a legally determinative fact more or less probative than it would be

without the evidence. Even if evidence meets this standard, a judge typically has the power to exclude it if the testimony's probative value would be outweighed by the dangers of it causing unfair prejudice, confusing the issues, misleading the jury, causing undue delay, wasting time, or needlessly presenting cumulative evidence (see, for example, Federal Rules of Evidence, sec. 403, which has been adopted by a majority of states). All these considerations will apply to evidence based on neuroscience.

Experts are also expected to adhere to the ethical standards of their discipline, but typically this is raised only if there is a substantial breach that casts doubt on the integrity of the process and its outcome. Otherwise, such matters are left to the disciplinary standards and procedures of the profession involved. Perhaps the most extreme example of the difference between legal and professional response to misconduct occurred in *Barefoot v. Estelle* (1983), in which the Supreme Court was asked to decide if in a capital punishment proceeding a psychiatrist's opinion about future dangerousness based on hypothetical questions and no personal evaluation violated due process. The psychiatrist, an infamous Dallas doctor named John Grigson, had testified in a large number of capital cases that the convict was certain to kill again if not executed, which was his testimony in this case. The jury sentenced Barefoot to death. The American Psychiatric Association and others all supported the petitioner, Barefoot, and considered this "expert" opinion utterly unjustified as a matter of psychiatric expertise. The Supreme Court nonetheless held that admitting the testimony did not violate due process and that any deficiencies in it were matters of weight that could be tested with cross-examination. Grigson was reprimanded twice and finally expelled from the American Psychiatric Association, but he never lost his medical license and continued doing forensic work until he retired. Thomas Barefoot was executed.

THE LAW'S PSYCHOLOGY AND LEGAL CRITERIA

The law's psychology is folk psychology. When I write about the law's psychology, I am not claiming that there is a reified anthropomorphic entity, "The Law," that has somehow officially adopted a psychology. I am offering a goodness-of-fit interpretation of legal doctrine and practice. Folk psychology is an explanatory causal theory that explains human behavior in part using mental-state variables such as desires, beliefs, plans, and intentions. For example, part of the explanation for why you are reading this chapter is, roughly,

that you desire to learn more about the subject to improve your forensic work. You believe that reading it will achieve that goal, and, therefore, you formed the intent to read it and are doing so. This is a practical syllogism, not a deductive one. Of course, this is only a partial explanation. A full explanation would be multifield/multilevel, using variables from biology at various levels, other psychological variables, and sociological variables. Folk-psychological theorists may differ about mental-state categories and how they should be individuated, but all agree that mental states are part of the explanation of human behavior. Folk psychology does not insist that the causal mental variables must be conscious and that every action is preceded by a practical syllogism of the type used earlier. It simply claims that mental states are consciously causal or rationalize actions, including mental-state actions, that may not have been preceded by conscious causal thought.

Many scientists think that folk psychology is primitive or false. I and many others, including those who are expert in the science and philosophy of mind and action (e.g., Fodor 1987), think the critics are wrong. For now, however, we do not have to resolve this question, because we are simply providing a descriptive account of the law as it is, not a prescriptive account of the law as some scientists or others might prefer it to be. People may be critical of the law's underlying assumptions and policies based on them, but no legally sophisticated commentator would deny that the account provided is accurate.

Existing legal criteria for responsibility and competence are completely folk psychological—actions and mental states. Again, no legally sophisticated commentator would disagree, and, at some level, every practicing forensic practitioner knows this. Nonetheless, it is so familiar that it is easy to forget, but doing so is perilous because then one runs the risk of doing irrelevant or misleading forensic work. There are no brain or other biological criteria in any of the criminal- and civil-law contexts in which forensic practitioners work. For example, competence to stand trial requires that the defendant has a rational understanding of the charges and proceedings and is able rationally to assist counsel. These are criteria about the defendant's level of understanding—a mental-state issue—and about his ability rationally to communicate with and otherwise work effectively with counsel—action and mental-state criteria. The standard is entirely behaviorally functional. An insanity defense obtains if a mental disorder results in a defendant's inability to know right from wrong. The mental-disorder criterion is itself proved behaviorally by considering the defendant's cognition, mood, and other mental-state variables. As is well known, there is no imaging test sensitive enough yet to diagnose mental

disorder, including major mental disorder. I might also add in passing that the mental-disorder criterion in any legal doctrine is a legal test and not a biological, psychiatric, or psychological test. Knowing right from wrong is a mental-state issue.

Now let us briefly address some issues that are often misunderstood by nonlawyers (and sometimes even by lawyers, who should know better). Metaphysical, libertarian free will, the ability to act uncaused by anything other than one's own agency, is not a criterion for any legal doctrine, and it is not even foundational for any part of the law (Morse 2007). Causation, whether by biological, psychological, sociological, or some combination of variables, is not per se an excusing or mitigating condition in law. All behavior is caused in a causal universe. If causation per se were an excuse, everyone would always be excused. Many people think that this is correct, but it is not the law we have, which excuses some people but finds most people responsible and competent. All action is caused, but not all action is excused. Causation only excuses if it produces a genuine excusing condition, such as lack of rational capacity, but in that case, it is the lack of rational capacity, a behavioral criterion, that is doing the excusing work. Causation is not the equivalent of compulsion, which can be an excusing condition. If all caused behavior were compelled, then all behavior would be compelled, and everyone would always be excused. But it is clear that not everyone is compelled all the time. Presumably no one is compelling you in any ordinary sense of the term to read this chapter, say, by threatening you with death if you do not read it. Finally, predictability is also not an excusing condition. Much of our behavior is completely predictable by ourselves and others, but unless some simultaneous, genuine excusing condition exists when we act predictably, we are responsible for our predictable behavior.

When considering the relation between the data from any other field to legal questions, it is crucial to understand the question under consideration. Unless, it is understood, it will be difficult to apply the other data to it properly. And that is what forensic psychiatrists and psychologists do for a living. They use their specialty methods and data to help answer a legal question. Whether they use the result of a diagnostic interview, a rating scale, a psychological test, or a brain scan, they are trying to relate their expert knowledge to the legal issue at stake. After examining the state of legally relevant current neuroscience, in a later section we will turn specifically to the relevance of the new neuroscience to the practice of forensic psychiatry and psychology.

THE STATUS OF CURRENT NEW NEUROSCIENCE

Most generally, the relation of brain, mind, and action is one of the hardest problems in all science. We have no idea how the brain enables the mind, how consciousness is produced, and how action is possible (Adolphs 2015, 175; McHugh and Slavney 1998, 11–12). The brain-mind-action relation is a mystery not because it is inherently not subject to scientific explanation but because the problem is so difficult. For example, we would like to know the difference between a neuromuscular spasm and intentionally moving one's arm in exactly the same way. The former is a purely mechanical motion, whereas the latter is an action, but we cannot explain the difference between the two. Wittgenstein famously asked: "Let us not forget this: when 'I raise my arm,' my arm goes up. And the problem arises: what is left over if I subtract the fact that my arm goes up from the fact that I raise my arm?" (1953, sec. 621). We know that a functioning brain is a necessary condition for having mental states and for acting. After all, if your brain is dead, you have no mental states and are not acting. Still, we do not know how mental states and action are caused. Wittgenstein's question cannot be answered yet.

Despite the astonishing advances in neuroimaging and other neuroscientific methods—especially in understanding systems such as vision and memory, for example—we still do not have sophisticated causal knowledge of how the brain works generally, and we have little information that is directly or even indirectly morally or legally relevant. The scientific problems are fearsomely difficult. Only in the present century have researchers begun to accumulate much data from fMRI imaging. New methodological problems are constantly being discovered (e.g., Bennett, Wolford, and Miller 2009; Button et al. 2013; Eklund, Nichols, and Knutsson 2016; Vul et al. 2009; for a contrary view, see Lieberman, Berkman, and Wager 2009). This is not surprising, given how new the science is. Moreover, although there are good studies of the neural correlates of legal decision making, virtually no studies have been performed to address questions that would specifically be relevant to legal practitioners and policy makers. Law and forensic psychiatry and psychology should not expect too much of a young science that uses new technologies to investigate some of the most intrinsically difficult problems in science and that does not directly address questions of normative interest. Caution is warranted, although many would think the argument of this chapter is too cautious.

Furthermore, neuroscience is insufficiently developed to detect specific, legally relevant mental content or to provide a sufficiently accurate diagnostic

marker for even a severe mental disorder (Frances 2009; Morse and Newsome 2013, 150, 159–160, 167). Many studies do find differences between patients with mental disorders and controls, but the differences are too small to be used diagnostically, and publication bias may have inflated the number of such positive studies (Ioannidis 2011). There are limited exceptions for some genetic disorders that are diagnosed using genomic information or some well-characterized neurological disorders, such as epilepsy, which is definitively diagnosed using electroencephalography (EEG), but these are not the types of techniques that are central to the new neuroscience based primarily on imaging. Indeed, when the American Psychiatric Association published its most recent version of the authoritative *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) in 2013, it conceded that no validated neurological diagnostic markers for major mental disorders such as schizophrenia and major affective disorder had been identified. Nothing has changed since then (Rego 2016, who also claims that dementias may be an exception.)

Nonetheless, certain aspects of neural structure and function that bear on legally relevant capacities, such as the capacity for rationality and control, may be temporally stable in general or in individual cases. If they are, neuroevidence may permit a reasonably valid retrospective inference about, for example, a criminal defendant's rational and control capacities and their impact on criminal behavior. Some legal questions, such as whether a defendant is competent and what the agent will do in the future, depend on current rather than retrospective evaluation of the agent. Such evaluations will be easier than retrospective evaluation. Nonetheless, both types of evaluation will depend on the existence of adequate neuroscience to aid such evaluations. Again, with the exception of a few well-characterized medical disorders, such as epilepsy, we currently lack such science (Morse and Newsome 2013), but future research may provide the necessary data.

Let us consider the specific grounds for modesty about the current achievements of cognitive, affective, and social neuroscience, the subdisciplines most relevant to forensic psychiatry and psychology. fMRI is still a rather blunt instrument to measure brain functioning. It measures the amount of oxygenated blood that is flowing to a specific region of the brain (the blood-oxygen-level-dependent [BOLD] signal), which is a proxy for the amount of neural activation that is occurring in that region above or below baseline activation (the brain is always and everywhere physiologically active). There is good reason to believe that the BOLD signal is a good proxy, but it is only a proxy. The time lag between alleged activation and measurement and its spatial

resolution are less than optimal (Roskies 2013). These difficulties will surely be ameliorated by technological advances, but studies to date, especially if they used lower-power scanners, do suffer from these limitations.

There are research-design difficulties. It is extraordinarily difficult to control for all conceivable artifacts, that is, other variables that may also produce a similar result. The same region of interest (ROI) may be implicated in the production of opposite behaviors, which also confounds inferences.

At present, most neuroscience studies on human beings involve small numbers of subjects, which makes it difficult to achieve statistically significant results and undermines the validity of significant findings (Button et al. 2013, Szucs and Ioannidis 2017). This phenomenon will change as the cost of scanning decreases, and future studies will have more statistical power, but this is still a major problem. Most of the studies in cognitive, affective, and social neuroscience have been done on college and university students, who are hardly a random sample of the population generally.

Many of the studies use other animals, such as rats or primates, as subjects. Although the complexity and operation of the neural structure and function of other animals may be on a continuum with those of human beings, and there may be complete similarity at some level, there is reason to question the applicability of the neuroscience of behavior of other animals to humans. The human brain is capable of language and rationality, which mark an immense difference between humans and other animals. To the best of our knowledge, other animals do not act for and are not responsive to reasons in the full-blown sense that intact human beings are. Is so-called altruistic behavior in orangutans, for example, the same as altruistic behavior in humans? Although the point should not be overstated, we should be cautious about extrapolating to human action from the neuroscience of the behavior of other animals.

Most studies average the neurodata over the subjects, and the average finding may not accurately describe the brain structure or function of any actual subject in the study. This leads to a more general problem about the applicability of group data to an individual subject, a problem called G2i, for "group to individual" (Faigman, Monahan, and Slobogin 2014). Scientists are interested in how the world works and produce general information. Law is often concerned with individual cases, and it is difficult to know how properly to apply relevant group data. For example, a neuroscience study that reports increased activation in some ROI bases its conclusion on averaging the activation across all the subjects, but no subject's brain may have activated precisely in the area identified. If such group data are permitted, as they now are for

functions such as predictions, the question is how to use probabilistic data to answer what is often a binary question, such as whether to release a prisoner to parole because he is deemed no longer a danger to society. This is a topic under intensive investigation at present, and I assume progress will be made. The forensic practitioner presenting group data must understand that this is a fraught, complicated topic.

A serious question is whether findings based on subjects' behavior and brain activity in a scanner would apply to real-world situations. This is known as the problem of "ecological validity." Does a subject's performance in a laboratory while being scanned on an executive-function task that *inter alia* allegedly measures the ability to control impulses really predict that person's ability to resist criminal offending, for example?

Replications are few, which is especially important for any discipline, such as law, that has public-policy implications and often immense consequences in individual cases (Chin 2014). Policy and adjudication should not be influenced by findings that are insufficiently established, and replications of findings are crucial to our confidence in a result, especially given the problem of publication bias (Ioannidis 2011) and reproducibility skepticism (Chin 2014, Open Science Collaboration 2015; see Gilbert et al. 2016 for a critique of the Open Science Collaboration paper that concludes that the point is not proven). Indeed, replications are so few in this young science, and the power is so low, that one should be wary of the ultimate validity of many results. Indeed, a recent analysis by Szucs and Ioannidis (2017) suggests that more than 50 percent of cognitive-neuroscience studies may be invalid and not reproducible. Drawing extended inferences from findings is especially unwarranted at present. If there are numerous studies of various types that seem valid, all converge on a similar finding, and there is theoretical reason to believe they should be consistent, then lack of replication of any one of them may not present such a large problem. The congruence of behavioral science and anatomical-imaging studies showing an average difference between adolescence and young adults is a good example. But such examples are at present few, especially in legally relevant neuroscience (these data were cited by the U.S. Supreme Court in the "juvenile trilogy" of *Roper v. Simmons* [2005; although this case cited only to behavioral science], *Graham v. Florida* [2010], and *Miller v. Alabama* [2012] to argue that adolescents are generally less responsible than adults).

The neuroscience of cognition and interpersonal behavior is largely in its infancy, and what is known is quite coarse-grained and correlational rather than fine-grained and causal (Miller 2010). What is being investigated is an association between a condition or a task in the scanner and brain activity.

These studies do not demonstrate that the brain activity is a sensitive diagnostic marker for the condition being investigated or either a necessary, sufficient, or predisposing causal condition for the behavioral task that is being performed in the scanner. Any language that suggests otherwise—such as claiming that some brain region is the neural substrate for the behavior—is simply not justifiable based on the methodology of most studies. Such inferences are only justified if everything else in the brain remained constant, which is seldom the case (Adolphs 2015), or if the investigator is able experimentally to disable some ROI temporarily, as has been done in some studies.

Law and forensic psychiatry and psychology are concerned with human mental states and actions. What is the relevance of neuroscientific evidence to decision making concerning human behavior? If the behavioral data are not clear, then the potential contribution of neuroscience is large. Unfortunately, it is in just such cases that neuroscience at present is not likely to be of much help. I term the reason for this the "clear-cut" problem (Morse 2011), and it is a major difficulty. Virtually all neuroscience studies of potential interest to the law involve some behavior that has already been identified as of interest, and the point of the study is to identify that behavior's neural correlates. Neuroscientists do not go on general "fishing" expeditions (but see Bennett et al. 2009 for an amusing exception). There is usually some bit of behavior—such as addiction, schizophrenia, or impulsivity—that investigators would like to understand better by investigating its neural correlates. To do this properly presupposes that the researchers have already well characterized and validated the behavior under neuroscientific investigation. Cognitive, social, and affective neuroscience are inevitably embedded in a matrix involving allied sciences, such as cognitive science and psychology (Abend 2016, Krakauer et al. 2017). Thus, neurodata can very seldom be more valid than the behavior with which it is correlated. In such cases, the neural markers might be quite sensitive to the already clearly identified behaviors precisely because the behavior is so clear. Less-clear behavior is simply not studied, or the overlap in data about less clear behavior is greater between experimental and comparison subjects. Thus, the neural markers of clear cases will provide little guidance to resolve behaviorally ambiguous cases of relevant behavior, and they are unnecessary if the behavior is sufficiently clear. It is in unclear, "gray-area" cases that forensic practitioners and the law need help the most, but it is in precisely these cases, alas, that the neuroscience is least helpful.

On occasion, the neuroscience might suggest that the behavior is not well characterized or is neurally indistinguishable from other, seemingly different

behavior. In general, however, the existence of relevant behavior will already be apparent before the neuroscientific investigation is begun. For example, some people are grossly out of touch with reality. If, as a result, they do not understand right from wrong, we excuse them because they lack such knowledge. We might learn a great deal about the neural correlates of such psychological abnormalities. But we already knew without neuroscientific data that these abnormalities existed, and we had a firm view of their legal significance. In the future, however, we may learn more about the causal link between the brain and behavior, and studies may be devised that are more directly legally relevant. Indeed, my best hope is that neuroscience and law will each richly inform the other and perhaps help reach what I term a conceptual-empirical equilibrium in some areas. I suspect that we are unlikely to make substantial progress with neural assessment of mental content, but we are likely to learn more about capacities that will bear on excuse or mitigation.

Here is an example of the current limitations of neuroscience for legal conclusions. A neuroscientist and I reviewed all the behavioral neuroscience that might possibly be relevant to criminal-law adjudication and policy. With the exception of a few already well-characterized medical conditions, such as epilepsy, our review found virtually no solid neuroscience findings that were yet relevant (Morse and Newsome 2013). Similar conclusions were reached after reviews of "brain-reading" studies, such as "neural lie detection" (Greely 2013) and the addictions (Husak and Murphy 2013). These conclusions are unsurprising. Behavioral neuroscience is a new discipline that is working on problems of immense conceptual and scientific complexity. Future conceptual and technological advances will certainly improve our knowledge base, but, for now, modesty is in order about what neuroscience can teach us that is relevant to adjudication, the making of legal policy, and the practice of forensic psychiatry and psychology. This is sobering news, but the good news is that it means that for the foreseeable future, forensic psychiatry and psychology will be essential to help law understand the acting human being who is the subject of legal interest (Morse 2015). Neuroscience will not supplant these specialties.

THE PROBLEM OF LEGAL RELEVANCE: LOST IN TRANSLATION?

Let us begin this section with an observation that will always be germane even if neuroscience makes huge leaps forward. Neuroscience is a purely mechanistic science. Neurons, neural networks, and the connectome do not have

reasons. They have no aspirations, no sense of past, present, and future. These are properties of agents, of acting human beings. Ethics and law are addressed to agents. Thus there will always be a problem of translation between the pure mechanism of neuroscience and the folk psychology of law. Neuroscience eschews folk-psychological concepts and discourse. Thus, the gap will be harder to bridge. Paradoxically, however, neuroscientists frequently write dualistically by suggesting that regions of the brain are little homunculi that do things and that there seems to be a struggle between the self and the brain as an independent agent (Mudrik and Maoz 2014). The translation problem is thus a much greater problem for neuroscience than for psychiatry and psychology. The latter sometimes treat people as mechanisms, but they also treat them as agents. Consequently, they are in part folk psychological, and the translation will be easier. It is the task of forensic practitioners always to explain precisely how neuroscientific findings, assuming that they are valid, are relevant to an ethical or legal issue. No hand waving is allowed.

The brain does enable the mind (even if we do not know how this occurs). Therefore, the facts we learn about brains in general or about a specific brain could in principle provide useful information about mental states and about human capacities in general and in specific cases. Some believe that this conclusion is entirely or largely a category error (Bennett and Hacker 2003, Pardo and Patterson 2013). This is a plausible view, and perhaps it is correct. If it is, then the whole subject of this chapter is empty, and there was no point writing it. Let us therefore bracket this pessimistic view and determine what follows from the more optimistic position that what we learn about the brain and nervous system can be potentially helpful to resolving questions of criminal responsibility and other legal issues if the findings are properly translated into the law's folk-psychological framework.

The question is whether some concededly valid neuroscience is legally relevant because it makes a proposition about responsibility or competence more or less likely to be true. Biological variables, including abnormal biological variables, do not per se answer any legal question, because the law's criteria are not biological. For instance, even a biological abnormality that seems causally related to criminal behavior does not per se establish that the defendant was not rational or could not control himself. The famous case of Mr. Oft, whose right orbitofrontal tumor caused pedophilic desires that were then acted on, is a perfect example (Burns and Swerdlow 2003; see Morse 2011 for an analysis of this case). For another example, even if criminal behavior is a sign of an established disorder, it does not follow that the defendant must be mitigated or excused. Any legal criterion, such as lack of rational or control

capacity, must be established independently, and biological evidence must be translated into the criminal law's folk-psychological criteria. That is, the advocate for using the data must be able to explain precisely how, for example, the neurodata bear on whether the agent acted, formed the required *mens rea*, or met the criteria for an excusing or mitigating condition. In the context of civil and criminal competence evaluations, the forensic practitioner must explain precisely how the neuroevidence bears on whether the subject was capable of meeting the law's functional criteria.

If the evidence is not directly relevant, the advocate should be able to explain the chain of inference from the indirect evidence to the law's criteria. At present, few such data exist that could be the basis of such an inferential chain of reasoning (Morse and Newsome 2013), but neuroscience is advancing so rapidly that such data may exist in the near or medium term.

Even if neuroscience does seem relevant to a legal issue, the concerns with prejudice, cumulation, and the other issues that the rules of evidence, such as Federal Rule 403, raise must be considered. The common wisdom about imaging data was that it was prejudicial compared to other equally valid sources of evidence, such as purely verbal expert testimony or psychological testing. That is, juries were likely to give brain images undue weight. More recent, better-designed studies have disclosed that this worry appears unjustified. With limited exceptions, decision makers do not give undue weight to imaging data (Roskies 2013, Schweitzer et al. 2011). The issue is not resolved empirically yet, but the default must be that the evidence is not prejudicial.

The more pressing concern is the value added by imaging. A scan is relatively expensive and somewhat time consuming. It thus has the potential for waste and delay unless there is genuine value added. More important, legally relevant neuroimages must be based on good prior behavioral science that identifies clearly the behavior to which the brain structure or function will be correlated. This raises the problem of cumulation. For example, studies of the anatomical abnormalities associated with schizophrenia must have clearly identified whether the subjects in fact met the diagnostic criteria for the disorder using behavioral criteria to make the diagnosis. Thus, we already knew behaviorally that the person suffered from schizophrenia. What does the scan add? For another example, the law has treated adolescents differently from adults for centuries based on undoubted average behavioral differences between adolescents and adults. Recall that the criteria for responsibility are behavioral. What does the diffusion tensor imaging (DTI) scanning data about incomplete myelination and pruning in adolescence add to what we

already knew? It is potentially causal information, and it is comforting that the brain data are consistent with the behavioral data. But the latter were already clear. After all, we have had a juvenile-court system for over a hundred years, and the common law had an immaturity defense for centuries. It is unsurprising in light of the behavioral differences that there are brain differences, but would we believe adolescents are not behaviorally different if the current brain-imaging data did not show a difference? Thus, in individual cases where the behavior is clear, the imaging data will be cumulative and unnecessary.

But, might not neuroscience be especially helpful in cases in which the behavioral evidence is unclear? The answer in principle is that of course it would be helpful, but as a practical matter it will not be, because the neurodata are based on correlations with clear behavioral data. The "clear-cut" issue identified in the previous section is the major stumbling block. Where the behavior is unclear, the neurodata will not be sufficiently sensitive to help resolve the behavioral issue even if the neurodata can distinguish the already behaviorally clear cases. These types of problems might be remedied by future advances in neuroscience, but such breakthroughs do not appear on the horizon yet.

A final point about the translation problem is that actions speak louder than images with very few exceptions. The law's criteria are behavioral—actions and mental states. If the finding of any test or measurement of behavior is contradicted by actual behavioral evidence, then we must believe the behavioral evidence because it is more direct and probative of the law's behavioral criteria. For example, if an agent behaves rationally in a wide variety of circumstances, the agent is rational even if his or her brain appears structurally or functionally abnormal. We confidently knew that some people were behaviorally abnormal—such as being psychotic—long before there were any psychological or neurological tests for such abnormalities. In contrast, if the agent is clearly psychotic, then a potentially legally relevant rationality problem exists even if the agent's brain looks entirely normal.

An analogy from physical medicine may be instructive. Suppose someone who has been in a workplace accident and is seeking disability compensation complains about disabling back pain, a subjective symptom, and the question is whether the subject actually does have such severe pain. We know that many people with abnormal spines do not experience back pain, and many people who complain of back pain have normal spines. If the person is claiming a disability and the spine looks dreadful, evidence that the person regularly exercises on a trampoline without difficulty indicates that there is no disability

caused by back pain. There is no good test to identify malingering, neural or psychological. If there is reason to suspect malingering, then neurodata may be useful in a commonsense fashion. In the example given, if there is not clear behavioral evidence of lack of pain, then a completely normal spine might be of use in deciding whether the claimant is malingering.

Unless the correlation between the image and the legally relevant behavior is very powerful, however, such evidence will be of limited help. If a biomarker were virtually perfectly correlated with a legal criterion, and were it less expensive to collect the biological data than behavioral data, then the biological variable might be a good proxy for a legal criterion. But this would be possible only with clear, bright-line legal rules and not with standards, such as whether a reasonable person would be aware of a particular circumstance, because the latter have an inevitably normative component for the decision maker to assess. Further, standards can evolve, and trying to use an external marker to adjudicate them would conservatively inhibit legal evolution. Moreover, such markers are beyond present neuroscientific expertise.

I believe that many of the claims for the relevance of neuroscience are best characterized as more "rhetorically relevant" than genuinely relevant. For example, defense advocates in capital-punishment proceedings, in which the threshold for admissibility of mitigating evidence is considerably lower than at trial, hope that the fetching images produced by "real" neuroscience will be more persuasive to decision makers than evidence provided by apparently more suspect social and behavioral science, even if the advocate cannot say precisely how the neuroscience bears on a genuinely mitigating condition. Having a brain lesion or injury is not a mitigating condition per se. The actual relevance of such evidence of brain abnormality therefore requires an account of why the brain evidence makes it more likely than not that a genuine mitigating condition, such as lack of rational capacity, obtains.

The foregoing consideration of relevance/translation has been general. Quite recently, however, we finally have preliminary data about how neuroscientific information is being used in criminal cases. Five very interesting empirical studies from the United States (Farahany 2015, Gaudet and Marchant 2016), England and Wales (Catley and Claydon 2015), Canada (Chandler 2015), and the Netherlands (de Kogel and Westgeest 2015) have attempted to discover the extent to which and in what way neuroscientific evidence is used in criminal cases. The question is what they disclose about actual practice that may be a guide for future ethical practice.

All the studies focus on appellate cases reported in various databases for somewhat different periods in the range of years from 2000 to 2012, and all are admirably cautious about the methodological limitations of the study sample. None purports to be an accurate representation of the use of neuroscientific evidence throughout the criminal-justice system, and other methodological quibbles may be raised, such as the failure to use independent interrater reliability for characterizing the cases. All use a very expansive definition of neuroscience that includes techniques and data that long antedate the new neuroscience. At most, the data are suggestive. Nonetheless, the studies are interesting and innovative.

The late, great baseball scientist Yogi Berra was apocryphally quoted as saying "It's déjà vu all over again." The data indicate that the courts make the classic mistakes about the relevance of neuroscience and behavioral genetics to criminal cases that have bedeviled the reception of behavioral science in general and of psychiatry and psychology in particular. The overarching classic mistake is misunderstanding or uncritically accepting the validity of apparently relevant science and misunderstanding the relevance of the science to the specific criminal-law criteria at issue, which are, once again, primarily acts and mental states. In particular, courts too often do not understand the following issues (discussed previously). Metaphysical free will is not a criterion for any criminal-law doctrine, and it is not even foundational for criminal responsibility in general. Causation in general and brain causation in particular, even causation by abnormal variables, are not per se mitigating or excusing conditions, and causation per se is not the equivalent of compulsion, which is an excusing condition. And, finally, people with the same diagnosis or condition are behaviorally heterogeneous, and, ultimately, it is the behavior that is legally relevant, not the diagnosis. In one form or another, most of these cases exhibit these mistakes and confusions. It is no surprise that one of the authors characterizes the cases as follows: "That use [of neurobiological research in criminal law] continues to be haphazard, ad hoc, and often ill conceived" (Farahany 2015, 488–489).

Not surprisingly, sentencing decisions were the most common context for the introduction of neuroscience evidence because the bar for admissibility is lower than at trial. It was also used to resolve questions about many criminal-responsibility doctrines and, surprisingly, about competence, which as we have seen, is a functional behavioral determination. Perhaps the most striking finding is how infrequently the new neuroscience of functional imaging and

related techniques is used. This varies across jurisdictions, but the large majority of cases involve the "old" neurology or the old neuropsychology, which uses classical structural imaging or behavioral methods to assess brain functioning associated with well-characterized neurological conditions, such as epilepsy and frontal-lobe injuries or lesions. Such diagnostic methods are far more common than fMRI, and in the Dutch and Canadian samples, there is virtually no functional imaging evidence.

In sum, these studies suggest that the influence of the new neuroinvestigative techniques applied to individual cases for forensic assessment is quite modest but confused nonetheless. Even when inferences are drawn in individual cases using group data about the consequences of various neurological conditions, the studies used are often classic behavioral studies rather than neuroimaging investigations. Indeed, careful examination of the expanded case studies that the papers present indicates that, in most instances, the neuroscientific evidence was far less important than the behavioral evidence, and the former was used largely to buttress the latter. The neuroevidence was rarely dispositive, and, in the other cases, it is impossible to know from these papers' summaries of the case reports how influential the additive neuroevidence was.

The first question when considering the admissibility of scientific evidence, as always, is the degree to which the basis of the testimony has been established. We have already seen that legally relevant neuroscience is not well established at present, which is no critique of contemporary neuroscience for the reasons previously given. For a specific example, the apparently wide but not universal Dutch acceptance of a brain-disease model of addiction that guides legal decision making fails to confront the hard questions about the status of the science. Judges are not yet in a good position to evaluate neuroscience and may be either too critical or too uncritical (see Rakoff 2016 for an analysis by a neuroscientifically informed federal judge).

For another example, fetal alcohol syndrome (FAS) plays a large role in the Canadian cases (although not in the other samples), but the potentially legally relevant aspects of the disorder are the cognitive and rationality defects, which are behavioral signs that sufferers demonstrate from an early age. Are the brains of FAS sufferers different from the brains of those without the disorder? Of course. This is just a necessary truth of biological materialism. If the behavior is markedly different, so will be the brain. Brain difference is not per se a mitigating or excusing condition, however. If a particular FAS sufferer is somehow sufficiently able rationally to regulate his behavior, then FAS is irrelevant to mitigation or excuse. Moreover, if a FAS sufferer exhibited lifelong

cognitive defects, as many do, that sufferer is potentially excusable even if sophisticated neurotechniques cannot identify the brain pathology or brain difference.

Many of the cases in these studies fail to understand the relevance of the neuroevidence. Even if there is clear evidence of brain damage or a neurological disorder, it does not mean that the defendant did not act, lacked *mens rea*, was less culpable, is incompetent, or will be dangerous in the future. All the criteria depend on direct assessment of the offender's behavior. The alleged relevance of neuroevidence to competence determinations, which occurs in many of the samples, is instructive but bewildering. Criminal competencies are behaviorally functional and again defined entirely in terms of mental states and in infrequent cases also in terms of actions. Does the defendant understand the nature of the charges, can he rationally assist counsel, does he understand the consequence of a guilty plea, does he understand the nature of the penalty about to be imposed on him and why it is being imposed? These normative, mental criteria must all be evaluated behaviorally. Either the defendant can perform these tasks to the requisite degree or he cannot.

These are continuum capacities, however, and it may be asked whether neuroscience can help with the gray-area, indeterminate cases. The answer is no, for reasons that have already been addressed. Any brain condition will have heterogeneous consequences. Some people with very broken brains have essentially normal mental functioning. But cannot group data about people with this condition help us draw inferences at the margin? Once again, the answer is no, in the present state of neuroscience, because of the "clear-cut" problem.

A critical reader of the empirical studies will be repeatedly struck by how many of the expanded cases either used irrelevant or weak (or nonexistent) neuroscience—for example, to assess competence or whether a defendant suffered from a mental illness—or could have been fully resolved with more careful behavioral evaluation. Of course there can be conflict about the behavioral evidence, but because act and mental-state questions must be resolved, it is the behavioral evidence that is doing the real work. And for the reasons given, neuroevidence will seldom be helpful in resolving the gray-area cases in which most help is needed.

Much is at stake in criminal cases, and, of course, forensic practitioners and judges would like scientific help to advocate for their clients and to resolve the vexing issues they must resolve. At present, however, turning to the neuroscience will do nothing more in most cases than to provide a rationalization for

a result the practitioner or judge wishes to reach on other grounds. It is once again a matter of rhetorical rather than real relevance. Convergent behavioral and neurodata might help solve some of these problems that cannot be resolved with either type of evidence alone, but such convergent lines of legally relevant evidence are very rare.

If a proper framework for the relevance of neuroscience to law is established, and if a cautious approach to the science is adopted, I think neuroscience can potentially help. It may refine legal mental-state categories, such as *mens rea* and mental disorder; it might also help the fairness and efficiency of criminal-law decision making by increasing predictive accuracy. The criminal law already uses predictions for purposes of diversion, sentencing, parole, and the quasi-criminal commitment of some sexual offenders. We have already decided as a normative matter that predictions are acceptable. If neural variables make this practice more accurate at reasonably acceptable cost, that is an advance. Finally, in tandem with behavioral science, neuroscience might help us more accurately understand legally relevant human capacities, such as the capacity for rationality and for self-control, which would again improve legal policy, doctrine, and adjudication. But all such optimistic outcomes will depend on precise understanding of legal relevance and valid science.

I shall end this section with an instructive case study, Herbert Weinstein, a.k.a. "Spyder Cystkopf," and an anecdote that illustrate the points being made in this section. Although the five studies discussed just above indicate that neuroscience evidence is increasingly sought to be introduced at criminal trials, much of the evidence is the old neurology or neuropsychology, and there are few rich case studies of the new neuroscience in court, especially imaging, to discuss. Thus I am using a famous, older neurological case that began the modern discussion of the relevance of neuroscience to criminal law. (The most complete discussion of the case can be found in Davis 2017.)

Spyder Cystkopf/Herbert Weinstein, a sixty-two-year-old retired businessman, punched and strangled his second wife, Brunhilde/Barbara, to death after she scratched at his face during a tirade against him. He then threw her out the twelfth-story window of their apartment building (*People v. Weinstein* 1992, Morse 1996; "Spyder Cystkopf" and "Brunhilde" were the pseudonyms first used in the literature). He was arrested and charged with murder.

Weinstein allegedly loved his wife and was preternaturally calm and optimistic. He believed every day was great and bound to get greater. He had no

prior history of angry outbursts or even of real anger. The killing seemed so out of character that he was extensively worked up for psychiatric or neuropsychological abnormalities by a noted forensic psychiatrist and associates. All the results were unremarkable except that he was slightly faster with his left hand on hand-eye tasks even though he was right-handed. On a hunch from this finding, an MRI was ordered, and it was discovered that Weinstein has a huge subarachnoid cyst pressing on and displacing a large amount of his left frontal lobe. The brain image showing the displacement is spectacularly arresting. Consequently, Weinstein was worked up by Alberto Damasio, then at Iowa. Based on his work with subjects with frontal damage, Damasio concluded that Weinstein was not able properly to use emotions to guide his decision making, which he termed a "somatic-marker" deficit. He also opined that Weinstein was very rigid and had limited emotional range or empathy.

Weinstein proposed to use these findings to support the defense of legal insanity, claiming that he could not conform his conduct to the requirements of the law, which was (and still is) one of the prongs of the defense in New York. The judge decided to admit the neuroevidence, but, in the event, Weinstein pled guilty to manslaughter the night before trial and was sentenced to prison. Throughout the criminal-justice process and thereafter he consistently denied that he felt remorse about killing Barbara, but he was sorry that he had lost his usual immense self-control. In both the criminal process and prison, where he was a model prisoner, Weinstein exhibited no further episodes of dyscontrol or other uncharacteristic behavior.

The ethical question is whether the brain-based evidence should have been employed, and the legal question is whether it should have been admitted. I think not, although clearly the judge disagreed, and many other people might also. It seems to defy common sense to conclude that such a large cyst did not affect Weinstein's behavior. There was no question concerning the presence of the cyst. The imaging studies clearly indicated this gross anatomical abnormality. There was dispute about whether the neural activity at the margin of the cyst was abnormal on a PET scan. Even if it was, it was not highly abnormal, and we do not have good base-rate physiological information from the general population. Subarachnoid cysts seldom have significant behavioral effects. Furthermore, Damasio's "somatic-marker" theory was not well established, and it was based on subjects with clear frontal damage, which Weinstein did not have. In short, the scientific basis for the claim that Weinstein could not control himself was very weak. Moreover, if Damasio's theory was

correct and properly applied to Weinstein, I would argue that it was more relevant to a claim of impaired rational capacity than to a claim of loss of control, but Weinstein claimed that he knew as he was attacking Barbara that it was wrong.

More importantly, the behavioral history and evidence were entirely inconsistent with the validity of this claim. There was no prior evidence of dyscontrol and none afterward. If the cyst had finally "flipped a switch," we would expect to see a pattern of further dyscontrol, much like the behavioral deterioration one observes in people with frontotemporal dementia. Weinstein also declined to have the cyst aspirated because the dangers of that procedure far outweighed any benefits that might accrue. A "broken brain" is not per se a mitigating or excusing condition, and actions speak louder than images or neuropsychological tests.

I think the far more parsimonious explanation for the homicide is that Weinstein's exceptionally rigid defenses were finally penetrated, and he "lost it" when Barbara physically assaulted him, which was apparently unprecedented. Good people can do bad things in certain circumstances. They are not at their rational best when they are in a fury, especially if they have no experience dealing with anger. This was a potential murder case, however, so perhaps the bar for ethical use and legal admission should be somewhat lower, but there was only the weakest basis for the scientific validity of the brain claim and for the legal relevance of the evidence. I submit that the brain evidence in this case was more rhetorically relevant than genuinely relevant.

I conclude with an instructive anecdote. I previously used the Weinstein case in teaching judges. At one such session with federal judges, after presentation of both the prosecution and defense arguments, 100 percent of the judges voted to convict. (I stopped using this case because it was too "easy" for the prosecution.) I then asked the judges if they would consider the cyst a mitigating factor at sentencing. About a third of them indicated that they would consider it, so I asked them why. The modal response was that the defendant had a proverbial "hole in his head." I asked why, if it didn't affect his behavior, it should be considered a mitigating factor. None of the judges who indicated a willingness to consider it had any adequate explanation except to repeat the (true) observation that the defendant had a gross anatomical abnormality. With respect, again, having such an abnormality is not per se an excusing or mitigating condition unless it produces a genuine mitigating condition such as diminished rationality or diminished control capacity. But there was not a shred of evidence that the defendant had such problems. The judges simply

believed that such an abnormality simply "must" have mitigating implications, but the relevance was rhetorical rather than real.

CONCLUSION: THE ETHICS OF CAUTION

There is little consensus about what ethical conduct demands in most contexts (see Morse 2008 for a full discussion of this point in the context of forensic psychiatric ethics). Probably most forensic practitioners would endorse the requirements of the "standard model" most ably advanced by Paul Appelbaum (1997): the forensic practitioner owes only the duty to act respectfully and honestly toward the subject and to perform his forensic functions with the highest level of professional skill. The standard model starts with impeccable moral precommitments to respect for persons and professional integrity. It suggests that forensic practitioners can serve a socially important and useful function if they adhere to those precommitments. The model appeals to public reason. Who could rationally object to this? The question, of course, is what counts as the highest level of professional skill when using the very young methods and data of cognitive, affective, and social neuroscience.

The message of this chapter has been that the forensic practitioner must understand the legal question at issue, must understand the limits of neuroscience methods and data, and, most importantly, must be able adequately to translate the mechanistic neuroscience information into the law's folk-psychological criteria. There is nothing new in these prescriptions that wouldn't apply to the use of any clinical or scientific information. Moreover, neuroscience techniques are not unusually invasive and cannot read minds, which would potentially raise hitherto unimaginable privacy issues. If they increase the accuracy of prediction practices we already think are justified, justice is better done. They can produce incidental findings, but this, too, is a traditional issue. When these findings must be disclosed to the subject is familiar ground.

If this chapter is correct about the current limits and legal relevance of neuroscience, the most important ethical admonition for the practitioner is to be modest and cautious and not to make claims for the relevance of neuroscience that cannot be adequately defended conceptually and empirically. Forensic psychiatrists and psychologists are not like some other experts, such as art authenticators, who have few objective criteria to help them form opinions. We are expected to be more objective. Even if mock juries in experimental work are not terribly swayed by the seemingly hyperscientific findings of

neuroscience, practitioners have a duty not to go beyond their data. That is the gravest ethical lapse possible in this area. I believe if we are suitably cautious, neuroscience may in the near future provide modest help in resolving forensic issues, and using it would be proper. At present, however, as the empirical studies disclose, that contribution is considerably less than many believe and that the law too often permits. We must police ourselves.

In two recent contributions (Morse 2006, 2013), I provisionally identified a maladaptive pattern of behavior that I termed "Brain Overclaim Syndrome" (BOS). Suffering from this syndrome is the forensic practitioner's greatest ethical danger. Fueled by overconfidence in the state of the neuroscience, insufficient understanding of the law, and the relation of the two, this disorder is marked by inflated claims for the usefulness of neuroscientific information to guide individual case adjudication, doctrinal change, legal policy, and specific legal practices. The criterial signs and symptoms, all of which are provisional until they are fully validated empirically, are (1) confusion about the brain-mind-action connection; (2) overconfidence about the current state of neuroscience, especially as it relates to human action; (3) confusion about the distinction between an internal and external critique of legal doctrine and practices; (4) misunderstanding the criteria for responsibility, especially failure to recognize that the criteria are fully folk psychological; and (5) confusion of positive and normative claims, especially failure to recognize that a behavioral or neural difference between groups does not per se entail different legal treatment. Inflated claims for the legal relevance of neuroscience in the courtroom are simply one manifestation of BOS.

In the previous papers, I recommended Cognitive Jurotherapy (CJ) as the treatment of choice. It is exceedingly safe, effective, and inexpensive. Nevertheless, combing the relevant literatures and attending numerous neurolaw conferences since first identifying BOS convince me that the syndrome is still endemic among writers, speakers, and practitioners in the relevant fields and that, apparently, too few have received CJ. Perhaps the Affordable Care Act or its potential replacement, if any, will remedy that to some degree.

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10

ETHICAL ISSUES IN THE USE OF PSYCHOLOGICAL TESTING IN FORENSIC ASSESSMENT

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DESPITE EARLY CRITICISMS that psychological testing did not have any place in the forensic arena (e.g., Ziskin 1981), psychological testing routinely plays a key role in forensic work today. Although it is true that many tests were not designed specifically to address psycholegal questions, the tests still are able to provide relevant data that can aid in answering forensic questions. Whether it involves assessing a person's response style in the context of a competency evaluation, exploring personality characteristics that may contribute to a person's risk, assessing a person's cognitive capacity to make a will or to consent to treatment, or describing a person's functional capacities in the context of a personal-injury case, psychological testing can both generate specific hypotheses for further exploration and can confirm or disconfirm those hypotheses (Heilbrun 1992).

At the same time, use of the tests in the forensic arena brings a host of unique ethical challenges for the forensic practitioner. In a context where mistakes or misuses of data could mean the difference between life and death, freedom and incapacitation, or preventing a violent rape and missing its potential, professionals must maintain a standard of conduct that respects the import of their work and its impact on others' lives. Working in such a field requires being attuned to a wider scope of potentially problematic situations.

THE IMPORTANCE OF A CODE

Having a code of ethics, a system of shared principles and professional aspirations, serves multiple functions. For the public, it instills trust that practitioners are there to serve the greater good, to benefit society, and to fulfill their

duties under a framework of decency and integrity. For practitioners, it provides a moral compass against which to judge professional behavior, and it instills a professional identity, a sense of loyalty and commitment to shared values. For educators and supervisors, as well as their professional progeny, it provides a concise way of transmitting the practice of psychology to the next generation, outlining an organized set of standards that can be applied to most situations without being so rigidly dogmatic that there is no room for extenuating circumstances or individualized decision making. And finally, for all stakeholders, it provides an agreed-upon source by which to resolve conflicts and to regulate the unprofessional conduct of practitioners, when necessary (Hess 2005). In this sense, it is useful to think about a specific framework for the ethical use of psychological testing in forensic work.

In coming up with such a framework, one source to draw upon is the court itself (that is, legal doctrine). The principles of *relevance* and *reliability* underscore the basis for the admissibility of expert testimony (Federal Rules of Evidence [FRE], 401, 702). To be considered relevant, the psychological test must measure some construct that is tied to the psycholegal issue at hand. If the forensic question is testamentary capacity, it may not be relevant to assess other emotional, personality, or clinical syndromes. If the standard for insanity in your jurisdiction is a strict M'Naghten standard, it may not be relevant to assess such constructs as emotional stability and impulsivity, as it would be in a jurisdiction that also considered capacity to conform one's behavior. If the question is competence to stand trial, it may not be relevant to assess (or to comment on) an examinee's risk for future violence. And in all cases, if the examinee does not fit the standardization sample for a particular test, the test may not be relevant for that person, regardless of the context. Thus, psychologists must be mindful that they restrict their selection of tests to those that are relevant not only for the task but also for the person being assessed.

The way courts use the term "reliability" has to do with whether the test measures what it purports to measure in an accurate, replicable manner. This definition captures both principles of reliability (or consistency) and validity (or accuracy) encountered in traditional psychological test development (Anastasi and Urbana 1997). A test must adhere to both principles to be considered reliable under the FRE. In the forensic arena, this extends beyond just establishing that the test meets the basic psychometric standards for any psychological test. It must be ensured that the test is reliable and valid for its intended forensic purpose. As stated above, most psychological tests were not designed specifically with a forensic or psycholegal construct in mind. As Butcher

and Pope (1993) noted, the simple fact that a test has been used for a particular purpose in the past does not mean that it is valid for that purpose unless there are sufficient research findings to substantiate its utility in doing so. This necessitates that practitioners stay abreast of the ever-changing literature with respect to psychological tests and what they do (or do not) measure.

This framework also can be structured from a clinical standpoint. Two decades ago, Appelbaum (1997) proposed that forensic practice be guided by the principles of truth telling and respect for persons, in the interest of achieving the value of justice. In applying the principle of truth telling to psychological testing, one not only must report their findings honestly but must select the appropriate tools to answer the question, consider the findings in context when interpreting them (including specific attention to the response style and motivation of the examinee), and communicate those findings in such a way as to ensure that others' do not misunderstand or misuse them. In this sense, it draws from both of the principles of relevance and reliability outlined above. In addition, the principle of respect for persons can be achieved by ensuring that one has the necessary knowledge and training to conduct the evaluation, that the examinee understands the parameters of the relationship (and, thus, does not expect that your purpose is to help or to advocate for them), that one restrict the evaluation to the specific issue at hand, and that one present the findings in a fair and impartial manner.

With this framework in mind, ethical practitioners must walk themselves through a series of steps (or questions) when faced with an ethical conflict. Naturally, one must recognize that there is a conflict and identify the issue at hand: What is the problem? What are the ethical principles involved? Next, one must identify the competing interests: Who has a stake in this conflict? Who will be affected by the outcome of my decision? Next, one must generate possible resolutions to the conflict and assess the impact to all involved: What recourse do I have to resolve this, and how will others be affected by that decision? This usually is done in consultation with others, whether one turns to the literature or to colleagues for guidance. Finally, one must select the option that minimizes harm to all involved, the one that best adheres to the universal principles of fairness, integrity, and respect for persons.

This chapter will provide guidance for the forensic practitioner in adhering to an ethical stance that centers on the principles of relevance, reliability, and respect for persons (the three Rs) when conducting or utilizing psychological testing in forensic work. Psychological testing will be construed broadly to encompass any standardized measure of behavior, including tests designed

to measure clinical constructs (e.g., personality characteristics, clinical syndromes) as well as tests designed to measure constructs central to the psycholegal question at hand (e.g., competence to stand trial). Specific ethical dilemmas are presented and deconstructed to inform the reader about the ethical principles that influence our decisions in a variety of forensic contexts. In some of the scenarios, workable solutions are presented, but the larger purpose of this chapter is to engage the reader to think about the issues at hand and how their own response might be guided by the overarching principles and aspirations of our professions. Because the subject matter of this chapter is psychological testing, the principles discussed will derive from the Ethical Principles for Psychologists and Code of Conduct (American Psychological Association [APA] 2010), hereinafter referred to as the Code, and the Specialty Guidelines for Forensic Psychology (APA 2013), hereinafter referred to as the Guidelines.

SCENARIO 1

A fifty-year-old Jamaican immigrant with intellectual disabilities is committed to an inpatient forensic unit for a competency-to-stand-trial evaluation. He grew up in the mountains of Jamaica, and he relocated to the United States at age seventeen, at the time speaking only broken English in place of his native Patois (Jamaican Creole). He has been treated in the past for schizophrenia, and he presents with bizarre somatic and paranoid delusions, rigid thinking, and poor social relatedness, although it is difficult for him to articulate his experiences given his intellectual limitations. He is referred for psychological testing for diagnostic clarification and for an opinion as to his prognosis for restoration.

This example concerns the principles regarding appropriate use of assessment instruments (Code, 9.02: Use of Assessments; Guidelines, 10.02: Selection and Use of Assessment Procedures). The tendency for psychologists to use a standard battery in conducting psychological evaluations for diagnostic clarification may be inadequate and inappropriate given the circumstances of the assessment or the characteristics of the individual being assessed. Factors such as geographical locale, cultural background, or formal education could distort, mislead, or negate the findings of psychological testing, thereby violating several principles with respect to adequate evaluation of an individual (Butcher and Pope 1993).

In this scenario, the examinee involved does not match the standardization sample for many psychological tests in any way other than the fact that he is male: he is not white; he is not an acculturated minority (that is, one who grew up in the United States or a similar Western culture); he has little formal education and never received any special education to address his intellectual deficits; he most likely has never been exposed to formal testing procedures (including timed tests); he learned English as an adult and still does not have command of its nuances to be able to express himself adequately; and he is placed in a maximum-security environment facing charges in a criminal-justice system he knows little about, with no real supports or familiar resources at his disposal. So, what are the potential pitfalls of administering such tests?

First, let us consider what can happen when tests are applied to individuals who do not match the population on which they were normed. Butcher and Pope (1993) describe a study conducted by Erdberg and colleagues back in the 1970s, in which the researchers discovered that a single item on the original MMPI (personality test) could distinguish all white test takers from all black test takers in a rural sample. Widely used computer scoring and interpretation services found 90 percent of black test takers to show profiles associated with psychiatric patients, despite no other evidence (from history or clinical interviews) supportive of such. Though this test underwent large-scale revision since then (now the MMPI-2 and its progeny, the MMPI-2-RF), at the time it was regarded as a precise, valid measure of psychopathology. Thus, it is imperative that psychologists (and the consumers of their evaluations) remember that ethical practice demands ensuring that tests are suitable for the individuals being tested, and this necessitates ongoing scrutiny of our measures and assurance through rigorous research that they continue to meet standards of reliability and validity.

Now back to our example. Cognitive testing may provide a description of this man's functional capacities in tasks associated with Western civilized cultures, but it may underestimate his innate potential if the stimuli, content, and context (for instance, the timed nature) are unfamiliar to him or if he fails to understand the task instructions. Personality testing to explore his thought content and process may be helpful, but again, his limited cognitive abilities combined with his cultural upbringing may cause him to misinterpret items that were standardized on a group that was quite differently acculturated. What may appear in test interpretation as paranoia and somatic preoccupation may simply reflect widely accepted, sanctioned cultural beliefs and practices. The uninformed psychologist who simply administers a standard battery of tests

without consideration of the examinee's background and cultural context risks confirming an inaccurate assumption made by others that the man is mentally ill and, thus, needs medication—medication that he does not need and that will do nothing to further his restoration to competence. A more appropriate course of action may be to refer the man to another psychologist who is versed in his culture or, if such is not possible, to seek consultation (from colleagues or the literature) to understand the man's experiences better.

SCENARIO 2

You receive a phone call from a social worker who works in the public defender's office, regarding a former (recently discharged) patient on whom you conducted a psychological evaluation as part of a competency-to-stand-trial evaluation. The patient is now undergoing a criminal-responsibility evaluation by a defense-hired psychologist, and the social worker is requesting the raw data from your evaluation to aid their psychologist in conducting his evaluation. She claims to have a release signed by the patient, and (while she has you on the phone) she attempts to ask "just a few questions" about the patient and your impressions of him.

There actually are a host of potential problems associated with this scenario, but let us start with the release of raw test data. Psychologists have been troubled by this principle (Code, 9.04: Release of Test Data) ever since the last revision of the Code. According to the Code, psychologists now must release test data (for instance, examinee's responses, psychologists' notes regarding an examinee's behavior during an examination) pursuant to a valid release, even when it means turning over portions of the test materials themselves (for instance, when test questions are printed directly on test-recording booklets). This bothers psychologists because it stands in contrast with another principle from the Code, 9.11: Maintaining Test Security. Certainly, if examinees are privy to the test questions and/or answers prior to an evaluation, they may be able to manipulate their response pattern to serve their own interest (either more or less pathological, depending on the nature of the evaluation). So, how are psychologists expected to maintain test security if they can be forced to turn over test questions along with the test responses?

One option may be to try to ignore the request or to stall any sort of official response to it. However, we must remember that we also are bound to maintain a certain level of cooperation with other professionals (Code, 3.09:

Cooperation with Other Professionals). Psychologists do not deliberately act in obstructionist ways, and refusal to turn over the data may not be fair to the defendant/former patient, as it may interfere with the defense's ability to prepare a legitimate mental-health defense. At the same time, simply sending the data directly to the defense attorney and his social worker may be problematic, as they may misinterpret or misconstrue the information itself. Psychologists also take steps to avoid misuse of their work by others (Code, 1.01, Misuse of Psychologists' Work), and failure to do so in this scenario may lead to a great miscarriage of justice if the court is misinformed about the implications of the data because they were relinquished to individuals not qualified to interpret them.

Another option is first to pull the examinee's test responses from the test materials prior to sending the data, but this may be extremely time consuming for you, the professional. A better option is to explain the situation to the person requesting the information, to make known your commitment to the Code, and to insist on releasing the test data only to the defense-hired psychologist. The request for release of information should come from (and the data to be released sent to) the psychologist. You do not have to release the data or answer any questions directly from the social worker. Although you ultimately may be forced by a court order to turn over the materials to the person requesting them, this should not be your first response. Psychologists can (and should) negotiate to maintain test security of the materials that are so essential to the work that they do.

Another potential problem with this scenario is the social worker's attempts to elicit information from you outside the context of the evaluation you conducted (pertaining to competency). Again, the principles of cooperating with other professionals and preventing misuse of one's work (the psychological testing you conducted) come into play. However, now they are pitted against another principle, drawn from the Guidelines, which has to do with maintaining an unbiased, impartial presentation of data (1.02: Impartiality and Fairness). Although it may seem like an innocent solicitation on the part of the social worker (and very well may be), and although it may seem that the psychologist simply is being helpful (and indeed, ethical) by ensuring that her data is not misinterpreted or misunderstood, the problem is that the psychologist's role was in service to the court, and now that service has been fulfilled. As such, it is unfair to provide information to one side (the defense) but not the other (the prosecution). If further explanation regarding the psychologist's work is needed, it can be drawn out in testimony at a hearing or trial. Thus,

psychologists must keep in mind under what circumstances and for what purpose they conducted psychological testing and where that duty ends in light of fairness for all involved.

SCENARIO 3

A psychiatrist administers and relies upon a computer-generated test interpretation of the MMPI-2 and MCMI-III personality tests in a forensic assessment speaking to the issue of criminal responsibility. The test interpretation suggests the presence of antisocial personality disorder, so the psychiatrist includes it in his formulation.

First, this scenario poses an interesting question about competence and scope of practice (Code, 9.07: Assessment by Unqualified Professionals). Although psychiatrists may have a solid grounding in the basics of psychometrics, such as test diagnostics, they are not routinely trained in some of its nuances, such as test construction and development, principles of reliability and validity, test bias, and so forth. They may not undergo years of rigorous practical training in different types of assessment instruments (e.g., cognitive, objective and projective personality, validity) under supervision to achieve competence, and not just in the general principles of testing but in the specific tests themselves. This is not to say that they could not, but they may not. So, from a competence perspective, it may be a fair assumption that many psychiatrists would not possess the knowledge, training, and supervised experience required to conduct psychological testing.

Even if there are exceptions—a psychiatrist who is as informed and as competent in the requisite knowledge and skill of psychological testing as any qualified psychologist—there still remain concerns regarding the larger scope of practice issue and its perception by the public. The standards of competence in psychological testing exist for a reason, so that the public may have faith in the quality of services received. Any practitioner who wishes to conduct psychological testing can pursue the requisite educational, training, and supervised experience to become qualified to do so. And any practitioner who does not achieve the requisite qualifications but who conducts it anyway is misleading the public. Further, for any forensic professional—psychiatrist or psychologist—if one is not familiar with the basic principles underlying the data on which they rely, they leave themselves vulnerable to cross-examination about their work or sanction by an ethics committee (Butcher and Pope 1993). Even worse

(for the justice system), their explanations to the judge or jury may neglect information that is crucial in understanding the test data, which may have negative consequences on the outcome of the case.

Second, this scenario raises an ethical issue with respect to interpretation of test results (Code, 9.06: Interpreting Assessment Results), which also influences the aforementioned scope-of-practice issue. Test-generated computer printouts make it tempting for practitioners to administer psychological tests, knowing that the computer will interpret the results for them. However, reliance on computers to interpret a psychological test can be short-sighted, depending on the test. Most of these computerized scoring programs (such as the MMPI-2 and the MCMI-III) are simply generic, algorithmic guides meant to provide the basis for hypothesis testing. Butcher and Pope (1993, 282) state it best: "Computer-derived descriptions are essentially textbook or prototype descriptions of a particular test pattern developed by examining patterns of test results and behavioral correlates." They still must be evaluated by the psychologist in light of other data. Some tests, such as the MMPI-2-RF (Ben-Porath and Tellegen 2008/2011), go a little further, by providing reference to the empirical literature for every interpretive statement made in the profile. Thus, for any interpretive statement, the evaluator can cite specific research findings that support its basis under cross-examination.

However, no computer-generated interpretive printout is able to consider the unique cultural or situational factors that may have influenced this particular individual's responses on this particular administration of this particular test. For instance, consider the case of a young man who has never been incarcerated before, who is wrongfully accused of committing a heinous crime, and who is facing years of incarceration as a result. Consider that this individual has slept very little in the two weeks since he was arrested and incarcerated, that he is threatened daily by other inmates and subtly derogated by staff because of his alleged crime, and that he has no idea whether his wife and children believe his innocence and stand behind him or not. Now consider an alternative scenario in which this man simply walks into a psychologist's office for psychological testing as part of a routine pre-employment screening. One can imagine that his MMPI-2 profiles might differ in the two scenarios, but while a computer may not appreciate or incorporate these contextual differences into its interpretation of his responses, a psychologist can and should (Guidelines, 10.04: Consideration of Assessment Settings).

Let us alter scenario 3 slightly to have the psychiatrist contract with a psychologist to conduct the psychological testing and provide an interpretation of the findings. The psychologist concludes, on the basis of the testing and all

available evidence, that the examinee does meet criteria for antisocial personality disorder but also suffers from bipolar disorder with psychotic features, which forms the basis for a legitimate insanity defense. The psychiatrist now must decide whether to include the information regarding the antisocial personality or whether it should be omitted.

First of all, the diagnosis could be invalid if there was no other evidence to support it (aside from the computer interpretation). An elevated score on the Psychopathic Deviate scale of the MMPI-2 is not, in and of itself, evidence of antisocial personality disorder. But, assume for this scenario that it is accurate. Not every psychological test's finding needs to be reported. The larger issue here is relevance to the psycholegal question: insanity. Antisocial personality could be relevant to the issue of criminal responsibility if an argument can be made that that is what precipitated the crime and not his coexisting mental illness. However, if it can be firmly established that his bipolar illness precipitated and legally negated his criminal responsibility for the crime (as stated above), it could be prejudicial to mention the antisocial personality, as it may unfairly bias the trier of fact to think that this is just another criminal. On the other hand, omitting any discussion of it also may mislead the trier of fact, who is responsible for considering all relevant data. Psychologists who conduct psychological testing must consider what is at stake when assimilating their findings and producing a report. Assuming that the personality disorder is not relevant to the commission of the crime, what is at stake for this individual? The psychologist could discuss the test findings, it could prejudice the jury, and an individual deserving of the insanity defense is not granted it. Alternatively, the psychologist could omit the test findings, but those findings could be discovered and raised by the prosecution, in the aims of discrediting the psychologist's testimony (which actually favors the defendant), resulting in a guilty verdict. Now let us envision a scenario in which the psychologist discusses the test findings, explaining how the entire diagnostic picture relates to the individual's mental state at the time of the crime, and the jury considers such information in rendering whatever verdict they deem appropriate. The bottom line is, you should always attempt to articulate the data that are relevant to the formulation of your opinion, including that which is supportive and that which contradicts it, and how you came to your conclusion in weighing both sides. As forensic practitioners, it is our responsibility to provide the data honestly, relevantly, and with respect for persons and to let the trier of fact decide (Guidelines, 10.01: Focus on Legally Relevant Factors).

SCENARIO 4

A psychologist naïve to the PCL-R uses it in conducting an assessment of risk in a death-penalty case. The psychologist is hired by the prosecution to assess the defendant's risk of future dangerousness, one component of a determination that death is deserved.

As practitioners of our professions, we are obligated to provide services within the scope of our competencies, based on our education, training, experience, or consultation (Code, 2.01: Boundaries of Competence; Guidelines, 2.01: Scope of Competence). This is even more important in the forensic arena, where (as this scenario suggests) the stakes literally are sometimes life and death.

Although there are not explicit guidelines for determining whether someone is qualified to use the test, the PCL-R manual suggests that appropriate users should possess an advanced degree in the social or behavioral sciences, meet the professional standards to purchase tests and conduct psychological assessments in their jurisdiction, have experience working with forensic populations, and be familiar with the clinical and research literature regarding psychopathy (Hare 2003). Hare (2000) adds that training can be provided by experienced users of the test, and he recommends that new users conduct at least five to ten practice assessments and achieve an acceptable level of interrater reliability before being permitted to conduct them on their own. In other words, it is ethically irresponsible to conduct an assessment of psychopathy by simply picking up the manual and reading it.

Again, we come back to the point made above about user qualifications and competence when it comes to psychological testing. The term psychological testing simply refers to "an objective and standardized measure of a sample of behavior" (Anastasi and Urbina 1997, 4). It encompasses a wide range of actual instruments, from self-report questionnaires and checklists that are highly face valid and easy to interpret, to aptitude and achievement tests that require astute attention to procedure for accurate results, to objective and projective personality measures that require considerable understanding of norms, context, response style, and hypothesis testing to interpret accurately. Even the most basic of instruments still requires a firm grounding in test development and psychometrics. An instrument such as the PCL-R, which taps into a construct

that can be rather pejorative and extremely influential on the outcome of a legal case, should only be used by those who have the training to administer it properly, and that training includes an awareness of its potential misuses (e.g., Edens 2001).

Recent findings indicate that the PCL-R may not be as reliable as once thought. Although the manual (and other well-controlled research studies) boasts interrater agreement levels ranging from .86 to .94, studies comparing evaluators in practice have found considerably lower levels of reliability (e.g., ICC = .47, Boccaccini, Turner, and Murrie 2008). One study examining PCL-R total scores generated by opposing experts—one hired by the prosecution and one hired by the defense—in sexually violent predator cases in Texas revealed that prosecution- and defense-retained evaluators differed by an average of 7.81 points, with the former rating examinees higher than the latter. This yielded an agreement level of .39, far less than that professed in the manual. Furthermore, the direction of the difference suggests that partisan bias, or allegiance to the side retaining them, may be one explanation for the difference in scores (Murrie et al., 2008).

The problem with the above scenario from an ethical standpoint is that, for a host of reasons, practitioners may fail to recognize the boundaries of their competence when it comes to psychological testing. Test manuals may appear to be fairly straightforward, and interpretation guides sufficiently explanatory, to give testers the impression that they understand the data. However, if they are unfamiliar with the subtle nuances of scoring differences, or the influence of context on particular scores, or the scope of behaviors they are evaluating, or their own personal biases with respect to constructs related to crime, violence, or victimization, suddenly the difference in outcomes is consequential. Perhaps one has a rather limited scope of exposure to psychopathic individuals; he or she would tend to perceive any evidence of the behavior or trait as "strong" evidence, warranting a score of 2. Alternatively, perhaps one has a generally lenient or forgiving worldview of people and tends to give others the benefit of the doubt when judging potentially negative characteristics; he or she would likely err on the side of seeing "some" or "no" evidence, warranting a score of 1 or 0. Such individual differences could change the overall score by 6 or 8 points (or more), painting a very different picture of the examinee in the eyes of the trier of fact.

When you combine that naïve incompetence with the high-stakes context of a forensic evaluation, particularly a risk assessment in the context of a death-penalty case, where the pull for allegiance to the side who retains you may be greater, the practitioner is all the more vulnerable to partisan bias (Guidelines,

1.02: Impartiality and Fairness). This is dangerous ground for the forensic practitioner. Attorneys may be pressured by the high stakes of the case, making them all the more emphatic about the narrative they wish to present. A psychologist who is on shaky ground in terms of familiarity with a test instrument, particularly one with as much emotional impact and stigma as the PCL-R, is vulnerable to subtle, perhaps not even conscious, pressures to "see" the data in a particular way. It is incumbent upon us, as forensic practitioners, not only to know the boundaries of our competence but also to undertake assessments with a humble acknowledgment that even the most experienced among us may fall victim to the subtle pressures and cognitive biases inherent in a system based on deciding the fate of others. Approaching each assessment in a structured and methodical way, using only the tools that we have the requisite competence to use, withholding judgment until we have all of the data, counterarguing our own conclusions to ensure that we have carefully considered each angle and hypothesis, and consulting with others who share our expertise can guard against the pressures of partisan bias (and our own inherent cognitive biases) to ensure that we have done our job with due diligence, objectivity, and fairness for all (Neal and Brodsky 2006, Neal and Grisso 2014).

CONCLUSION

The ethical dilemmas and principles discussed in this chapter are but a few of those encountered routinely by forensic professionals working at the nexus of psychology or psychiatry and the legal system. One key point to keep in mind with respect to the ethical use of psychological testing is that it is but one piece of data, one piece of the puzzle. It is meant to tell us something about a person, in order to help the trier of fact decide the legal issue at hand. It almost never tells us the full story, and it must be considered in relation to the other data—history, interviews, collateral interviews or reports, evaluator and third-party observations, other medical testing—in formulating our opinions and conclusions about the psycholegal question (Heilbrun 1992, Heilbrun et al. 2009). If we, as forensic professionals, can keep that one maxim in mind, we are less likely to fall prey to pressures that might cause us to misuse our tools, misconstrue our findings, or go beyond what the data tell us. This has implications not only for the individual being examined but also for court personnel, who may base rulings on invalid or irrelevant data, and for society in general, whom the courts serve and whose justice is undermined by unfair outcomes.

A simple way to ensure that testers are adhering to our ethical guidelines regarding psychological testing is to ask oneself a series of questions at the outset:

1. What do I need to know about this individual to answer the psycholegal question?
2. Is there a psychological test(s) that can tell me that?
3. Does the individual to be examined fit the standardization sample for that test(s)?
4. Am I (or do I know someone who is) competent to administer, score, and interpret that test(s)?
5. What other factors might influence the test results (including motivation and response style)?
6. Can I talk myself out of my conclusions (that is, have I ruled out all other possible interpretations or hypotheses that could fit the data)?
7. Have I conveyed my findings to the respective parties clearly, concisely, and in accordance with the principles of relevance, reliability, and respect for persons?

As noted in the examples here, few ethical quandaries are black and white. Often, there is more than one right answer to a dilemma. There always are multiple stakeholders involved who are affected by our decisions, and inevitably some are going to be pleased and others not. At the end of the day, however, you have to be able to defend your position with a confidence deeply rooted in your professional values and guided by the principles that inspire professionals to pursue excellence in their work. If you have done your due diligence to ensure that you have arrived at a conclusion that has considered all the relevant data points and have taken steps to ensure that your work, and your profession, are not misrepresented, misused, or misunderstood by others, then chances are you can rest easy that you have acted in an ethical and respectable manner.

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11

ETHICS AND THE MANDATED VIDEO RECORDING OF FORENSIC EVALUATIONS

Richard Martinez and B. Thomas Gray

BEGINNING IN JANUARY 2017 in Colorado, through changes in statutory law, all psychiatrists and forensic psychologists who are evaluating sanity and related criminal-responsibility questions in high-level felonies and certain sex offenses are required to video-audio record the relevant interviews. Colorado's current system of forensic evaluation in sanity cases and other criminal-responsibility cases is triggered when a defendant enters a plea of not guilty by reason of insanity (NGRI) or informs the court that considerations regarding mental condition will be introduced as part of the defense of the defendant (CRSA Title 16, Art. 8, 2016). After months of negotiation involving a variety of organizations and interested parties, the Colorado District Attorneys' Council (CDAC) submitted Senate Bill 16-019, requiring that all interviews involving felony class 1, felony class 2, and some sex offenses must be video-audio recorded, preserved as part of the evaluation record, and subject to review by both the prosecution and defense. The development of this legislation, the clinical and ethical issues surrounding this new requirement, and the implications for possible similar requirements in other states are the topic of this chapter.

THE AURORA THEATER SHOOTING

On July 20, 2012, many in Colorado and throughout the United States awoke to the news of the horrific mass shooting at the midnight screening of *The Dark Knight Rises* in an Aurora, Colorado, Century 16 movie theater; twelve were killed and some seventy injured in the attack. At the time, this was the largest number of casualties in a shooting in the United States and the deadliest shooting in Colorado since the Columbine High School shooting in 1999 (*Los*

Angeles Times 2016). The gunman, dressed in tactical clothing, was arrested outside of the theater minutes after the shooting. The startling image of a wild-eyed James Eagan Holmes with his unruly shock of bright red hair was circulated worldwide when his booking photo was released to the media. Thus began a debate, often highly contentious, with some quickly and confidently concluding that Holmes was "crazy." Others, equally certain, were adamant in asserting "he knew what he was doing" and occasionally insisting that everything, including his "insane" appearance, was planned.

Negotiations between the prosecution and defense in early 2013 to remove the death penalty from consideration in exchange for a guilty plea and life in prison failed (see Holmes Motion). This resulted in the entry of an insanity plea on Mr. Holmes's behalf. Over the course of the next year, Mr. Holmes was seen by a host of mental-health professionals. The defense had secured evaluations of his sanity at the time of the offense by two different psychiatrists, supplemented by a neuropsychological assessment. A court-ordered evaluation of sanity was completed by another psychiatrist, and after contentious review, including testimony by a psychiatrist and a psychologist hired by the prosecution to criticize the court-ordered evaluation, Judge Carlos Samour Jr. ordered a second sanity evaluation. This final evaluation was video recorded, a choice made by the evaluating psychiatrist as a standard of his forensic practice. (Dr. William Reid discussed this at the American Academy of Psychiatry and Law annual conference in Portland, Oregon, on October 30, 2016.)

In April 2015, the trial began, after a "death-penalty-qualified" jury was selected. During the trial, the vast majority of the twenty-two hours of video-recorded interviews of Mr. Holmes was shown to the jury and became central to the proceedings. In July 2015, the jury found Mr. Holmes guilty on twenty-four counts of first-degree murder and 140 counts of attempted first-degree murder. After the jury was unable to decide unanimously on the death penalty, Judge Samour sentenced Holmes to twelve life sentences without parole and 3,318 years on additional related charges. For the prosecution, the video-recorded interview of Mr. Holmes was considered advantageous in Mr. Holmes's prosecution and rebuttal to the insanity defense.

COLORADO'S NEW LEGISLATION

In the aftermath of the Holmes trial, the CDAC proposed new legislation in 2016 requiring video-audio recording of all forensic criminal-responsibility evaluations across the state. According to members of the CDAC, they believed

the legislation would bring greater transparency to the forensic-evaluation process. This would include both formal insanity evaluations and other "mental-condition" evaluations, which often involve questions of diminished capacity to form the culpable mental state but do not meet threshold requirements for insanity. The initial bill proposed in the Colorado Senate would have involved over 130 cases across the state annually, with many of these evaluations (70 percent) conducted in jails. In addition, at the time this legislation was introduced, the state of Colorado was under a binding stipulated agreement in federal court to solve problems with a growing number of competency assessments and restoration-to-competency cases, a number that had increased threefold in the preceding ten years. In response to these demands, Colorado established procedures to minimize delays in completing competency evaluations in jails across the state and in transferring those adjudicated incompetent to proceed to the only forensic state hospital for restoration treatment, in Pueblo, Colorado.

Bed capacity at that state facility was already challenged in meeting the requirements of the federal lawsuit. Administrators and clinicians were gravely concerned when confronted with the possibility of increasing demand for beds in order to accommodate mandated video-audio-recorded evaluations. Facing the possibility of increasing bed utilization in order to perform mandated video-audio-recorded criminal-responsibility evaluations presented additional logistical and financial challenges. Of the 130 criminal-responsibility evaluations ordered each year from district courts, Colorado, similar to other states, was finding about 12 to 20 percent of these individuals NGRI and requiring hospitalization at the state facility. Given uncertainty about jails being able to provide space and equipment to conduct video-audio-recorded assessments, there was concern that this legislation would result in considerable increased utilization of beds at the state hospital for evaluations as well. Delay in assigning and completing sanity and "mental-condition" assessments was undesirable, especially since the state was already responding to the federal lawsuit involving competency issues. Last, a large number of these evaluations were noted to include lower felony offenses and even some misdemeanor offenses.

With the initial legislative proposal, several interested organizations entered into an active discussion with the CDAC to discuss clinical, legal, logistical, fiscal, and technical concerns if video-audio recording were to be required. After discussion with the Colorado Psychiatric Society and the Colorado Psychological Association, CDAC agreed to several changes in the initial legislation to accommodate concerns. However, this became an

arduous and difficult process, as even within the professional societies there was considerable disagreement about the benefits and potential harms in supporting or opposing such legislation. While some forensic experts were opposed to any mandate for video-audio recording for various reasons, others argued that politically it would be unwise to resist legislation that was asking for greater "transparency" in the forensic-evaluation process. After all, competent forensic experts have nothing to hide; wouldn't video-audio recording of evaluations make the process more open? Ultimately, the final bill passed and became law on January 1, 2017.

The key elements of the law include:

1. All class 1 and class 2 felonies and designated felony sex offenses must be video and audio recorded and preserved.
2. A copy of the recording must be submitted to the court along with the examination report.
3. The facility, including jails, where the court orders the examination to take place must permit the recording and must provide space and equipment. However, if the space and equipment are not available, there is a mechanism for the court, defense, and prosecution to intervene and find alternatives, including ordering the defendant to the state forensic facility for evaluation with video-audio recording.
4. The psychiatrist or forensic psychologist shall assess whether the recording is likely to cause or is causing "mental or physical harm" to the defendant or "will make the examination not useful to the expert forensic opinion."
5. If such a determination is made, the psychiatrist or forensic psychologist shall not record the examination but must notify the court and other parties of this determination and reasons.
6. The report is admissible without recording the examination, but the court shall inform the jury that failure to record may be used in determining the "weight to afford the expert witness testimony."
7. Psychometric testing is exempt from recording.
8. The court shall determine the admissibility of any recording subject to all available constitutional evidentiary objections.

Colorado appears to be one of only three states that now mandate videotaping as a component of forensic mental-health assessment in prescribed situations. While Colorado restricts mandated video recording in sanity and other

criminal-responsibility evaluations to high-level felony cases, including some sex offenses, it does allow some professional discretion for the recording not to occur at all or for the recording to be stopped if recording "is likely to cause or is causing mental or physical harm to others or will make the examination not useful to the expert forensic opinion" (Colorado Revised Statutes 16-8-106(1b)). In Illinois, legislation requires fitness (competency) examinations to be video recorded but also includes a clause allowing for exceptions if "doing so would be impractical" (See 725 ILCS 5/104: Code of Criminal Procedure of 1963). There is no explanation as to what might be considered "impractical," and to our knowledge, there is no case law addressing the question. South Dakota has adopted a relatively expansive use of this requirement for recording evaluations: "Upon written request of defense counsel, the court may order a video tape record made of the defendant's testimony or interview" in evaluations of competency or sanity (South Dakota Codified Laws 23A-46-5).

There have been no challenges of which we are aware to the Illinois, South Dakota, or Colorado statutes, although we have been told that some appellate cases are in preparation. In this vein, it is noted that the Illinois and Colorado measures have been only recently implemented, and we must wonder how much either might be shaped by future rulings. At the same time, certain grounds for appeal have already proven largely unconvincing to judges in other jurisdictions involving questions related to video-audio recordings in forensic assessments, even when Fifth Amendment protections have been raised. (*State v. Wampler* 1977, *People v. Rich* 1988, *United States v. Byers* 1984).

CLINICAL CONCERNS

Clinically, there are both advantages and disadvantages to recording forensic interviews in the case of sanity and criminal-responsibility examinations. Recordings have been used as a basic component of training for decades. Audio- and videotaping have long been employed particularly for supervisory purposes in training and/or monitoring therapy sessions (Anders 2014, Gladfelter 1970, Lautch 1970). Some mental-health professionals are staunch advocates of recording evaluations conducted for forensic purposes (Pitt et al. 1999), although there is by no means consensus on this question (AAPL Task Force 1999). While some have adopted videotaping, in particular, as a routine part of practice, there is some resistance to this on the part of many (Brodsky and Reid 2011).

There are many advantages to video recording forensic evaluations. As noted in previous publications, reviewing video recordings when preparing a report may improve accuracy and recall. Testifying may be enhanced by reviewing video recordings before trial. Accuracy of what the defendant did or did not say, how the defendant appeared, and the subtleties of interaction with the evaluator are among the features preserved for all to see when recordings occur. Increased transparency and holding evaluators to higher standards are values that may be promoted by the video recording of evaluations. Although there is little written on the subject of effects of video recording in forensic evaluations, there are publications that address the related issue of how therapy sessions may be affected by video and audio recording (Gelso 1973, Goldstein 1988). In addition, there is research on the subject of how third-party observers may affect the interview and evaluation process (Simon 1996, Otto and Krauss 2009).

At the same time, having such a record will open the possibility of interminable disputes about the interpretation of what was said or not said by the evaluee and challenges to the questions asked or not asked by the examiner. Ultimately, such recordings will potentially be used to deflect and raise doubts about the quality and credibility of the evaluation itself, at the same time reducing the content and medico-legal issues in importance and consideration. Additional evaluations will likely be pursued. The time taken to review video recordings in anticipation of writing one's report and before testimony will increase dramatically, and this will increase time and cost for the evaluation process and for the court and the legal teams preparing these cases.

While a fair critique of the quality and credibility of the evaluation process is desirable in legal proceedings, mandatory video recording may unfortunately place an unnecessary emphasis on the standard and quality of the examination in directions that further backlog an already stressed judicial system, delay the availability of forensic hospital beds for evaluations and treatment, and increase the time necessary to perform and complete forensic assessments and reports. A myriad of new questions is anticipated. Issues of quality and standards will be debated. What is a reasonable time to spend on a particular evaluee? How many times did the evaluator meet with the defendant? Why weren't certain questions asked in the interview, and why were some questions asked in the manner posed? Just as there are disagreements about what constitutes a quality report and opinion, similar debates will ensue as to the quality and adequacy of a forensic examination. This will likely result

in improvement in the quality of assessments, and thus reports and hopefully opinions. Greater scrutiny and transparency are potential good outcomes.

However, misuse of the video recordings for purposes of obfuscation—for example, misleading and confusing juries—is an undesirable outcome. Explaining to juries that the defendant, evaluated months or even years after the instant offense and now on psychotropic medications, may appear quite different from the individual who committed a violent act will be required. And explaining that the defendant's report of her actions, as captured on video recordings, of what she was thinking and experiencing months and years before the actual interview, must be interpreted and understood through the expert's experience and knowledge of reconstructed memory and post-hoc attempts to understand and explain. These statements in video-recorded evaluations may not necessarily reflect or capture the state of mind at the time of the instant offense. Individuals on juries are unlikely to possess the experience to understand these psychological, emotional, and cognitive phenomena, which are important in the forensic expert's assessment and development of an opinion. There is high risk that members of the jury will place greater emphasis on the video recordings and give less consideration to the forensic evaluator's methods and experience, including explanations that the question of a defendant's insanity is an assessment of the state of mind at the time of offense, not how the individual may appear in court while on medication or during a recorded interview.

STANDARD OF PRACTICE

The American Academy of Psychiatry and the Law (AAPL), the national professional organization that includes over 1,800 forensic psychiatrists in the United States and Canada, has considered the issue of audio and video recording of forensic evaluations over the last twenty to twenty-five years. The Executive Council of the AAPL adopted and published Task Force recommendations in 1999 (AAPL Task Force 1999). While recognizing numerous clinical and educational advantages of video and audio recording of forensic evaluations, the AAPL Task Force also identified many situations where audio and video taping could be detrimental to the assessment process. They therefore concluded that this practice should be elective but is ethically acceptable. In the Colorado statute, making recording mandatory supports a standard of practice inconsistent with the recommendations of the AAPL and its members

in the United States and Canada. Additionally, in a recent publication by an AAPL Task Force developing guidelines for forensic assessments, AAPL's Executive Council restated the position of the organization that video and audio recording is "an acceptable but not a mandatory procedure" (AAPL Task Force on a Forensic Assessment Guideline 2015).

The AAPL recognizes that not all situations are identical and that recording should be considered on a case-by-case basis and at the discretion of the clinician. While forensic practice involves a professional-client relationship that is notably different from the traditional physician-patient relationship, ethically, the forensic-assessment relationship is rooted in some of the foundational principles and strategies of therapeutic and medical practice. Forensic psychiatric and psychological evaluations are conducted within the construct of a health professional–client "special relationship," recognized in law and ethics as involving certain obligations and duties that are drawn from traditional physician-patient relationships yet different from the traditional physician-patient relationship. While the forensic evaluation in the criminal setting involves exceptions to some duties and obligations toward the individual under evaluation, the forensic evaluator continues to have obligations toward the evaluee, balancing duties to the individual and to society. The forensic expert, ordered by the court, is a "neutral expert" and works for neither the prosecution nor the defense. The preservation of neutrality in both reality and appearance is important to complete an objective and fair evaluation effectively.

The AAPL Ethics Guidelines for Forensic Psychiatry, revised in 2005, make it clear that forensic evaluators are "bound by underlying principles of respect for persons, honesty, justice, and social responsibility" (Commentary in Section I of AAPL Ethics Guidelines 2005). Respect for the individual's right to privacy and the maintenance of confidentiality within certain limits are central obligations during forensic evaluations. While notifications of the limits of these duties to evaluees are reviewed prior to assessments, the psychotic, delusional, and/or cognitively impaired evaluee may not fully comprehend or appreciate the nature of the warning. When a requirement for audio and/or video recording is added, additional ethical complications will undoubtedly arise. The court-appointed forensic evaluator should be impartial and does have obligations to avoid acting as a partisan for either the prosecution or defense. The psychotic, delusional, and/or cognitively impaired evaluee is at a disadvantage to make rational and considered judgments about the presence of such recording devices and the consequences of agreeing or refusing to consent to such recordings. Therefore, the defendant may be unable to make an

informed decision, legally or clinically, as to the benefits and harms that may accrue as the legal proceeding moves forward.

LIMITATIONS OF CONFIDENTIALITY NOTIFICATIONS

Standard in all forensic evaluations, in the absence of video recording, evaluators typically begin with a notification of the purposes of the evaluation and the limitations on confidentiality. Unlike the clinical discussion of confidentiality, the forensic evaluator notifies the evaluee of the reality that confidentiality and privilege as usually understood do not apply in the forensic evaluation. Thus, some refer to this notification process as the "Miranda warning" for the forensic interview. Of course, the problem with such a notification in all forensic cases is that it is not possible to anticipate the detailed and nuanced ways in which information gleaned from the forensic interview may be used to prosecute the evaluee. These notifications are often generic and nonspecific but at least allow the evaluee and his or her attorney to make a somewhat informed decision about whether the potential benefits of entering a mental-condition defense outweigh the possible risks that accrue in openly discussing the offense. In Colorado, as in most jurisdictions, certain Fifth Amendment protections are maintained even in mental-condition defenses. In general, the state is not permitted to utilize information obtained from the forensic assessment to prosecute the defendant but only to address the question of mental state.

With video recording, the potential for harm and misuse of information grows significantly and further complicates the forensic evaluators' notification process. In the notification process, the evaluator will inform the evaluee of the purposes of the evaluation and the limitations of confidentiality depending on who has requested the evaluation. In addition, many forensic evaluators will remind the evaluee that the evaluator is guided by principles of fairness and neutrality, meaning the evaluator is ethically bound to strive for an objective and thorough analysis. Included in the notification is a reminder that the findings may or may not be useful or supportive of the evaluee's desired outcome. Finally, the evaluator reminds the evaluee that his or her open and complete participation will best support a thorough and honest understanding and support the primary goal of seeking the truth about the evaluee's mental state. The evaluator also may tell the evaluee that he or she will not include gratuitous and unnecessary information in the report to the court and will not include information that is unrelated to the question at hand. While one can't always know in advance what information obtained in the interview will be

important to the medico-legal question, it is reasonable to build rapport with the evaluee by stating that while all information may be in the report and therefore shared with the court and prosecution, the evaluator is trying to understand the person and mental state of the accused, not take a side for the prosecution or defense, and to seek understanding and the truth about the evaluee's state of mind at the time of the instant offense.

With the introduction of video recording, the notification process is transformed dramatically. What is a notification of limited confidentiality when video recording is not involved becomes a notification that there is no confidentiality when there is mandatory video recording. The evaluator cannot anticipate the downstream decisions of what will be considered by the court admissible and what will be seen as unnecessary or irrelevant private information. The evaluator can't predict or anticipate what might be shown to a jury or, in capital cases, how this recorded material might be used in sentencing (*Estelle v. Smith* 1981). Moving the default position to mandatory video recording in certain forensic criminal assessments places the defendant at a disadvantage, legally and clinically, as the implications and potential use of the recording downstream in the legal process cannot be fully understood or anticipated. Does information about the evaluee's adolescent sexual experiences have any relevance to a sanity case involving first-degree murder thirty-five years later? The discussion of previous criminal behavior becomes explicit and potentially misused or misinterpreted once the video is distributed. In the current practice without mandatory video recording, notifying the evaluee about some of the limits of confidentiality and reminding the evaluee that the forensic evaluation involves exploring medical and psychological issues relevant to a legal question can build trust and encourage disclosure. The presence of a camera will often impede and motivate defendants to be much more cautious and withholding of elements that could have been quite helpful in developing the relationship in the direction of obtaining uncensored information. The presence of the video recording has the potential of inhibiting and altering the interview process, raising questions about the integrity of the evaluation and ultimately the opinion itself.

ZONE OF PRIVACY

While the Colorado law provides notification in advance to the defendant that the evaluation will be recorded, the requirement fails to recognize the importance of a zone of privacy that is ideally present in all forensic assessments. We

consider the preservation of such a privacy area as an essential element for an effective and valid interview process, which then leads to a valid and reliable report and opinion. Most human beings find ways to balance what one considers private and remains internal, what is private but is shared with trusted others, and what is private but permitted to be shared in public discourse. Social networking continues to redefine our expectations and practices in this balancing process. The nature of intimacy between human beings usually requires trust and some belief that the person with whom one is sharing information does not seek to do harm or have other malicious intent. The sharing of private information with strangers is exceptional in our society. Revealing private information to clergy, therapists, physicians, and attorneys is necessary for one to benefit from the services of those professionals. Ethical standards involving confidentiality have developed in order to protect the goals and purposes of these relationships. Forensic criminal evaluations, of course, are not the same as these traditional professional fiduciary relationships, where there is strict confidentiality with few exceptions, such as duties to third parties under narrowly defined circumstances. But forensic assessments require a *zone of privacy* in order to be effective, reliable, and serve the larger goal of revealing truths about the defendant's state of mind.

The forensic evaluator must balance obligations to the legal process and its ends with continued responsibilities to approach the evaluee respectfully, honestly, and nonjudgmentally. The forensic evaluator provides notification to the evaluee as to the limits of confidentiality but does not tell the evaluee that she should withhold information in order to protect herself. Quite the contrary, openness and full disclosure are desirable to assist the goal of truth seeking. Transparency and revelation are encouraged to assist the forensic evaluator in forming an accurate opinion of a narrow medico-legal consideration. A reliable outcome is partly dependent on the degree to which the information obtained in the interview process is honest, open, and uncensored.

To succeed in these goals, the nature of the forensic interview requires probing of private aspects of the evaluee, an investigation of private aspects of the self that may or may not be necessary to answer a narrow medico-legal question. The problem of course, is that the evaluator cannot always know in advance what may be essential and important information and what may be irrelevant. When the evaluation is conducted without video recording, in a situation that supports the zone of privacy, one barrier to disclosure and openness is eliminated. With video recording, the risk of third-party effects is clear. Paranoid patients, patients who have been psychotic and have residual

psychotic symptoms, and individuals who are delusional and wish to use the medium of recordings to further their delusional views are but a few examples of situations in which recording equipment may alter the interview and compromise the quality of the assessment and, ultimately, the report and opinions. Where the goals of truth seeking and full disclosure drive the forensic interview, the presence of the video recorder may affect the interview in a manner contrary to those ends.

OTHER CONSIDERATIONS

There are potential downstream consequences of video recording. Video recording introduces questions of relevance that may be legitimate but may come at the expense of negatively affecting the interview process and unnecessarily making public what should remain as private information. While prosecutors who introduced the Colorado requirement claimed that video recording of forensic evaluations is no different from videotaped police interrogations, we believe this analogy is a poor one. In the case of police interrogators, it is clear that the police are motivated by the state's interest in prosecution. (This in spite of the claims that may be made by some law-enforcement officers during interrogation to give the false impression that the well-being of the defendant is their concern.)

In forensic evaluations, the ethical obligation to strive for objectivity, to maintain neutrality, and to reflect honesty are central, guiding principles. The forensic evaluator is not an agent of the goals of the state in its prosecution of a defendant and should not allow intrusions into the assessment process that create advantages for one side over the other in the adversarial process. What meaning can be taken from mandating video recording other than the state's attempt to gain advantage, either by discounting the expert's credibility or by looking for selected information that can undermine legitimate and credible conclusions about the defendant's mental state?

It is a long-standing ethical expectation that the forensic evaluator, while balancing duties to society, in the form of the court's order, and duties to the evaluee, must make discretionary decisions to avoid reporting on information obtained in the interview that may be gratuitous, personally embarrassing when unrelated to the medico-legal question, and immaterial to the forensic enquiry. The nature of the forensic interview requires probing of private aspects of the evaluee that extends beyond what is necessary to answer narrow

legal questions, and it is impossible to know in advance what personal information is important and even essential, rather than that which is marginally or even totally irrelevant to the legal question (Simpson and Evans 2005).

CONCLUSION

There are different schools of thought as to how important the therapeutic alliance is in establishing trust and disclosure in forensic assessments, and there are ethical requirements to provide the evaluee a notification of limitations on the confidentiality of the evaluation. But as therapists, it is recognized that for another, especially a stranger, to confide and share delicate information requires some trust and belief that the person seeking that information does not intend to harm, distort, or malevolently misuse it. In the assessment process, it is not uncommon for unrelated and embarrassing information to be disclosed by the evaluee. The process of sharing and discussing such information can build trust and confidence to reveal more. There is some professional discretion and even individual style involved in this process, which is the trade-off in order to establish the zone of privacy that supports disclosure and truth seeking. These are, of course, the core purposes in having forensic experts do these evaluations and offer opinions in the first place. If the parties involved in the judicial process could uncover the medical, psychiatric, and psychological elements important to these medico-legal questions without establishing this ritual of the expert witness, then we would not need a system of forensic-expert assessments. With mandated video recording, we fear that the zone of privacy will be eroded, making the evaluation process less reliable and the judgments and opinions that emerge from that process less reliable.

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12

CURRENT ETHICS DILEMMAS IN THE ASSESSMENT AND TREATMENT OF SEX OFFENDERS

Dominique Bourget and John Bradford

SEX OFFENDERS, AS A GROUP, face a number of challenges. It is often assumed that sexual offenses are committed out of the individual's own free will, meaning the behavior is ego-syntonic. Thus, they have the inner power to resist deviant sexual impulses and to curb their behavior to adapt to societal norms. Further, it is presumed they have the ability to understand that their actions are wrong when it comes to sexual offending. There are many instances where these assumptions are contradicted. While a large part of society believes that sexual offenses are committed voluntarily, clinical experience with sex offenders reveals that many are indeed unable to resist their deviant sexual impulses. In this population, social stigmatization is the norm rather than the exception, which creates further challenges with regards to an ethical approach in assessment and treatment.

The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (American Psychiatric Association 2013) defines the criteria for a paraphilic disorder as the individual must experience significant distress or impairment in social, occupational, or other important areas of functioning. The term "paraphilia" is defined as the presence of intense and persistent sexual interests that fall outside the norm of genital stimulation or fondling between mature and consenting human partners. Generally speaking, paraphilic interests concern either erotic activities or erotic targets. For instance, a person may be sexually aroused to an erotic target such as shoes, which is defined as a fetish. The simple presence of a paraphilia on its own does not automatically mean that an individual will transgress social rules or that clinical intervention and/or treatment will be necessary. When the presence of a paraphilia threatens the integrity of another person or is likely to result in harmful consequences to others, it needs to be addressed. *DSM-5* also differentiates between a paraphilia and a paraphilic disorder.

The diagnosis of paraphilic disorder involves two main criteria: (1) the presence of abnormal sexual interest over a minimum period of six months as manifested by fantasies, urges, or behaviors; and (2) that the person has acted on these sexual urges or that the sexual urges or fantasies cause clinically significant distress or impairment in an important area of functioning (APA 2013). Paraphilic disorder is considered to be a psychiatric illness. The individual suffering from paraphilic disorder does not choose this disorder any more than a person with schizophrenia chooses to develop a schizophrenic disorder. There are several nonspecific temperamental and environmental risk factors. Although the exact etiology of paraphilic disorders is not understood, neither is the etiological basis of many other mental disorders. Most experts working in the field of paraphilic disorders assume there is some underlying neurobiological cause to these conditions. Some studies have raised the possibility of genetic risk factors for pedophilia (Labelle et al. 2012, Langstrom et al. 2015). Further, conditions such as intellectual disorder, mood disorders, psychotic disorders, or use of substances may contribute to abnormal sexual behavior, whether or not the individual suffers from a diagnosable paraphilic disorder.

Societal lack of tolerance for sexual-offending behavior, while understandable, has led legislators to intervene in several aspects of the clinical assessment, treatment, and risk assessment of sexual offenders. This, in turn, has created increasing ethical dilemmas for clinicians. This chapter will address some important ethical quandaries in the assessment and treatment of individuals accused of a sexual offense. Central to the problem is the complex task of obtaining freely given, fully informed consent for the assessment and treatment of these offenders. Additional difficulties arise from court-ordered evaluations of sexual offenders, their coerced treatment, and prison sentences that are based on various risk assessments.

ETHICS AND CONSENT

Obtaining free and informed consent is the paramount ethical concern when it comes to the assessment and treatment of individuals who have committed a sexual offense. A valid consent must meet prerequisite criteria. First, consent must be given by a capable person. The capable person is one who is able to understand information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of that decision. Capacity is normally presumed. The presumption of capacity can be reversed by evidence that a patient lacks the requisite elements of capacity. The consent must

be specific to a proposed procedure or treatment. Consent must be informed, with the person aware of the nature of the proposed procedure or treatment, anticipated benefits and material risks, alternatives if any, and consequences of inaction. Finally, consent must be voluntary. Voluntary consent cannot be obtained through coercion. When an accused is referred by the court for a sexual-behaviors assessment, the imbalance in power between the court and the accused causes potential for implicit coercion (Bourget 2016). Such referral from the court usually takes place early in the court process or prior to sentencing. Despite the fact that the accused has the legal right to consent or not to testing or treatment, his refusal may be perceived by the court as a lack of cooperation, or worse, and be given a negative inference, which might affect his sentence. This is usually based on the premise that in the absence of a full evaluation the court cannot appraise future risk and the chance of rehabilitation. Knowing this, an accused may feel compelled to participate in the assessment, which calls into question the voluntariness of his decision.

The clinician's approach has to be guided by a careful inquiry into the presentation of the accused, his motivations, and his understanding of his rights. In many cases, the court will make an effort beforehand to ascertain the accused's willingness to submit to an evaluation, and the accused will have consented through his counsel. However, the degree to which the accused needs to be informed remains with the clinician, since the amount of relevant information necessary to obtain an informed consent belongs to the clinical arena.

Flagrant refusal may be rare, but it is sometimes encountered, which renders the task of the clinician fairly simple. Similarly, there are individuals who are completely willing to undergo the procedure, having no problem whatsoever with eventual consequences. Other individuals may manifest ambivalence. These are the ones where caution must be exercised to ensure they fully understand their rights. In some cases, an individual who feels he has no real choice may still be deemed capable to provide a free and informed consent, as long as the conditions cited above are met. For instance, having weighed the pros and cons and considering all options, an individual may state unequivocally he wishes to go forward with the assessment or treatment. These are situations where the clinician will not have a real ethical dilemma.

ETHICS AND ASSESSMENT

The assessment of individuals who have displayed deviant sexual behavior is normally conducted in specialized clinics where professionals have received

specific training and are familiar with paraphilias and paraphilic disorders. A sexual-behaviors assessment has several objectives: first, to determine the cause for the deviant sexual behavior; second, to identify treatment needs; and third, to evaluate the risk for future deviant behavior. It goes without saying that the assessment needs to be comprehensive and to involve a clinical diagnostic interview, a series of sexual-behaviors questionnaires, psychometric tests, and phallometric testing when appropriate.

Any individual presenting to a specialized sexual-behaviors clinic would receive a careful assessment. However, the assessment per se is not devoid of significant ethical concerns and dilemmas. The importance of considering these ethical issues beforehand is underscored by the very nature of the tests used, the sensitivity of the information gathered, and its potential future use.

PROCEDURES

A typical sexual-behaviors assessment in the laboratory consists in measuring sexual arousal to a variety of sexual stimuli. Phallometry, or penile-tumescence testing, is still, as of today, considered the gold standard in order to obtain measures of sexual arousal to both "normal" and deviant sexual stimuli (Murphy et al. 2015a). This procedure is not intended to determine guilt or innocence of the accused, nor should it serve as a lie-detector test. It is used to measure sexual preference. Sexual preference is a measure of the highest relative arousal comparing deviant and nondeviant stimuli (paraphilic and normophilic stimuli). In theory, sexual preference drives sexual behavior. An individual who has a deviant sexual preference would also then be more likely to act out deviant sexual behavior in the direction of the sexual preference. For example, in the case of pedophilia, the sexual preference would be in the direction of prepubertal males or females. A person with this type of sexual preference would be much more likely to act out in a sexually deviant way with prepubertal children compared to a person who does not have such a sexual preference.

Testing is completed in a laboratory setting, where maximum efforts are made to preserve the privacy of the individual. However, the nature of the procedure requires the individual to place a circular sensor on the shaft of his penis. Some individuals are more sensitive than others and are reluctant to participate in a procedure that involves partial undressing and manipulation of their genitals. Stimuli can be presented in various forms: visual pictures/videos, auditory scripts, or some combination. For many years, real child models were used to provide the visual stimuli in the testing material to detect

abnormal arousal to children. It is now strictly forbidden in the United States to use photographs of nude persons under the age of eighteen, even for clinical, legal, or research purposes, as it is considered child pornography (Card and Olsen 1996; Fedoroff, Kuban, and Bradford 2009; Murphy et al. 2015b). In the wake of the Adam Walsh Child Protection and Safety Act of 2006, the U.S. Department of Justice issued the Revised Regulations for Records Relating to Visual Depictions of Sexually Explicit Conduct (*Federal Register*, vol. 73, no. 244 (2008): 77431–77472). For the purposes of the regulations, sexually explicit conduct includes acted or simulated lascivious exhibition of the genitals or pubic area of any person, where the exhibition is intended or designed to elicit a sexual response in the viewer. This would apply to phallometric testing as well. The use of visual stimuli employing child models is still legitimate in Canada when it serves a clinical or research purpose. In recent years at least, blurring the faces of the nude children models is the generally accepted norm of presenting these visual stimuli.

To circumvent ethical concerns for what may be considered child pornography as well as a somewhat intrusive procedure, researchers have looked at other potential methods of assessing individual sexual interests, such as using virtual models and virtual reality. In *Ashcroft v. Free Speech Coalition* (2002), the Supreme Court concluded that the prohibitions extending the definition of child pornography to include virtual images produced without using real children were overbroad and unconstitutional.

Virtual reality utilizes computer-generated avatars of adults and children and offers the advantage of depicting animated 3-D characters, which allows the possibility for more powerful stimuli than still images. Video- and audiotaped stimuli of preferred sexual scenarios (e.g., sadistic or masochistic scenarios) have been found to be more effective than still slides in eliciting sexual arousal in some men (Fedoroff, Kuban, and Bradford 2009). Virtual reality has been tested against other methods to measure sexual interests by recording observable behavior, including viewing time of virtual models' erogenous zones (Renaud et al. 2002, 2005, 2010). Videotapes depicting sexual violence have rarely been used, however, and their use is virtually nonexistent nowadays out of legal and ethical concerns. Virtual reality in experimental situations has been used to measure sexual arousal in males when they would be acting out in virtual reality to molest a child or to molest an adult female, including various levels of violence, up to homicidal violence. The clinical significance of this type of evaluation is still unknown. The more complicated the type of stimuli beyond simple static visual images, the more likely the

chance that the person participating in the assessment may "learn" sexually deviant behavior depicted in audiotaped stimuli, videotaped depictions, or in the powerful medium of virtual reality.

This raises another potentially serious ethical dilemma, which is poorly documented but is discussed among sex researchers. The ethical dilemma is that the assessment through the stimuli that are presented could potentially "teach" the person being evaluated more serious sexually deviant behavior than would have been their sexual preference prior to the evaluation. For example, a pedophile without any sadistic or violent sexual preferences to children could develop such an interest secondary to the sexual-preference evaluation. There is no clearly documented description of this occurrence. However, it remains a possibility. More clearly documented as a concern is that a person coming in for evaluation as an outpatient may be stimulated by the assessment stimuli, which in theory could increase the risk of acting out in a sexually deviant way immediately after the assessment. This is not clearly confirmed in the scientific literature, but it remains a theoretical concern.

Beyond the ethics problems related to the stimuli sets, there are other significant considerations applicable to the procedure for testing sex offenders. Murphy et al. (2015b) advocate for standardization of the stimulus set and the protocol for assessment, analysis, and interpretation of data, in order to reduce errors caused by the current lack of standardization. To this day, results obtained from phallometric testing are not admissible in court in many jurisdictions, other than at the sentencing phase in some cases. Certainly, when used in sentencing, this can be helpful in determining whether the person is a reasonable candidate for treatment. Such use may also document risk factors, such as some level of sexual preference for sexual sadism or sexual violence.

SPECIAL POPULATIONS

We have addressed the issue of freely given informed consent earlier. In youth and vulnerable individuals, it is more complex, as parental consent or guardian consent may also be required prior to testing. The doctrine of the "mature minor" recognizes that notwithstanding his age, a young person who is cognitively mature enough to meet the test for capacity to consent ought to have the right to consent. The right for autonomy and recognition of cognitive maturity is ethically defensible. However, the mature-minor rule is in effect only in a minority of U.S. states (Coleman and Rosoff 2013). Parental authority

still prevails in a large number of jurisdictions. Practically speaking, unless unavailable, parental consent will almost always need to be obtained. This creates unique challenges, such as having a substitute decision maker acting in the best interests of the child or adolescent when faced with a decision to consent or not to sexual-behaviors testing, the protection of the young person's sensitive information and privacy, obtaining a reliable evaluation if the young person is not part of the decision-making process, or ensuring that professional assistance is available throughout testing in order to optimize the information-gathering process. These challenges underscore the importance of considering the youth as a significant player in the decision-making process and of obtaining a good level of cooperation for the assessment to be conducted in an ethical manner.

The above risks also need to be weighed against the purpose or benefits sought from phallometric testing in particular. Exposing a youth or a vulnerable person to sexually explicit materials is one of the ethical concerns about conducting phallometric testing. More specifically, there is a concern that harm such as emotional disturbance, inducing negative cognitions, or behavioral dysregulation could occur in vulnerable persons, including adolescents, during a critical period of sexual development (Hunter and Lexier 1998). There is no research demonstrating this clearly, however.

Another argument is that the reliability and validity of phallometric testing in youth is highly questionable. Adolescents, who are in a period of active hormonal and sexual development, may be easily aroused, causing them to react in a nonspecific manner to sexually suggestive stimuli in general, rather than to specific ones, rendering the results difficult to interpret and potentially leading to false positives (Kaemingk et al. 1995). In clinical practice, phallometric testing in adolescents is rarely obtained for the above reasons. The Abel Assessment for Sexual Interests (AASI-2) for boys and girls is an instrument that has been developed to evaluate boys and girls between twelve and seventeen (Abel et al. 2004). The AASI consists of objective measurements of sex interest using visual reaction time to visual stimuli and incorporates a battery of other ratings. The visual stimuli are of clothed pictures of males and females ranging in age from about five years of age to adulthood. Not only are the visual stimuli clothed; they are also not in any type of sexual pose. The instrument was shown to provide a nonintrusive and valid measure of sexual interest in adolescent-male child molesters (Abel et al. 2004).

Whichever method is used to assess juveniles and adolescents, results must be interpreted in a meticulous and cautious fashion. Special care should be

taken to ensure that raw results are protected and kept private. Although a rare occurrence, the court can produce an order to have raw test data made available to the parties, which can lead to misuse and misinterpretation of results, with potentially harmful consequences.

As with adults, self-reports have been found to be unreliable in adolescents, with minimization or denial of deviant sexual interests (Hunter, Becker, and Kaplan 1995). An overall comprehensive evaluation and careful inquiry into the youth's sexual interests and practice will often be more indicative of difficulties than any type of measurements. Clinical judgment should be exercised to determine the need for further specialized intervention. Objective testing either through phallometric testing, if appropriate, or visual reaction–time testing is very important to establish whether a paraphilic disorder is present. Without the appropriate objective diagnostic testing, risk assessment, treatment, and rehabilitation become problematic to implement.

CONSEQUENCES OF DIAGNOSIS

The diagnosis of paraphilic disorder, and more particularly pedophilic disorder, can bear serious consequences in both the short term and longer term for any individual. It is therefore imperative that the clinician qualify the diagnosis when indicated, listing risk factors and protective factors and addressing the risk of relapse into sexual-offending behavior.

A relatively new phenomenon is the increasing propensity of the courts to order sexual-behaviors assessments for individuals convicted of possession of child pornography. While possession of child pornography constitutes a criminal offense, the additional label of pedophilic disorder in this population may lead to a harsher sentence, out of a perception of increased risk for the safety of the public. A study that examined child-pornography offenders has shown that between 47 and 65 percent of child-pornography offenders meet the DSM criteria for pedophilic disorder (Nielssen et al. 2011). Yet it was also demonstrated that accessing child pornography is not in its own right a predictor that an individual with only a history of child-pornography offenses ("hands-off," or noncontact sexually deviant behavior) will commit a contact offense (Seto, Hanson, and Babchishin 2011).

Court-ordered sexual-behavior assessments constitute a unique ethical challenge. It usually occurs postconviction for a sexual offense, with the expectation that it will help the court determine the most appropriate sentence based on future risk. It is ironic that the courts rely on these assessments when

it comes to sentencing but will not consider their usefulness in other aspects of legal proceedings. The clinician is faced with several difficulties in conducting these assessments. We have already discussed the issue of ensuring that the assessment is freely consented to, covering every procedure. There will usually be a deadline by which the court expects the production of an expert report. Often the information relayed from the court will be minimal, and there will be insufficient time to complete the assessment, without the request for an extension of the order, to obtain past medical records and other relevant information to guide the diagnosis. In ordering a sexual-behaviors assessment, the courts in Canada will expect phallometric testing to be conducted (this is not the same in the United States), even though its use in criminal proceedings remains controversial from a clinical perspective, given the lack of standardized assessment methods and variability of data on sensitivity and specificity (O'Shaughnessy 2015; Purcell, Chandler, and Fedoroff 2015).

ETHICS AND TREATMENT

It is recognized that treatment is effective in reducing problematic sexual behaviors and lowering recidivism rates (Weinberger et al. 2005). The use of surgical castration, except perhaps in extreme cases, would not be considered ethical nowadays, when reversible and less intrusive pharmacological treatments are available. Selective serotonin-reuptake inhibitors (SSRIs) are recommended in mild cases of paraphilic disorders (Thibault et al. 2010). As the severity of the illness or the risk of recidivism increases, treatment recommendations include the addition of antiandrogen medication and hormonal agents such as medroxyprogesterone acetate (MPA) or cyproterone acetate (CPA), the latter not being available in the United States. In most severe cases, the use of luteinizing hormone-releasing hormone (LHRH) agonists (triptorelin or leuprolide acetate) is indicated (Thibault et al. 2010). Psychopharmacological treatment is usually well tolerated and accepted by those who seek a reduction in their deviant sexual fantasies and urges.

Another dominant treatment approach for sexual offenders is cognitive-behavioral therapy (CBT), most often offered in a group format (Association for the Treatment of Sexual Abusers 2001). Other individual and group approaches to foster self-esteem or address particular problems may also be offered when appropriate.

ACCESS TO TREATMENT

Knowing that treatment can help individuals with paraphilic disorders, it follows that there should be referral mechanisms in place to facilitate access to treatment. On one end, clinics specializing in assessment and treatment of individuals with problematic sexual behaviors are not legion. Access will therefore represent a major difficulty in both the United States and Canada. Most clinics are established within a forensic psychiatric environment, as most individuals with paraphilic disorders will be referred to a specialized clinic after a crime has been committed. Some clinics will accept direct medical referrals or referrals from other mental-health professionals. However, some individuals may be reticent to disclose problem sexual behaviors to their family doctor or other professionals. There is little information in the public domain for an individual with a paraphilic disorder to know where to start and how to access assessment and treatment. A few specialized clinics are privately operated but involve costs that are prohibitive.

Mandatory-reporting laws that oblige professionals to report suspected child abuse to child-protective agencies or other authorities might also deter paraphilic individuals to seek or engage in treatment. It is customary to warn patients of the existence of such a duty to report upon their initial presentation to a specialized clinic. Not all patients meet the test for mandatory reporting, where there may be variances in definitions from one jurisdiction to another. The applicable statutes will determine the situations for which mandatory reporting will be applicable. The Johns Hopkins Sexual Disorders Clinic of Maryland showed the deterrence effect of mandatory-reporting laws, with a significant drop in self-referrals over a ten-year period after the passing of the laws (Berlin, Malin, and Dean 1991). This raises concerns that previously undetected child abusers, who might have otherwise sought treatment, would continue to be at risk to abuse children. From an ethical perspective, encouraging treatment to prevent potential or future harm remains an optimal approach.

COERCED TREATMENT

Another preoccupying ethical concern is the issue of coerced treatment. Historically, surgical castration has been used as a form of criminal punishment (Heim and Hursch 1979). Surgical castration is rarely heard of nowadays, with the availability of reversible pharmacological castration. "Chemical"

(pharmacological) castration has proven effective in reducing recidivism to such an extent that agreeing to chemical castration has sometimes been made a formal condition of parole or as alternative to further incarceration. With incentives of this sort, sex offenders may agree to treatment. Ethicists looking at these circumstances question the extent to which such consent is truly voluntary.

Some authors have argued, however, that concerns about the issue of valid consent need not be the only considerations at play. Since considerations of autonomy lie at the very core of the principles underpinning valid consent, it may be justified to offer chemical castration to individuals if the end goal is indeed to increase their autonomy (Douglas et al. 2013). By providing alternatives, an individual may weigh the benefit/risk ratio as it applies to him and make a rational choice, even if this choice may appear partially coerced in the eyes of others. This is an interesting line of argumentation that deserves thoughtful reflection on current and future practices. Evidently, there is a difference to be made between (1) offering the choice of treatment and obtaining an explicit agreement and (2) compulsory treatment without the individual's will, as is permitted in Florida and some other jurisdictions (del Busto et al. 2011).

Not unlike coerced treatment, civil commitment of sexually violent predators (SVP) has raised concerns with regards to the potential misuse of psychiatric diagnoses to justify indefinite psychiatric hospitalizations (Fabian 2011, Frances and First 2011). Civil commitment of SVPs was legalized in the United States after two renowned Kansas cases. For instance, the court ruled in *Kansas v. Crane* (2002) that indefinite civil commitment was justified when an individual exhibited a "serious difficulty in controlling his sexual behavior" because of a mental abnormality or personality disorder.

ETHICS, RISK ASSESSMENTS, AND SENTENCING

RISK ASSESSMENTS

Risk assessments are based upon a variety of factors deemed to predict sexual reoffending. There exist many scales in use nowadays, such as the Violence Risk Appraisal Guide (VRAG), the Violence Risk Appraisal Guide–Revised (VRAG-R), the Sex Offender Risk Appraisal Guide (SORAG) (Harris et al. 2015, 286–299), Static-2002 (Hanson and Thornton 2003), the Minnesota Sex Offender Screening Tool–Revised or MnSOST-R (Epperson et al. 1998), and Sexual Violence Risk-20 (SVR-20) (Boer et al. 1997). Most instruments take into consideration historical variables such as childhood and adult antecedents

and general criminality. While actuarial risk-assessment scales provide helpful estimates as to the risk of one individual committing a sexual offense, they cannot accurately predict the actual reoccurrence of deviant sexual behavior by a given individual. Modifiable factors, often referred to as "dynamic" factors, must be considered in the overall assessment of risk. One of the ethics challenges with the use of actuarial risk assessments, besides the fact that they only provide rather rough estimates, is the reliance on those to determine sentence, in particular the duration of prison sentences.

Clinical factors may strongly influence the evolution over time of a paraphilic disorder. For instance, a sexual offense committed while the individual is under the influence of substances, alcohol, or nonprescription drugs is unlikely to recur if the individual remains sober. We also know that treatment of a paraphilic disorder may significantly alter its course. Müller et al. (2014) conducted a retrospective chart review that showed post-treatment changes in approximately half of the individuals diagnosed with pedophilia, using penile-tumescence testing. Those findings challenge the notion that pedophilic interests are chronic and unlikely to change over time.

With regards to recidivism, there are two distinguishable groups of sexual offenders (Tewksbury, Jennings, and Zgoba 2012). In the majority of cases, the risk of recidivism is low, with or without treatment. A smaller group will reoffend significantly more. The approximated risk for sexual recidivism declines substantially the longer a sex offender remains in the community without reoffending (Hanson et al. 2014). In categories of low-, moderate-, and high-risk predictions using the Static-99R tool, the rates of sexual recidivisms were 1–5 percent for the low-risk category, while the rate was 4.2 percent for the high-risk category after ten years (Hanson et al. 2014).

From an ethical perspective, the ability to distinguish properly between the two groups is important in terms of adequate planning of service provision and preventing future risk to society. Risk assessments have obvious limitations that need to be clearly stated. Predicting risk does not equate to recidivism, nor should this be the only factor to determine proper sentencing. Their predictive utility also needs to be explained and placed in context. Reliance on actuarial measures or otherwise to determine sentence and punishment is problematic at best.

MINIMUM SENTENCES

Judicial discretion in sentencing individuals convicted of a sexual offense no longer exists when statutes dictate the imposition of mandatory minimum

sentences. This trend began in the mid-2000s to apply to many offenses related to child pornography and the exploitation of children. From an ethical standpoint, concerns lie with the fact that punishment has shifted from the offender to the offense committed, without regards to circumstances that contextualize the event. With a trend to try juvenile offenders in adult courts, therefore being subjected to a sentence as an adult (Hunter and Lexier 1998), one can imagine how destructive this can be on young individuals convicted of a first sexual offense, when potential could exist for rehabilitation.

Since the late 1990s, numerous jurisdictions have passed legislations to create and enforce mandatory registration of convicted sex offenders. In the United States, the Violent Crime Control and Law Enforcement Act of 1994, in an effort to control the crime rate, called for the establishment of registries of sex offenders. The act was amended in 1996 with the passing of "Megan's Law," which required law-enforcement agencies to release relevant information with regard to registered individuals for the protection of the public (Hunter and Lexier 1998). Moving forward, the Pam Lychner Sexual Offender Tracking and Identification Act of 1996 directed the attorney general to establish the National Sex Offender Registry (NSOR). This act enabled the FBI to track certain offenders and to disseminate information necessary for the protection of the public to various law-enforcement agencies (Report of the Virginia State Commission 1997). In 2006, Congress enacted the Adam Walsh Child Protection and Safety Act, which led to the creation of the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART) within the Department of Justice, to administer new standards regarding sex-offender registration and notification (H.R. 4472). In Canada, the National Sex Offender Registry is maintained by the Royal Canadian Mounted Police (RCMP) and serves to track sexual offenders convicted of designated sexual offenses (Sex Offender Information Registration Act 2016). The information can be accessed by accredited Canadian police agencies to assist in the investigation of sexual crimes.

The establishment of mandatory registries remains a subject of debate. Critics have raised concerns about the lack of evidence of their effectiveness and the stigmatization it may cause to registrants and their families, further impeding their rehabilitation in the community (Jennings, Zgoba, and Tewksbury 2012; Lasher and Stinson 2016).

Federal legislation also requires the registration of juvenile sex offenders, allowing public access to juvenile-court records in several states (Hunter and Lexier 1998). The medium- to long-term impact of carrying the label of sex

offender through a registration system in the youth population has not been measured and is concerning from an ethical perspective, considering the fact that they may benefit from early interventions.

CONCLUSIONS

This chapter highlights some of the most important ethical considerations with regards to the assessment and treatment of sex offenders. There are a number of ethical concerns that can arise in individual cases, and often the clinician will need to rely on his professional judgment to navigate through the complexities of the matter at hand.

Ethical concerns begin very early in the process, perhaps as early as the initial referral. Offenders who have committed a sex offense will most often be referred by the court or by a parole or probation officer. More rarely, they will be referred by a medical doctor or be self-referred. Except in this last circumstance, they will ideally have given a clear and explicit consent for the referral to be made. Unfortunately, this is often not the case. Facing the court, they may have felt they had no real choice but to appear cooperative and comply. It will remain the responsibility of the clinician to obtain a free valid consent for the assessment. The issue of consent is at the core of the entire process and is more complex than one might think at first glance. Clinicians would do well to continue reflection on this issue, as there may not be a "one-size-fits-all" solution. On the contrary, humans' motivations, as well as their values, are diverse. Respect for the individual's autonomy requires an individualized approach, establishing a rapport, and providing information and clinical care in a courteous and professional manner.

Ethical dilemmas will always exist. At least part of the current set of ethics dilemmas is imposed by the system in which we work, with decisions made by legislators and public perceptions influencing them. We need to acknowledge those dilemmas in our interactions with examinees and tailor our approach in a harm-reducing manner.

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13

THE INTERNET AND FORENSIC ETHICS

Patricia R. Recupero and Frederic G. Reamer

Digital technology in behavioral health, including forensic evaluations, is now prominent and assumes diverse forms. It includes the use of computers (online chat, text messaging, and e-mail) and other electronic means (such as smartphones and videoconferencing technology) to deliver services, communicate with patients, manage confidential case records, and access information about patients and third parties (Menon and Miller-Cribbs 2002, Zur 2012). The use of information and communications technology (ICT) in the practice of forensic psychiatry can be traced back to the growth of telepsychiatry in the 1950s (Shore 2015). Additional mental-health resources and services emerged on the Internet in 1982 in the form of online self-help support groups (Kanani and Regehr 2003; Reamer 2015a, 2015b). By the late 1990s, groups of clinicians were forming companies and e-clinics that offered online counseling services to the public using secure Web sites (Skinner and Zack 2004).

Early discussions of electronic tools focused on practitioners' use of information technology and the ways in which they could use Internet resources such as online chat rooms and Listservs joined by colleagues, professional networking sites, newsgroups, and e-mail (Daviss, Hanson, and Miller 2015; Martinez and Clark 2000). Behavioral-health professionals now use a much wider range of digital and electronic options to serve patients who struggle with mental-health and behavioral issues and, using powerful online search engines, access and manage information about them (Kanani and Regehr 2003, Lamendola 2010, Menon and Miller-Cribbs 2002, Reamer 2015a, Zur 2012).

Thus far, most scholarly publications focusing on pertinent ethical issues have examined the *clinical* use of technology, such as the ways in which behavioral-health practitioners use digital technology to search for information about patients, communicate with patients, and deliver services. Key

topics have included challenges related to obtaining patients' informed consent when services are provided remotely, protecting patients' confidential information when it is transmitted and stored electronically, balancing patients' privacy rights and practitioners' searches for online information about them, and maintaining professional boundaries in patients' and practitioners' online relationships (Gabbard, Kassaw, and Perez-Garcia 2011; Lamendola 2010; Reamer 2015b; Zur 2012).

Relatively few discussions have addressed ethical issues associated with practitioners' use of digital and other technology specifically for forensic purposes (American Academy of Psychiatry and the Law 2015; Metzner and Ash 2010; Neal et al. 2013; Neimark, Hurford, and DiGiacomo 2006; Pirelli, Otto, and Estoup 2016; Recupero 2008; Recupero and Rainey 2005). Analyses to date suggest that forensic professionals should develop ethics-based protocols related to (1) decisions about whether to search for Internet-based information; (2) assessment of the utility, validity, and reliability of information obtained from the Internet; and (3) informed consent and transparency. Key questions include: Under what circumstances is it appropriate for forensic experts to conduct online searches related to patients or forensic evaluees without their knowledge or consent? In what ways are forensic experts obligated to assess the validity and reliability of information they locate using electronic search engines (such as Google, Bing, Yahoo, Facebook, and LinkedIn)? What threshold criteria should forensic experts use to judge the veracity of information available through Internet searches? Should forensic experts inform patients or forensic evaluees when they conduct online searches about them and their personal circumstances? Should forensic experts perform online searches and document these searches in patients' or evaluees' medical records or reports in the spirit of transparency, even if the patient or evaluee has not consented to the search?

CHALLENGING ETHICAL ISSUES: COMMON PATTERNS

Forensic specialists in behavioral-health settings must be mindful of several patterns that have emerged among ethical challenges associated with their use of the Internet and other digital technology.

ETHICAL MISTAKES

There is a current ethical standard requiring mental-health professionals to use the utmost care to protect the confidentiality and privacy of their patients

or clients; there also are legal standards requiring such protection. Forensic experts should be vigilant in their efforts to avoid inadvertent mistakes that compromise their integrity and violate prevailing ethical standards. Such mistakes can occur by omission or commission. An example involving omission is failing to encrypt protected health information (PHI), thus permitting access to it by unauthorized parties. In one case, a forensic psychologist used Google Docs (free, Web-based software for word processing, spreadsheets, and multimedia presentations) to prepare an assessment in a criminal-court matter. She made two errors. First, she did not realize she had clicked the "share" option associated with the document, which enabled unauthorized contacts to view the document. Second, the psychologist was not aware that her document would be HIPAA compliant only *after* she followed Google's (2016) published protocol for configuring her Gmail account to be HIPAA compliant.

In forensic practice, it is incumbent upon the forensic specialist to be aware of the issues related to attorney-client privilege and confidentiality and to work-product protections. In another instance, a forensic social worker forwarded an e-mail attachment containing sensitive clinical information to three parties who were confidential consultants in a bitter child-custody matter. The fact that the experts were being consulted was confidential; initially they were not aware of one another's involvement. The social worker made the mistake of including all three recipients' contact information in the "To" field of the e-mail headers, thereby informing each recipient of the identity of the other two parties. The social worker could have avoided this mistake—an act of commission—by entering the three names in the "Bcc" field of the e-mail message.

Cloud-based data-storage/management options (e.g., Google Drive, Dropbox) can pose special legal and ethical implications for clinicians and forensic specialists alike (Klein 2011). While cloud computing offers many benefits in the form of convenience and accessibility, it carries risks related to the ownership and security of user-created data (Irion 2015). Evidence suggests that many users of technology often fail to review the privacy policies or "terms of service" to which they "agree" when using a website or service (McDonald and Cranor 2008/2009; Steinfeld 2016). However, failing to read a terms-of-service agreement for a cloud-based data-storage/management service before using it for documents containing PHI would be a serious ethical mistake. The agreement might contain, for example, clauses stating that the data storage method is not HIPAA compliant, that the company offering the service disclaims liability for data breaches, that the company reserves the right to sell the data to

third parties (such as marketers or data brokers), or even that the user forfeits the right to ownership or control of such data once the information has been uploaded to the cloud.

Forensic mental-health professionals should also be aware of the risk of misinterpreting electronic or digital evidence. Information obtained from the Internet and social media can be taken out of context and easily misunderstood. For example, sarcasm often translates poorly online, and the meaning of inside jokes between Facebook friends or within a Twitter feed may be lost on the forensic specialist, who is not familiar with the evaluee's life, cultural background, or personality. To use a common example, a frustrated parent might post something like, "I swear, I'm gonna kill that kid!" in a parenting group on Facebook, but such a post does not necessarily reflect true homicidal ideation. Other examples may be less obvious and require further exploration.

A reasonable degree of "digital-culture" literacy is necessary in order to interpret many forms of electronic communications, such as the use of common text abbreviations. For the practitioner who needs to learn more, websites such as the Urban Dictionary (http://www.urbandictionary.com/) and Wikipedia (see, e.g., https://en.wikipedia.org/wiki/SMS_language) can be useful resources. Internet memes can also contain significant clues in the forensic evaluation. For example, in performing an assessment of an adolescent suspected of committing a hate crime, the appearance of a meme associated with white-nationalist groups on the adolescent's Twitter feed (see, e.g., http://knowyourmeme.com/memes/events/savepepe) could be very relevant. When confronted with an unfamiliar phrase, image, or other type of meme, the mental-health professional should have sufficient Internet literacy to do some preliminary research but should also be prepared to request more information or clarification from the evaluee, the retaining attorney, or a colleague in a consulting role.

The forensic specialist should be cautious about drawing premature conclusions or being unduly biased as a result of information found in an online search. Suppose the consultant Googles an evaluee and finds a newspaper article stating that the person had been convicted for assault and battery several years ago. Before concluding without more evidence that the person has a criminal history or a history of violent behavior, it may behoove the forensic professional to ensure that the person in the newspaper article is the same person whose condition the specialist has been asked to evaluate, not simply someone who shares the evaluee's name (Clinton, Silverman, and Brendel

2010). Locating unusual findings in a Web search (e.g., possible criminal history) would warrant further inquiry in order to provide context and clarification. A Web search might also yield inaccurate or unflattering information about the evaluee on a commercial website or blog (Clinton, Silverman and Brendel 2010). For example, a website called "ExRated" (http://exrated.co/index.php) invites users to post reviews of former dating partners; the content is unsubstantiated, reviews can be posted anonymously, and persons who receive unfavorable reviews have minimal recourse. Furthermore, recent political events have demonstrated that "fake news" has become prevalent online.

ETHICAL MISCONDUCT

Sadly, some ethical issues related to behavioral-health professionals' use of the Internet and digital technology have involved misconduct. In some cases, practitioners' use of the Internet and other digital technology has been used as evidence against them in criminal-court and licensing-board proceedings. In one particularly egregious case, an adolescent-psychiatry resident was sentenced to a thirty-year prison term following his conviction for using the Internet and text messages to harass a teenage girl with whom he was attempting to pursue a sexual relationship (*U.S. v. Batchu* 2013). While conduct that rises to the level of criminal behavior is easily recognized as unethical, mental-health professionals should be wary of the "slippery slope" of boundary crossings that can precede serious boundary violations (Gutheil and Gabbard 1998), particularly when considered in light of the disinhibiting nature of electronic communication (Suler 2004). In a recent survey of medical boards throughout the United States, inappropriate electronic communication with patients (including sexual misconduct) was the most common basis for a charge of unprofessional conduct online (Greysen et al. 2012).

Another common ethical misstep among professionals is the failure to separate one's personal and professional activities in social media. Given the ubiquity of social media and its increasing role in professional activities, it may be helpful to maintain separate accounts on social-networking sites: one account for personal use (with careful use of privacy tools) and a separate account for one's professional identity (Gabbard, Kassaw, and Perez-Garcia 2011).

With respect to one's personal activities online, inadequate privacy management in social media can lead to ethical dilemmas. In one survey of younger physicians, for example, roughly 25 percent reported *not using* Facebook's

privacy settings despite using the site regularly for personal social networking; one respondent in the sample belonged to a group called "perverts united" (MacDonald, Sohn, and Ellis 2010). Even when privacy settings are used, posting information about patient encounters (even deidentified information) can also raise ethical issues when the purpose is self-serving rather than educational (Gabbard, Kassaw, and Perez-Garcia 2011).

Many clinicians post comments on the websites of local newspapers, medical/professional blogs (e.g., KevinMD.com), and professional-networking sites (e.g., LinkedIn); some professionals even publish their own blogs. At times, the comments feeds on these forums can spark heated debates over political issues, so it is important to be temperate in one's language. Although social media is often characterized by informal language, engaging in baiting and insulting commentary when these discussions degenerate into flame wars or angry rants can raise ethical issues, particularly when patients, forensic evaluees, or other third parties are involved in the discussion. Similarly, criticizing one's colleagues or other third parties (e.g., a judge) can be ethically problematic.

When browsing the Internet or social media, the forensic specialist may come across questionable or unethical online conduct posted by one's professional colleagues. In such cases, one may have an ethical responsibility to notify the colleague "so that he or she can remove it and/or take other appropriate actions" (American Medical Association 2011). If the content is not removed or fixed, it may be necessary to report the misconduct to the licensing board or professional-ethics committee (AMA 2011), particularly where the ethical misstep is more egregious or possibly illegal (e.g., breach of confidentiality).

Forensic mental-health specialists may be asked to perform fitness-for-duty or return-to-work evaluations of professionals whose Internet activity or conduct on social-networking sites has raised concerns about possible ethical misconduct (Recupero 2008). As clinicians and administrators gain increased awareness of potential ethical problems associated with inadequate maintenance of professional boundaries online, complaints against clinicians that are based on some type of ethical misconduct via Internet communications may increase. Before performing a forensic evaluation of a professional whose Internet use is problematic or otherwise directly relevant to their fitness for duty, it is important for the forensic specialist to have a solid understanding of the type of Internet activity in question. Without sufficient digital-media literacy, the specialist may miss opportunities to gain the necessary information during the psychological assessment.

ETHICAL JUDGMENTS

Many forensic mental-health professionals have websites on which they describe their forensic practice, educational background, and professional experience. A basic website may be analogous to a business card (albeit a lengthy one) and contain the specialist's contact information, curriculum vitae, and links to other resources (e.g., one's professional associations, such as the APA or NASW). The more interactive a website, the more complicated the legal and ethical implications will be (Recupero 2006).

Deciding what information to include on a practice website is an important ethical judgment for the specialist to make (D'Angelo and Van Der Heide 2016). A professional website that contains excessive and unnecessary personal information can be ethically problematic. Examples of ethically questionable material might include:

- Flattering swimsuit photographs of you during your recent vacation to the Bahamas
- Photographs of you with your family
- Political material (e.g., links to websites for political candidates or parties you support)
- Religious material (e.g., quotations from the Bible, links to your congregation's website)
- Promotional materials for your own side ventures or friends' businesses (e.g., coupons for your daughter's new dog-grooming business)
- Links to pharmaceutical companies' websites
- Links to your personal Facebook profile, Twitter feed, or other social-networking site (SNS) profiles, where patients or evaluees could learn more about your private life

It is important to avoid false advertising, such as overselling one's qualifications or holding oneself out to be an expert on a topic in which one has limited expertise. As the AAPL ethics guidelines for the practice of forensic psychiatry (2005) note, "expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience."

While it is common to provide information on one's practice website about areas of expertise, providing too much information about a specific case can represent a lapse in ethical judgment. The ethics guidelines of the American

Academy of Psychiatry and the Law (2005) emphasize the ethical principle of respecting an individual's right of privacy and the maintenance of confidentiality.

Another important ethical consideration for a practice website might include whether to engage the services of a website-development company or other entity that provides search engine-optimization (SEO) services. When hiring a coder or company to help design, host, or maintain your website, it is important to read the fine print in any agreement. Does the company offer a discount in return for allowing advertisers to purchase space on the practice's website for banner advertisements? If so, and if the forensic professional accepts such a discount, how does one ensure that the businesses that purchase ad space on the site are appropriate? Could a prospective patient or attorney see an advertisement for a branded prescription medicine or a "natural herbal remedy for depression" as the practice's "sponsored ad"? Arguably, it is ethically inappropriate to allow a third party (such as a website-hosting company) to control the content on one's practice website, including sponsored links. The appearance of "sponsored" content on a professional site may imply the forensic practitioner's endorsement and may be inappropriate or misleading to patients.

Issues relating to the maintenance of professional boundaries online may be among the most important ethical judgments that a forensic specialist will make. Although the AAPL ethics guidelines (2005) do not specifically address boundaries, the AAPL Committee on Ethics has alluded to the forensic professional's "ethical requirement to maintain professional boundaries" (AAPL 2013, question 1). While anonymously researching a forensic evaluee in order to obtain collateral information may be ethically permissible, friending that evaluee on Facebook or retweeting material the evaluee has posted on Twitter could constitute a departure from appropriate boundaries. Forensic specialists and clinicians alike should be mindful of their motivations for performing Internet searches to learn more about patients or forensic evaluees. Although searching for collateral information about forensic evaluees may be less ethically problematic than researching clinical patients online, digital forensic research is not without ethical dilemmas. Most clinicians lack sufficient competency in performing electronic searches of Internet and digital evidence, so it may be necessary for the attorney in a case to retain the services of an expert in information technology to compile a complete, authenticated picture of the data. A comprehensive Internet search would require the sophistication to search all potentially relevant sites, such as Instagram, Snapchat, Pinterest,

LinkedIn, and others; relying on unsubstantiated information gleaned solely from one website or app would be unprofessional.

When reviewing an evaluee's or patient's electronic communications or social-networking activity, it is important to keep one's voyeuristic curiosity in check (Clinton, Silverman, and Brendel 2010). In a competency-to-stand-trial evaluation, is it really necessary to peruse the content of sexts exchanged between the defendant and his girlfriend? When possible, searches should be restricted to the data relevant to the specific question(s) that the forensic expert was retained to address. Before accepting a case, the mental-health professional may wish to clarify with the retaining party the scope of materials that one is expected to review in the course of preparing the expert opinion. Similarly, the forensic professional should avoid presenting in testimony or forensic reports any data that are irrelevant to the instant question and potentially prejudicial or sensitive.

Conversely, *avoiding* the use of social media or other digital information when it can be informative to the forensic evaluation may represent a failure to be thorough. At times it may be necessary to revisit with the retaining party the issue of the scope of materials to be reviewed by the mental-health professional if, for example, one comes across collateral material that deserves a closer review or determines that an additional review of electronic data would be wise. As the forensic psychiatrist and educator Annette Hanson writes:

> Forensic psychiatry involves training in the evaluation of criminal defendants in order to determine legal sanity. Social media content is increasingly part of this process, given the real-time data that it provides about a defendant's mental state at the time of the crime. A student in forensic psychiatry may review Facebook posts, tweets or online videos made by a defendant during the offence.
>
> (DAVISS, HANSON, AND MILLER 2015, 170)

As more of our lives and actions are posted or broadcast online or recorded in digital media, the volume of electronic information that may be relevant to forensic evaluations will continue to grow; it is important for the forensic consultant to request and review these materials whenever they are available (Pirelli, Otto, and Estoup 2016).

Another important ethical judgment may be whether it is appropriate to perform a forensic evaluation via videoconferencing without meeting the evaluee in person. The evidence base supporting the effectiveness and validity of telepsychiatry, telepsychology, and telemental health has expanded

significantly in recent years. However, forensic evaluations by videoconferencing may require some safeguards in order to enhance the reliability of the assessment. For example:

- Has the evaluee's identity been verified?
- Is it possible that someone else is in the room with the evaluee, coaching them on how to respond to your questions?
- Can the evaluee see you and respond to your questions in real time (are you using two-way synchronous videoconferencing)?

While a detailed discussion of the legal and ethical issues relating to forensic telepsychiatry is beyond the scope of this chapter, readers who are considering adopting this practice are encouraged to consult appropriate ethical guidelines (see, e.g., American Psychological Association 2013) and one's liability-insurance carrier.

Both forensic and clinical healthcare professionals should consider the Internet even when not actively using it. For example, many academic institutions and professional organizations routinely record and publish educational material on publicly accessible sites such as YouTube. In the educational setting, it is common to share personal information and humorous anecdotes during lectures and presentations in order to establish rapport with the audience. Mental-health professionals who discuss real clinical or forensic cases in educational settings should be especially cautious. It is important to find out whether the school or conference in question will be recording, transcribing, distributing, or publishing the content of one's lectures and to keep forums like YouTube in mind when preparing content that will be shared with others.

Finally, the forensic specialist may need to decide whether (or how) to respond to unsolicited contacts from third parties, such as prospective patients, colleagues, or members of the public. Friedman and colleagues (2016) provide some guidance on the ethical implications of responding (or not responding) to unsolicited e-mails. Friend requests from patients or third parties (such as patients' or evaluees' relatives) may also be ethically troublesome.

EMERGING STANDARDS

In recent years, numerous health organizations and associations have embarked on efforts to develop new standards of care related to practitioners' use of the Internet and other digital technology. These standards are relevant

to forensic experts. For example, the Association of Social Work Boards (ASWB 2015), whose membership includes licensing and regulatory bodies throughout the United States and Canada, recently adopted model regulatory standards for the use of technology in social-work practice, developed by ASWB's International Technology Task Force. These standards address a number of ethical issues related to informed consent, privacy and confidentiality, boundaries and dual relationships, conflicts of interest, records and documentation, collegial relationships, and electronic practice across jurisdictional boundaries. An ongoing project jointly sponsored by the National Association of Social Workers, Council on Social Work Education, ASWB, and Clinical Social Work Association is developing comprehensive practice standards designed to guide practitioners' use of technology.

In 2015 the American Psychiatric Association established the Ad Hoc Workgroup on Telepsychiatry, focused on relevant practice, research, and policy issues. This followed a 2014 call by the American Medical Association for each specialty group and organization across medical disciplines to develop their own telemedicine standards. Also, the American Psychological Association has developed standards related to clinicians' use of technology (2013). The standards address a range of ethical issues pertaining to standards of care, confidentiality, security and transmission of data, disposal of data, and interjurisdictional practice. The Federation of State Medical Boards (2011) has also published guidelines for the use of social media in medicine.

In light of these diverse developments and the evolution of thinking about pertinent ethical issues (AAPL 2015; Lakhani 2013; Pirelli, Otto, and Estoup 2016), forensic professionals are encouraged to consider the following guidelines and principles:

- Forensic practitioners should consult ethics standards when deciding whether to conduct online searches for information about patients.
- Forensic practitioners should assess the validity and reliability of information obtained from online sources.
- Forensic practitioners and clinicians should inform evaluees and patients about any policies concerning the use of online searches about the patient/evaluee and the ways in which information from these searches might be used.
- Forensic practitioners who obtain information about patients or evaluees from online sources should be willing to respond to questions about the accuracy of the information.

- Forensic practitioners should disclose the ways in which they have relied on information gleaned from online sources in the formulation of their expert opinions.
- Forensic practitioners should employ state-of-the-art security tools, such as encryption technology, in order to protect the confidentiality of electronically stored information, particularly when using protected health data (PHI).

CONCLUSION

The advent of digital technology has transformed the nature of contemporary forensic practice. Unlike their predecessors, today's forensic practitioners frequently use this technology to conduct evaluations, access information about evaluees and third parties, and manage protected health information. These developments have created unprecedented ethical and risk-management challenges.

Forensic practitioners should keep pace with rapidly changing technology developments and standards of care. To protect evaluees and themselves, forensic professionals should take reasonable steps to prevent ethical mistakes, avoid ethical misconduct, and make sound ethical judgments pertaining to their use of technology. Practitioners would do well to review and monitor changes in pertinent ethical standards, practice standards, regulations, statutes, and case law. In the end, these diligent steps greatly enhance the likelihood that forensic practitioners will practice ethically and minimize risk.

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14

ETHICAL DILEMMAS IN THE FORENSIC PSYCHIATRIC EVALUATION OF GUANTÁNAMO DETAINEES MASS-ADMINISTERED MEFLOQUINE

Remington L. Nevin and Elspeth Cameron Ritchie

SINCE THE WAR ON TERROR began in 2001, hundreds of individuals have been medically processed and subsequently detained at U.S. Naval Base Guantánamo Bay, Cuba ("Guantánamo"). There, beginning shortly after their arrival, many were subject to interrogation to gain intelligence to aid the U.S. government in its war on terror. In recent years, it has become well known that the U.S. government employed harsh methods, including simulated drowning (or "waterboarding"), to aid in this interrogation (Physicians for Human Rights 2007). Health professionals allegedly played a role in facilitating this interrogation by abetting these harsh methods (Institute on Medicine as a Profession 2013, Rubenstein and Xenakis 2010). For example, a U.S. Central Intelligence Agency (CIA) directive counseled its physicians caring for Guantánamo detainees not to undermine "the anxiety and dislocation that the various interrogation techniques are designed to foster" (Bloche 2016). It is less well known that health professionals also played a role in the prescribing of a medication—the antimalarial drug mefloquine—that was subsequently mass-administered to detainees. This drug might also have facilitated these interrogations by fostering similar effects as the other more well-known harsh methods.

Mefloquine was previously considered by the U.S. military to be its drug of choice for the treatment and prevention of malaria. However, in recent years, knowledge has grown of the drug's severe adverse psychiatric effects, including anxiety, insomnia, nightmares, confusion, and hallucinations. It is increasingly clear that these adverse psychiatric effects may in some cases last years after use and confound the diagnosis of several psychiatric disorders, including post–traumatic stress disorder (PTSD) (Nevin 2015, Nevin and Ritchie 2015). Recently, for these and other reasons, mefloquine was formally declared a drug of last resort by the U.S. military and is now prescribed only by exception, in those

rare cases where safer and better tolerated antimalarials are contraindicated (Nevin and Ritchie 2016).

THE MASS ADMINISTRATION OF MEFLOQUINE TO GUANTÁNAMO DETAINEES

In 2010, researchers uncovered evidence of the universal administration of treatment doses (1,250 mg) of mefloquine to detainees immediately or soon after their arrival at Guantánamo during their medical processing (Denbeaux et al. 2010, Leopold and Kaye 2010). Based on available documentation cited in this original research, this practice appears to have begun around the time of the arrival of the first detainees to Guantánamo in 2002 and to have continued through at least 2005, if not possibly longer (Denbeaux et al. 2010).

The administration of antimalarials was originally hailed as an example of the quality of medical care Guantánamo detainees received upon their arrival (Martz 2002, Edmonson 2002). However, as the original research and a later critical analysis revealed, the clinical motivation for this practice, which appeared to be a form of empiric or presumptive treatment, was decidedly unclear (Denbeaux et al. 2010, Nevin 2012). There was no precedent in the medical literature for the mass administration of mefloquine in this manner (Slutsker et al. 1995, Miller et al. 2000, Barnett 2004, Centers for Disease Control and Prevention 2012).

Even if mass administration of an antimalarial at treatment doses was deemed justified on clinical grounds, the use of mefloquine in place of safer and better-tolerated drugs for this indication is not easily explained. A prominent U.S. military expert has commented that with "the availability of better-tolerated drugs, there is no need to use mefloquine for treatment unless other options are unavailable" (Magill 2006). Other U.S. military authors would later note that mefloquine will "likely not find use" for such mass administration in treatment among "asymptomatic, otherwise healthy" persons because of its association with adverse effects (Milner et al. 2010).

Intriguingly, a U.S. military representative has subsequently claimed that although "the risks and benefits to the health of the detainees were central considerations," the mass administration of mefloquine was not actually directed for the clinical benefit of the detainees (Leopold and Kaye 2010). Instead, this practice was "entirely for public health purposes to prevent the introduction of malaria to the Guantánamo area" (Leopold and Kaye 2010).

Per the U.S. military representative, a decision was made to "presumptively treat each arriving Guantánamo detainee for malaria to prevent the possibility of having mosquito-borne [*sic*] spread from an infected individual to uninfected individuals in the Guantánamo population, the guard force, the population at the Naval base or the broader Cuban population" (Leopold and Kaye 2010).

Despite this seemingly plausible explanation, the later critical analysis revealed discrepancies in this justification. As mefloquine does not block transmission of malaria, use of the drug in this manner could not have served the public-health purposes claimed (Nevin 2012). This same critical analysis also contrasted the use of mefloquine among Guantánamo detainees with the alternative methods of malaria control used successfully a decade earlier, when over 14,000 potentially malaria-infected Haitian refugees were housed at Guantánamo without resorting to the mass administration of antimalarials (Nevin 2012).

The critical analysis on the use of mefloquine among Guantánamo detainees speculated that use of the drug was simply erroneously directed by officials who were "overly confident of the drug's safety and unfamiliar with its appropriate use" (Nevin 2012). However, the original research and subsequent critical analysis also articulated a reasonable concern that use of the drug could have been informed, at least in part, by knowledge of the drug's adverse psychiatric effects (Denbeaux et al. 2010, Nevin 2012).

Described elsewhere as "pharmacological waterboarding," the use of mefloquine intentionally for its adverse psychiatric effects could have served to facilitate the interrogation of detainees in a manner that would be plausibly deniable (Leopold and Kaye 2010). For example, were the U.S. military alleged to have used mefloquine intentionally to induce the same "anxiety and dislocation" among detainees that other methods of interrogation were intended to foster, the U.S. military might plausibly respond in its defense that it would not employ a drug on detainees intentionally for this purpose, given that it was using it routinely among its own personnel during that time (Bloche 2016). In contrast, use of other classes of psychotropic drug to facilitate interrogation would not have been plausibly deniable (U.S. Department of Defense Inspector General 2009).

The U.S. military has never publicly acknowledged the inconsistencies in its explanation for the use of mefloquine, inconsistencies that were identified in the later critical analysis (Nevin 2012). Neither has the U.S. military directly challenged allegations made by the original researchers that use of the drug

could have plausibly facilitated interrogation (Denbeaux et al. 2010, Leopold and Kaye 2010).

A former U.S. military hospital commander who is known to have ultimately directed the administration of mefloquine to Guantánamo detainees has emphatically denied its intentional use for its adverse psychiatric effects (Task Force on Detainee Treatment 2013). This individual has claimed that in directing the drug's use in this manner, they were merely acting on the recommendations of experts at various U.S. government agencies, including the U.S. military and the U.S. Centers for Disease Control and Prevention (CDC) (Kaye 2012). However, representatives from the CDC have subsequently claimed they were never consulted on the use of mefloquine among Guantánamo detainees and played no role in the decision to recommend its use (Shane 2011).

The intentional use of mefloquine for the purposes of facilitating interrogation therefore remains a plausible but ultimately speculative explanation for its mass administration to Guantánamo detainees, and simple erroneous use—based on a lack of familiarity or acknowledgement among U.S. military experts of the drug's adverse psychiatric effects—must also be considered a possible explanation.

INCREASING EVIDENCE OF ADVERSE PSYCHIATRIC EFFECTS OF MEFLOQUINE

Mefloquine was developed by the U.S. military during an extensive Vietnam War–era drug-development program that spanned over two decades (Tigertt 1969). Until recently, both the U.S. military and other U.S. government agencies had repeatedly failed to recognize and acknowledge evidence of the drug's adverse psychiatric effects. For example, during the drug's development, there were early reports of the drug causing severe psychiatric symptoms, including confusion and hallucinations, particularly at treatment doses (World Health Organization 1991).

Despite these reports, soon after the drug's licensing by the U.S. Food and Drug Administration (FDA) in 1989, mefloquine was recommended for use within the U.S. military and quickly became its drug of choice for the prevention of malaria, at a weekly dose of 250 mg (Armed Forces Epidemiological Board 1989). A postmarketing study conducted among members of the U.S. military soon thereafter acknowledged that even at this lower preventive dose, the drug caused common and disturbing symptoms of insomnia and vivid

dreams, described as often "terrifying nightmares with technicolor clarity which were vividly remembered days later" (Boudreau et al. 1993). Yet despite the results of this study, mefloquine was described as "well-tolerated" (Boudreau et al. 1993). The drug was subsequently widely used among U.S. military personnel throughout the 1990s and as the "War on Terror" got underway in 2001 (Nevin 2015).

By 2002, the year detainees began arriving in large numbers at Guantánamo, results of several studies had been published in the medical literature that contained seemingly unimpeachable evidence that mefloquine commonly caused adverse psychiatric effects, both when used in the prevention of malaria and at the higher treatment doses ultimately recommended during this time for use in mass administration among Guantánamo detainees (Overbosch et al. 2001, Rendi-Wagner et al. 2002).

Specifically, in September 2001, results were published from a randomized double-blind study, which found that 14 percent of healthy subjects taking mefloquine at 250 mg weekly reported strange or vivid dreams, 13 percent reported insomnia, and 4 percent reported anxiety—in each case, a statistically significant excess as compared with the better-tolerated alternative (Overbosch et al. 2001). Similarly, in February 2002, results were published from a prospective study involving administration of treatment doses of 1,250 mg of mefloquine to healthy subjects, which found that 59 percent reported insomnia, 27 percent reported anxiety, 14 percent reported confusion, and 5 percent reported hallucinations—in each case, clearly causally related to the drug (Rendi-Wagner et al. 2002). In many cases, these symptoms lasted days to weeks after dosing.

Despite the seemingly convincing results of these studies, a U.S government interagency working group that met in April 2002—only months after the purported recommendation by certain of the participants to mass-administer mefloquine was made—was generally dismissive of these results. Citing the "subjective nature" of many of the psychiatric adverse effects and the "suggestible nature of human beings," the interagency working group concluded there was only sufficient evidence to "raise the question" of whether psychiatric adverse effects should limit the use of mefloquine but that "sufficient evidence does not exist to answer the question" (Office of the Assistant Secretary of Defense for Health Affairs 2002). In October 2002, a U.S. military memorandum claimed that when used for the prevention of malaria, psychiatric effects from mefloquine, including anxiety and hallucinations, occurred in as few as 1 in 13,000 users (U.S. Army Office of the Surgeon General 2002).

CHANGING USE OF MEFLOQUINE AMONG GUANTÁNAMO DETAINEES AND U.S. MILITARY PERSONNEL

As use of the drug continued among newly arriving Guantánamo detainees during this time, the U.S. military continued its own widespread use of the drug among its personnel in Afghanistan (Nevin 2015). Despite growing concerns about the drug's adverse psychiatric effects, when combat operations began in Iraq the following year, the drug was also widely used among U.S. military personnel there (Nevin 2015).

Over the following years, as the burdens of psychiatric illness from the wars accumulated among U.S. military personnel, concerns about the potential role of mefloquine in contributing to these effects also accumulated (Nevin 2015). However, as late as 2007, official U.S. military documents continued to claim that psychiatric symptoms from mefloquine were not observed in studies and "must be very rare, if they are related to mefloquine, given the background of millions of doses used worldwide over the decades" (Office of Public Health and Environmental Hazards 2007).

After the Obama administration took office in 2009, no new detainees arrived at Guantánamo (*New York Times* 2016a). Presumably none was therefore subsequently exposed to mefloquine. That same year, the U.S. military deprioritized the use of mefloquine among its personnel in Afghanistan (Nevin 2015). Faced with growing evidence of the drug's dangers, by 2013 the U.S. military had formally declared mefloquine an antimalarial drug of last resort (Nevin 2015, Nevin and Ritchie 2016).

That same year, the U.S. FDA concluded, after over a decade of intermittent study, that mefloquine could have long-lasting psychiatric effects and required that a boxed warning (or "black box") appear on the drug's labeling (U.S. Food and Drug Administration 2013). The U.S. Army Special Operations Command (USASOC) subsequently prohibited the use of mefloquine entirely and took the unusual step of directing assessment of its personnel to determine whether they might have lasting psychiatric effects attributable to the drug (Nevin and Ritchie 2016).

U.S. military authors have subsequently concluded that the lasting psychiatric effects of the drug, even at the lower doses used to prevent malaria, can confound the diagnosis of PTSD among U.S. military personnel (Livezey, Oliver, and Cantilena 2016). Likely because of such confounding, U.S. military research has since concluded the drug may increase the risk of PTSD diagnosis relative to better-tolerated antimalarials (Eick-Cost et al. 2016).

It is not known how many U.S. military personnel have been diagnosed with PTSD or other psychiatric disorders because of symptoms primarily attributable to mefloquine (Nevin 2015). The U.S. Department of Veterans Affairs has recently awarded at least one disability claim to a veteran claiming psychiatric disability from the drug, and similar future claims are considered highly probable (Nevin and Ritchie 2016). Similarly, as awareness of the chronic effects of mefloquine among U.S. military personnel has grown, awareness has also grown that several Guantánamo detainees are suffering chronic psychiatric problems (Higgins 2013, *New York Times* 2016b). These include insomnia, anxiety, and symptoms of PTSD similar to those suffered by military veterans exposed to mefloquine (Nevin 2015; Nevin and Ritchie 2016; Livezey, Oliver, and Cantilena 2016).

Despite these significant developments, senior representatives from the U.S. military have yet to acknowledge formally any clinical implications, either among U.S. military personnel or among Guantánamo detainees, from awareness that the use of the drug is associated with chronic psychiatric effects.

ETHICAL CONSIDERATIONS IN THE FORENSIC PSYCHIATRIC EVALUATION OF DETAINEES ADMINISTERED MEFLOQUINE

U.S. military and civilian psychiatrists may be asked to perform forensic psychiatric evaluations on Guantánamo detainees for the purposes of facilitating military justice. Evaluations for these purposes are referred to as "706 boards" or "sanity boards," after the corresponding rule in the *Manual for Courts-Martial* governing their conduct (Montalbano 2012). Commonly these are done to answer questions related to the detainee's psychiatric diagnosis, his competency to stand trial, and his criminal responsibility at the time of the alleged crimes (Montalbano 2012, Simmer 2012).

The second author, a former U.S. military psychiatrist, conducted four sanity boards on Guantánamo detainees in 2009, prior to the FDA concluding there could be long-lasting psychiatric effects from mefloquine. Other U.S. military psychiatrists have also conducted similar sanity boards (Simmer 2012). The mission of these boards was already made challenging by the need to consider the impact of PTSD and other psychiatric disorders resulting from waterboarding and other harsh methods of interrogation, the presence of often difficult life circumstances prior to confinement, and the effects of seemingly indefinite confinement.

Although it is not known how many Guantánamo detainees have chronic psychiatric symptoms that may be related to mefloquine, with new knowledge of these chronic adverse psychiatric effects, the U.S. military or civilian psychiatrist asked to perform forensic psychiatric evaluations on Guantánamo detainees may now be faced with the additional challenge of considering the possible confounding effects of mefloquine in their evaluations (Ritchie, Block, and Nevin 2013).

Any such consideration must begin with the psychiatrist establishing evidence of the detainee's plausible exposure to the drug. Available documentation suggests that mass administration of mefloquine was carried out among all newly arrived Guantánamo detainees through at least 2005 by standard operating procedure (SOP) directed by the U.S. military commander of the detainee hospital (Denbeaux et al. 2010). Although in each of two instances where medical records of detainees have been publicly released, documentation corroborates the practice during this period, it remains unclear whether all of the many hundreds of detainees who have been processed through Guantánamo were in fact issued mefloquine under this authority (Denbeaux et al. 2010).

For example, it is conceivable that more junior U.S. military medical officers or nurses may have attempted to challenge or sought to overrule the order to administer the drug based on ethical considerations stemming from awareness of the potential harm of the practice. Given the stated position of U.S. military officials on the safety of mefloquine during the period, however, it is also conceivable that individual U.S. military personnel involved in the care of Guantánamo detainees may have been unconvinced, or simply even unaware, of the potential harmful effects of the drug. Other analyses have demonstrated that U.S. military personnel involved in the care of Guantánamo detainees overlooked or neglected to report or intervene in cases where there was clear medical evidence of use of harsh methods of interrogation (Iacopino and Xenakis 2011). For this reason, even had any U.S. military personnel harbored ethical concerns for the safety of the practice, it is reasonable to question whether this would have resulted in the administration of the drug being overruled.

ESTABLISHING EVIDENCE OF MEFLOQUINE EXPOSURE

In any psychiatric evaluation, the U.S. military forensic psychiatrist considering attribution of certain psychiatric symptoms to mefloquine should first review available detainee medical records. This is partly to confirm whether

documentation exists that a conscientious U.S. medical officer or nurse may have overruled the administration of the drug.

Absent such documentation among detainees processed during the period through 2005, if medical records are incomplete, exposure to mefloquine should be considered highly probable on the basis of the available SOPs. Similarly, if documentation of administration under the SOP is available, exposure to mefloquine should be considered confirmed.

For detainees who were processed subsequent to 2005, if the medical records include documentation of mefloquine administration, or if the detainee is a reliable historian and endorses receipt of a treatment dose (typically five 250 mg tablets, administered either all at once or over the course of eight to twelve hours), exposure to mefloquine should also be considered confirmed.

With exposure confirmed, the U.S. military forensic psychiatrist considering attribution of certain psychiatric symptoms to mefloquine would then need to be aware of certain specific ethical considerations in the conduct of any such evaluation.

SPECIFIC ETHICAL CONSIDERATIONS

The first set of considerations relate to the ethics of attribution of certain psychiatric symptoms confidently to mefloquine, rather than to other potentially confounding causes. Detailed guidance has been published by the authors for evaluating issues of causation related to mefloquine exposure during the forensic psychiatric evaluation (Ritchie, Block, and Nevin 2013). Given that chronic psychiatric effects from mefloquine may present with comorbid but often subtle vestibular, visual, auditory, or neurological disorders, the psychiatrist should consider the potential utility of specialty consultation, particularly by neuro-otologists or neuro-optometrists, or by ear, nose, and throat specialists, to aid in their identification. Absent the availability of such consultants, evidence of psychiatric symptoms that develop coincident with certain neurological symptoms, or the development of certain more severe psychiatric symptoms, such as confusion, amnesia, and hallucinations, in close temporal relation to mefloquine exposure, may aid the psychiatrist in ethically attributing chronic symptoms to the drug (Ritchie, Block, and Nevin 2013).

The second set of considerations relate to the consequences of such attribution. As the symptoms caused by mefloquine in this context may be considered the result of a form of involuntary intoxication, the attribution of certain symptoms to mefloquine, such as hallucinations or other symptoms

of psychosis, could also have important legal implications in the evaluation of detainees' subsequent actions, including any allegations of misbehavior or self-harm. Similarly, the diagnosis of certain chronic psychiatric conditions, including PTSD, bipolar disorder, anxiety disorder, or psychotic disorder, for which the forensic psychiatrist concludes the chronic effects of mefloquine could have plausibly contributed to diagnosis, could affect attribution of causation in claims of harm (Nevin and Ritchie 2015). While a civilian forensic psychiatrist may not be ethically challenged by such attribution, the unique circumstances underlying the mass administration of mefloquine may expose the U.S. military forensic psychiatrist to concerns of dual agency or loyalty (Clark 2006).

Specifically, attribution in either case could have adverse implications for fellow U.S. military medical officers and nurses implicated in the drug's administration. The clinical use of mefloquine for the purposes for which it was purportedly mass-administered is already known to have been highly questionable clinically (Nevin 2012). However, absent a substantiated finding of harm from the practice, any ethical concerns from the practice have thus far remained theoretical.

Any finding of lasting psychiatric effects from the mass administration of the drug would substantiate actual harm from this practice and result in a potentially actionable basis for a complaint of inappropriate medical or nursing care. Such a complaint could, in theory, expose both the authorizing U.S. military officials and the U.S. military medical and nursing staff involved in the administration of the drug to allegations of malpractice and other forms of professional sanction or to other forms of military legal proceedings, including formal investigations, whether still on active duty or retired. For this reason, it is at least plausible that the U.S. military forensic psychiatrist may face significant ethical dilemmas in the formal attribution of psychiatric symptoms to the drug.

CONCLUSIONS AND RECOMMENDATIONS

This chapter has identified significant ethical dilemmas that may be faced by the U.S. military forensic psychiatrist in the attribution of certain psychiatric symptoms to the prior mass administration of mefloquine among Guantánamo detainees. Although there are likely very few U.S. military forensic psychiatrists who may face these ethical dilemmas in practice, their existence should nonetheless be of significant concern to the broader forensic psychiatric community, which therefore has a role to play in exploring the implications of

the information presented here and in seeking resolution of the ethical dilemmas identified.

For example, there have been long-standing calls for further investigation into the precise circumstances surrounding the unusual decision to recommend mass administration of mefloquine to Guantánamo detainees (Nevin 2012). Evidence exists of which individuals and organizations could have plausibly contributed to this recommendation (Armed Forces Epidemiological Board 2002, Kaye 2012).

However, there remains conflicting evidence as to the ultimate origin of the recommendation to direct the drug's use (Leopold and Kaye 2010, Task Force on Detainee Treatment 2013). Further investigation could afford these individuals and organizations an opportunity to clarify what involvement they had, if any, in formulating this recommendation and could similarly establish what was known by these individuals and organizations of the drug's adverse psychiatric effects at the time this recommendation was made.

Somewhat ironically, the involvement of a key former U.S. military medical official who was directly involved in the decision to mass-administer mefloquine in subsequent efforts to investigate other ethical violations at Guantánamo has been cited to justify deferring further exploration of these issues, owing to the presence of conflicts of interest (Task Force on Detainee Treatment 2013). Such conflicts of interest should be avoided in future investigations of these matters.

In the coming years, as the psychiatric conditions among Guantánamo detainees become better characterized and as recognition continues to grow of the potentially significant burden of psychiatric disability attributable to mefloquine, such investigations will take on added importance to the forensic psychiatric community.

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15

TERRORISM AND NATIONAL-SECURITY EVALUATIONS

Ethics Dilemmas in Forensic Practice

Stephen N. Xenakis

THE ATTACKS ON the World Trade Center and Pentagon on September 11, 2001, fundamentally changed our nation's national-security strategy and conduct of war. Fear and anger dominated the country's emotional climate and mobilized the government to respond aggressively with a broad array of countermeasures. The pronouncements of the president and senior leadership shortly after the attacks on the World Trade Center clearly spelled out that the country was going to war to defend against a new threat, that "the war on terror is a war like no other," and that "we must take all measures possible to stop the enemy" (Public Law 2001, 107-56).The major shift in strategy and tactics affected clinicians and influenced their roles and responsibilities. Several changes in policies and programs across the government and war-fighting operations directly affected the health professions.

The changes in policies and programs have imposed ethics dilemmas, particularly for providers in uniform serving the military, and have caused significant predicaments regarding core principles. The revelations that physicians, psychiatrists, and other mental-health professionals had assisted with interrogations that bordered on torture alarmed the health-professional associations. Psychiatrists and other mental-health practitioners have been thrust since September 2001 into unique roles when confronted with warfare in the twenty-first century. Their involvement draws them into the epicenter of an ongoing conflict. The realities of modern warfare push them beyond the principle of "first, do no harm," which has historically grounded the healing professions, and into unprecedented predicaments that challenge roles and responsibilities (Xenakis 2014, 506). Practitioners are faced with fundamental dilemmas in both their clinical and forensic cases and with the challenge to adhere to principles in the face of political and personal agendas. The realities

of the Global War on Terror (GWOT) challenge practitioners to ponder the duties and obligations embedded in their clinical and forensic practices. The array of issues that has emerged in the past fifteen years with the surge in terrorism has ranged from participation in interrogations, harsh treatment of accused terrorists, medical care and support to detainees imprisoned at Guantánamo, force-feeding detainees on hunger strikes, and assessing the mental responsibility of young Muslim men and women recruited by the Islamic State (ISIS/ISIL).

ETHICS DILEMMAS: DUAL ALLEGIANCE OR DUAL RESPONSIBILITY

The ethics dilemmas for psychiatrists engaged in the war on terrorism and national-security operations have been framed often as conflicts over *dual loyalty*: allegiance to the command and governmental (USG) authorities as opposed to the duties and responsibilities to the individual and to do no harm. Simply stated, psychiatrists are challenged to choose between the demands of the mission and the profession's traditional responsibilities to patients and clients. Senior leadership in the Department of Defense (DoD) contended in 2004 that military medics are not medics *all the time* and that their role and identity as doctors are operationalized in the restricted setting of the formal "doctor-patient" relationship (Bloch and Marks 2006, 4–5). At other times, medics are like any other soldier and are subject to orders—and thus can advise interrogation teams on sleep deprivation and other tactics that are widely criticized as outside the bounds of military tradition and practice. In other words, the subject or object of interrogation is not a patient and is therefore exempt from receiving the medical deference of a sick or injured man or woman. The DoD issued policy, and the Office of the Assistant Secretary for Health Affairs (ASDHA) contended, that the legitimate objective of fighting terrorism trumps the ethical responsibility of the healing practitioner, endorsed by public statements of military practitioners. "The ends justify the means," and a few brutalized prisoners are a small price to pay for protecting the citizens of the United States (Davis 2013).

This chapter explores the questions and elements confronting practitioners involved in national-security operations and terrorism across a broad array of activities and roles. The approach is heuristic rather than

prescriptive or directive. It introduces a conceptual framework for shaping the role and responsibilities of practitioners engaged in warfare in the twenty-first century. We cannot dismiss the psychiatrists and psychologists who participated in interrogations in Guantánamo and helped devise the abusive practices as mere rogues or outliers. We recognize that they were actors on a much larger stage, swept up by a pervasive and persuasive attitude that subsumed the country and energized a military plan to seek the criminals wherever they might be found. The sentiments and momentum to punish terrorists and defeat the terrorist threat, without hesitation, endure today in the face of all-too-frequent horrendous attacks and propaganda campaigning by enemy entities such as ISIS. The changing and continuing nature of the threats to national security have mobilized a broad array of initiatives. The intense emotion and accompanying rhetoric more often obfuscate than clarify the debate over the roles and responsibilities of all involved parties. Both clinical and forensic practitioners are burdened with reconciling ethics dilemmas tethered to fear and basic instincts for safety and security. Probing and analyzing the underlying elements of the ethics dilemmas will encompass aspects of human rights, the traditional ethics principles of medicine, the influence of scientific evidence on decision making and policies, the scope of mental-health practice, and the nature of warfare in the twenty-first century. We believe that responsible clinical and forensic practitioners involved in any kind of national-security operation must contend responsibly and ethically with the questions and problems encountered in these domains of professional life.

ETHICS PRINCIPLES AND HUMAN RIGHTS

The ethics dilemmas as related to *dual loyalty* encompass aspects of human rights that have customarily informed both the military and health professions. Regulations stipulate that military personnel are not expected to comply with illegal or inappropriate orders and directives. In part, deciding on whether to follow the orders of a superior and execute an assigned mission depends on ascertaining what is right and ethical. Many issues, problems, and missions encountered by health professionals are ambiguous and complex. Ascertaining the proper course of action involves analysis and clarification of the core elements. Understanding the bearing of human-rights issues on military and professional conduct helps us navigate pertinent ethics dilemmas.

Fundamentally, the principles of human rights are enshrined for all Americans, especially those in government service, in the Declaration of Independence and the Constitution:

> that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. —That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed.

The values and principles are affirmed in the Bill of Rights, are argued in the courts, and animate lively political discourse. The military profession, answering to civilian and elected authority by law, is particularly grounded in basic values of human rights—a common allegiance to the Constitution and to the founding principles of democracy. Since antiquity, the great nations have acknowledged that honor and civilized conduct must imbue the spirit of the warrior (Shay 1994). Military officers, and other government officials, take an oath to the Constitution to uphold the laws of the nation and to defend the nation against all enemies, foreign and domestic (5 U.S.C. § 3331, Oath of Office). Traditionally, military medical officers are conferred unique respect and privileges as special staff in the military with inherent expectations of unfailingly acting in the individual interests of their fellow service members and patients, even prisoners. The overriding rules of uncompromising care and support extend beyond the bounds of the doctor-patient relationship and reach back to a long tradition of ethical service in military medicine grounded in individual rights.

On a larger scale, human rights are vital to national security in the twenty-first century. Under President Obama, the White House framed human rights as "both fundamental to American leadership and a source of our strength in the world" (Goldberg 2016). American democracy and national-security strategy have been erected on the foundations of human rights that "allow us to acknowledge the realities of the world we live in, to recognize the opportunities to progress toward the fulfillment of an ideal, and to look to the future with pride and hope" (Report of the United States of America Submitted to the U.N. High Commissioner for Human Rights in Conjunction with the Universal Periodic Review 2010). Furthermore, the principles of human rights that anchor American democracy "stand in opposition to aggression and injustice, and our support for universal rights is both fundamental to American leadership and a source of our strength in the world."

In today's world, the professional domain of both clinical and forensic psychiatrists intersects with growing social and political trends, particularly the power of individualism and the impact of human rights. Emerging social and political dynamics across the globe illustrate how much attention gets focused on the personal and individual. Handheld devices, Twitter, Facebook, and Google deliver information and capabilities to the lone warrior, businessman, or independent commentator anywhere and at any time. The dominance of formal nation-states has been challenged by the rise of individuals, social groups, businesses, and crime organizations that act autonomously of so-called legitimate states. Over the past years, tumult across the Arab world has demonstrated that seemingly insignificant individuals can command the international spotlight and spark dramatic changes in their governments and societies. These developments underlie the significance of individual and human rights in the twenty-first century, diminish the power of nation-states, and reshape the role of individual practitioners such as doctors and lawyers. Clinical and forensic practitioners encounter novel and complicated cases that spotlight tensions in medical ethics, national security, and professional responsibilities.

The ethical principles of the health professions are embedded in human rights. For centuries, the medical profession has followed the cardinal principles of nonmaleficence ("first, do no harm"), beneficence, autonomy, and justice. To the average practitioner, these tenets anchor unique elements of the professional relationship and frame both the clinical and forensic settings. Typically, *clinicians* treating patients feel bound by these principles at all times. Customarily, *forensic* mental-health practitioners do not abandon or negate the cardinal ethics of healthcare, even as their practice mingles the domains of the legal system and medicine. Perplexing and complicated questions about competency or criminal responsibility do not open the door to violate fundamental human rights. Almost all individuals function in complex systems or societies, and neither the clinical nor forensic practitioner can escape acknowledging the interplay of the rights of the individual and the respective social environment.

Resolving the ethics dilemmas over *dual loyalty* entails, in part, clarifying the applicability of core human-rights principles to military medical operations. Do military medical practitioners have exceptional responsibility to adhere to the fundamental principles of human rights when those principles affect their role and responsibilities as military officers and health professionals? Do core human-rights principles enable military practitioners to resolve

ethics dilemmas and the imposed competing tensions of *dual loyalty* to command and profession? Particularly, should military medical practitioners participate in interrogations if assigned, force-feed hunger strikers if ordered, send troops that may not be fit or healthy into battle if "needed" by command, or engage in other USG operations?

The historical record of physicians and medics in combat attributes to them an inherent expectation to advocate for and protect human rights. The long traditions help generally frame analysis of the pertinent ethics dilemmas. Medical personnel have the privilege of carrying special recognized identification according to the Geneva conventions and receiving corresponding protection in combat (chap. IV, art. 25 of the Geneva Convention). The stipulations of the Geneva conventions imply that medics have unique roles and responsibilities that differentiate them from fellow combatants. Medics do not shift out of the role of healthcare professional to combatant duties and retain the protections. The corollary proposition is that medics are recognized as proponents of human rights in support of the military mission and national-security strategy. Violating human-rights principles weakens the effectiveness of the overall military mission and undermines the broader political, economic, and social strategy in support of national security. The ethics dilemmas embedded in situations of *dual loyalty* are reconciled, in part, by ascertaining and adhering to core principles of human rights that anchor both the military and medical professions and frame the role and responsibilities of the medical practitioner.

ENHANCED INTERROGATIONS

The senior DoD leadership had grown frustrated with the limited intelligence gleaned from the detainees in 2004 and authorized USG psychologists to develop and implement enhanced interrogation tactics (Mitchell 2017, 10), widely regarded as torture (Rubenstein and Xenakis 2008, 569). The government engaged psychologists in efforts to obtain information on the planning for the attacks of 9/11, intelligence of other planned operations, and the source of threats to the country (Select Committee on Intelligence 2014). The Central Intelligence Agency (CIA) enacted these programs and methods of enhanced interrogation in response to an internal finding that it "was unprepared and lacked core competencies to respond effectively to the decision made in the aftermath of the 9/11 attacks" and "that the Agency undertake

what would be an unprecedented program of detaining and interrogating suspected Al Qaeda and affiliated terrorists" (Director of the Central Intelligence Agency 2013). It is widely known that the CIA, with the assistance of two contract psychologists, "decided to initiate a program of indefinite detention and the use of interrogation techniques in violation of U.S. law, treaty obligations, and our values" (Select Committee on Intelligence 2014). Legal opinions from the White House and Department of Justice covered the authorization of the programs and tactics, including waterboarding. As Steven G. Bradbury, the acting chief of the Justice Department's Office of Legal Counsel, said, "'water torture' . . . was subject to 'strict limits, safeguards, restrictions'" (*Washington Post* 2008). The American Psychological Association issued guidance that the participation of psychologists in interrogations and related activities conformed to its ethical guidelines and scope of practice (Report to the Special Committee of the Board of Directors of the American Psychological Association 2015). For several years, the hands-on role of the psychologists was denied by government agencies, and the APA that claimed the doctors and psychologists had two purposes: to advise on techniques based on their knowledge of human behavior and monitor the procedures so that they did not become too dangerous. Subsequent disclosures by the Senate Intelligence Committee and CIA have confirmed that the contract psychologists designed and initiated the programs of enhanced interrogation tactics (EITs) with oversight and approval of senior government officials (Select Committee on Intelligence 2014).

My observations of professional activities across the Department of Defense and assessments of multiple cases of accused terrorists have revealed that the practices of enhanced interrogation were not just confined to detainees (the so-called worst of the worst) subject to rendition and held in secret sites (Xenakis and Sherman 2015). The environment of condoning harsh interrogation tactics, including abuse, had broad implications across military culture and institutions and contributed to improprieties in the combat theaters of Iraq and Afghanistan. Over the years, leadership of the DoD, CIA, and other government agencies engaged in deception and collusion with implementing EITs, and this compromised the credibility and effectiveness of the military's medical departments.

Do "the ends justify the means," and are a few brutalized prisoners a small price to pay for protecting the citizens of the United States? What questions should military and government psychiatrists and psychologists ask when navigating the ethics dilemmas of being ordered to participate in EITs considered by many to be torture? What are the implications of

implementing and condoning EITs? The principles of true evidence-based practice in integrating the best-available research, clinical judgment, and individual preference apply to discerning the ethics dilemmas over participating in EITs (Steenkamp 2016).

A review of the science and evidence accumulated on the effectiveness of harsh interrogations and torture does not support a utilitarian perspective and justification of the methods. Despite the proclamations of the contract psychologists and developers of the programs, the CIA's internal review of the techniques and methods of interrogation had established that such activities were not appropriate for gathering intelligence (Director of the Central Intelligence Agency 2013). The claims that had been advertised were not substantiated by careful review, in contrast to commentary in the media or political campaigns (Select Committee on Intelligence 2014). We recognize that the psychiatrists and psychologists in the field may not have had access to the research and findings to inform their decisions about engaging in such practices or opposing orders by higher authorities, but substantial data exist in the open literature to raise doubt about the effectiveness of the proposed techniques and alert clinicians to the consequences. It is best summarized by Shane O'Mara's (2015) comprehensive review of the methods and related research on torture.

The failure to anticipate the adverse conduct and health consequences of harsh interrogation tactics ignored substantial research and well-recognized lessons learned by the CIA and DoD over the previous decades. Research studies, direct clinical observations, and reviews of medical records document the adverse and harmful effects of tactics associated with enhanced interrogation. Sleep manipulation contributes to cognitive impairment and disruption, with psychotic features emerging within one week, and can lead to self-harm, including symptoms resembling paranoid schizophrenia. Sensory deprivation, including hooding and isolation, leads to severe anxiety, depression, and psychotic-like thinking, with serious health consequences. Repetitive exposure to frightening and life-threatening circumstances contributes to debilitating post–traumatic stress disorder. Victims of abusive interrogation suffer with anxiety and depressive disorders; manifest brief psychotic disorders, including delusions and hallucinations; develop obsessive-compulsive disorder; and are moved to the brink of suicide. The combined techniques of sleep manipulation, social isolation, and sensory bombardment with loud music can lead to vivid imagery approaching hallucinatory and delusional processes, body-image distortion, temporal disorientation, and cognitive impairment (Goldberger 1982, 412).

Statements made by detainees in an impaired mental state when interrogated have not been admissible in court proceedings (Rubenstein and Xenakis 2008).

A confounding factor in navigating the ethics dilemmas of enhanced interrogation intersects with predominant thinking on evidence-based healthcare research. Commonly, hard and controversial policy decisions are put to the test of scientific research based on empirical findings of randomized-controlled studies. No such studies on the effectiveness of enhanced interrogations and benefit to vital intelligence were possible or could be conducted. The urgency of the situation and fear over the threat to national security did not facilitate undertaking standard research. By default, both senior leadership and practitioners in the field had to rely on the lost art of common sense, which compels even the average observer to recognize that waterboarding, sleep deprivation, walling, cramped confinement, stress position, death threats, and temperature manipulation obviously impair mental state and cognition and undermine confidence in the quality of information gained in interrogations. The ethics dilemma over participating in enhanced interrogations and navigating the competing loyalties to senior officials and professional judgment reduces, in part, to compiling and analyzing relevant research and applying clinical judgment on the effect of proposed tactics. Paradoxically, the dangers and potential harm of the program and EITs were recognized by the interrogators. Implementing policies stipulated that physicians and other clinicians be attached to the interrogation teams to ensure that the techniques were "medically safe," to protect the subject being interrogated against excessive and improper—or perhaps just overzealous—actions by the interrogators. The guidelines published by the Office of Medical Services (OMS) of the CIA recognized the inherent dangers of waterboarding and other stress-inducing tactics (Central Intelligence Agency 2005). The OMS warned that waterboarding creates risks of drowning, hypothermia, aspiration pneumonia, or laryngospasm; that cramped confinement could result in deep-vein thrombosis; and that death could result from lengthy exposure to cold water. The policies and programs challenged the practitioners to maintain boundaries between harm, health, and safety. It is impractical to expect the "average" practitioner in the field to balance reasonably the competing objectives in the combat environment and the climate of fear-inducing threats. Accordingly, the deliberation over the ethics dilemmas loops back to the proposition that brutalizing a few prisoners is a small price to pay for protecting the citizens of the United States.

FORCE-FEEDING AND HUNGER STRIKES

The U.S. government asserts that detainees in Guantánamo are still agents of Al Qaeda and continue to engage in asymmetrical warfare, with tactics including hunger strikes. The basis for this assertion has not been disclosed for reasons of national security in personal communications with senior officials in the Department of Defense. The government's perspective aligns with that of experts who have concluded that the overwhelming number of hunger strikers are engaged in a political protest and do not want to die. Hunger striking has been used as a protest tactic (by, among others, Gandhi, British and American suffragettes, and the Irish Republican Army) to shame the authorities. Hunger strikers are willing to use their bodies to protest degrading conditions or to promote their cause (WMA Declaration 2006). There is a consensus that engaging in a hunger strike is a political act and is considered a military tactic in circumstances such as being imprisoned in Guantánamo.

The compelling picture of starvation and potential death understandably alarms healthcare personnel and practitioners. The clinical picture of self-induced starvation is not unique to hunger striking and is encountered in cases of anorexia nervosa. Unlike anorexia nervosa, a recognized but hard-to-treat medical condition, hunger striking is an act of protest in support of political goals and not a medical condition. The DoD maintains that it has a responsibility to detainees not to allow them to die. It asserts it has no choice but to force enteral feeding where there is a risk of death or severe harm to health. The military orders the medical staff to treat aggressively (Joint Medical Group 2013). A decision to undertake compulsory intervention to treat a hunger striker is made by the Joint Task Force commander (not a medical officer), based on the physician's medical assessment and recommendation that "immediate treatment or intervention is necessary to prevent death or serious harm."

Almost all parties agree that hunger striking is an intentional behavior, a military and political tactic, and not a medical condition. We recognize that medical personnel generally oppose letting patients die when medical interventions can help. So, the management of hunger strikers becomes confounded by the endgame leading to starvation and death and challenging to the practitioner who has aggressive treatment available to divert the outcome. Experience shows that many hunger strikers take some form of nutrition while foregoing usual meals, with support and advice from their doctors.

How do practitioners handle cases of apparent intentional behavior that carry serious morbidity or mortality? The dilemma of letting a patient die or

providing treatment against his will confounds most clinicians. Few psychiatrists, psychologists, or other clinicians have treated patients with anorexia nervosa and have encountered the profound heartache and consternation of allowing a young woman voluntarily to starve to death. Moreover, there is no uniformity among practitioners and the public regarding the "right to die" and palliative care. Although these medical conditions seem different from hunger striking, they share common ground. They encompass issues of treating and managing behavioral problems in the context of intentional and conscious decision making that could lead to death. The medical-ethics principle of autonomy helps reconcile the inherent tension of "watching patients die" in cases of anorexia nervosa or end-stage cancer, as patients have the right to decide on receiving treatment and control what happens to their bodies. The principle of autonomy is blurred in the national-security setting. It is not clear that hunger strikers have decided to starve to death out of hopelessness and the formidable challenge of the political and social circumstances imposed on them. Is feeling hopeless about interminable incarceration in an "unjust or illegal judicial situation" (as many regard their detention in Guantánamo and trials) a sign of major depression or a realistic assessment of an irresolvable politico-military standoff? No doubt, managing hunger strikers imposes ethics dilemmas on healthcare practitioners and tensions over the dual loyalties to the mission and medical ethical principles. The practitioner encounters confusion in roles as a *medic* or *combatant* analogous to the circumstances of participating in interrogations. On the one hand, forced enteral feeding may be an appropriate intervention to a hunger-striking detainee with obvious signs of depression and hopelessness and not able to manage his daily life. Such a detainee may require comprehensive and intensive therapy and treatment for his apparent neuropsychiatric illness. What does the practitioner do, knowing that the treatments and interventions are generally not available or provided? On the other hand, forcibly feeding a detainee engaging in a hunger strike with outspoken political and social objectives comprises, in effect, constitutes a military countermeasure.

The resolution of the issues regarding the detention, adjudication, and management of a detainee in Guantánamo on hunger strike goes beyond the realm of standard medical care and usual clinical roles. The military practitioner gets caught in an ambiguous web of discerning different roles and responsibilities, either as a uniformed healthcare provider or combatant. Providing aggressive treatment including enteral feeding for a depressed and hopeless detainee on hunger strike conforms to customary medical practice. In contrast, providing the same aggressive intervention as a military countermeasure to a

hunger-striking detainee acting with political motives shifts to the role of being a combatant. The practitioner is confronted with agreeing to defer judgment to authorities in charge or exercise independent discretion as a healthcare provider.

MATERIAL SUPPORT

The Center on National Security at Fordham Law School reported on fifty-nine cases of young Americans in 2015, arrested for planning to travel to Syria and join ISIS (Center on National Security at Fordham Law 2015). The majority (81 percent) were U.S. citizens with a median age of twenty-four years. Many were native born and raised in comparatively closed and cloistered Muslim communities. They had limited fluency in Arabic and a modest understanding of Islam. They were considered impulsive, lacking the capacity to assess the consequences of actions, and lacking histories of engaging in violent or aggressive conduct. These cases present ethics dilemmas for forensic specialists seeking to assess them for dangerousness to national security, competence to understand the impact of their verbalizations and actions, and formulating recommendations for appropriate sentencing. The USG prosecutes the young defendants as threats to national security under provisions of material support to terrorist organizations. Federal statutes stipulate: "Whoever knowingly provides material support or resources to a foreign terrorist organization, or attempts or conspires to do so, shall be fined under this title or imprisoned not more than 20 years, or both, and, if the death of any person results, shall be imprisoned for any term of years or for life" (18 U.S. Code § 2339A, 18 U.S. Code § 2339B).

In the interest of homeland security, the law has been used to undertake approximately nine hundred investigations and track 250 Americans who have traveled or attempted to travel to Syria and Iraq. The law applies uniformly to individuals charged with supporting terrorist organizations, but the characteristics of the accused men and women separate into distinct cohorts (Center on National Security at Fordham Law 2016). The average age overall of those indicted for ISIS-related crimes is twenty-six, and the most common age is twenty. Those who conducted lethal attacks, all of whom were killed by law enforcement, were older, with an average age of twenty-nine. The younger cohort behaved like seekers for identity, probing for religious grounding, and they lacked criminal records. They showed facility with the Internet and

participated in chat rooms and conversations with aggressive recruiters of recognized terrorist organizations. Almost all of them have been convicted in federal courts, and many are serving substantial sentences of ten to twenty years, with an average sentence of 9.2 years.

The USG has not established a formulation for assessing the dangerousness of defendants or developed programs for countering violent extremism, despite nascent efforts by various governmental agencies. By default, these cases are handled by criminal prosecution by the FBI, including targeting by undercover agents who lure the youngest into fanciful and impractical schemes. The FBI identifies the younger defendants, predominantly older adolescents and early adults, from chat rooms and conversations with putative ISIS agents. The evidence in several cases includes documentation that the FBI undercover agent has suggested and fashioned a potentially dangerous act and induced the young defendant into committing illegal acts. The actions of the FBI agents and corollary activity do not rise legally to the level of entrapment and leave the defendant open to conviction for terrorist acts.

Such cases present poignant ethics dilemmas for practitioners. The defendants are prosecuted for committing acts that threaten national security and constituting a dangerous risk. Accordingly, the forensic practitioners are engaged to assess competence, capacity, and dangerousness. The contour of the dilemma touches issues such as the impact of the defendant's immaturity, developmental stage and capabilities, evidence of mental disease and illness, history of aggression and violence, exercise of First Amendment rights and expressions, and elements of dangerousness as contextualized for terrorist threats. Specifically, how dangerous to national security and safety are young people who seem to be exploring Islam, searching for faith, and expressing a desire to visit and/or serve the caliphate (as propagandized by ISIS)? The cases demonstrate wide variation regarding dispositions and propensity to serve in combat roles and engage in violent activity, capacity for mature judgment and deliberation, and understanding of religion and politics. Consequently, each case requires detailed, careful, and objective evaluation and analysis.

The landscape of terrorist prosecutions influences the assessments by forensic and clinical practitioners. On the one hand, governmental authorities insist that aggressive identification and prosecution are the most effective means for protecting the homeland. On the other hand, the young defendants may demonstrate obvious vulnerability to influence by both terrorist recruiters and undercover FBI agents and lack a record of criminal or aggressive behavior. The absence of effective programs to counter potentially extremist

behavior and provide mental health consigns these cases to the court system, aggressive adjudication, and lengthy sentences. The effects of incarceration for ten years, such as the long-term consequences or benefit to society, are not taken into consideration in the handling of these cases. The practitioners face ethics dilemmas of deferring to governmental agencies, which impose imprisonment and punishment, or advocating for best practices for mental-health treatment, including early identification and comprehensive therapy. In other words, does acting on the behalf of the defendant, particularly an immature adolescent or young adult, and delivering better therapy and treatment provide better and more effective defense in support of homeland security than adjudication and jail? Is the practitioner's agreeing to assist in the defense of an accused young man or woman lawfully deserving of assistance helping or hurting the safety and security of our communities and nation?

CONCLUSION

The relentless threat of terrorist attacks since 9/11 has altered the social fabric of the nation as well as its military strategy and security policy. Tactics and operations have shifted from focusing on institutions and organized states to individuals acting independently and exerting significant harm. These changes stretch across the political and social mosaic of the country and have significantly influenced the practice of forensic mental health. The customary programs and procedures in support of military and national-security operations have been superseded by ad hoc responses to persisting threats and dangers. In the past, military and political strategies were directed toward governments and ideologies that competed or threatened the country. Now, the rhetoric drills down on individual actors and illegitimate terrorist groups. In other words, the fight has become "personal" and drifted away from being institutional. Psychiatrists and psychologists have been drawn into a more one-on-one struggle. They have been placed on the front lines to tackle and defang the threatening individual actors. This change in role and responsibilities in the military and national-security arenas have imposed new ethics dilemmas on practitioners in clinical and forensic settings. The dilemmas extend beyond the historical debate over *dual loyalty* and challenge psychiatrists and psychologists to reformulate better their roles and responsibilities in support of national security. Typically, psychiatrists and psychologists, supporting frontline forces, have deferred questions of military strategy and political

security to USG authorities and commanders. That deference may no longer operate when putting clinical and forensic practitioners on the front lines and imposing different duties and requirements on them. The foundation of human-rights principles for both the democratic institutions of the country and healthcare professions oblige psychiatrists and psychologists to assert their ethical and moral principles more forcefully and constructively.

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ETHICS AND FORENSIC SPECIALISTS INTERACTING WITH THE MEDIA

Brian K. Cooke

FORENSIC SPECIALISTS ARE OFTEN FOUND in televised, print, and online media commenting on events involving mental illness or other aberrant behavior. Journalists seek this expertise to provide their work with a scientific grounding. Forensic specialists may accept these invitations, hoping to contribute to the social discussion, clarify misconceptions, and share opinions. In the case of a tragedy, some may feel compelled to help the public "seek to interpret the uninterpretable" (Schumann 2013, 830). Others enjoy the publicity and seek the limelight. Anecdotally, many psychiatrists and psychologists admit they have been invited by the media to provide commentary but have declined to participate for a variety of reasons.

Once journalists seek their expertise, psychiatrists and psychologists may then say and do things that evoke questions about the ethics bases of their commentary. Just as the media are pressured to deliver a news story, some specialists feel pressured to accept the invitation to interact with the media. The pressure might be internal (e.g., a sense of obligation or feelings of guilt) or external (e.g., pressure from the individual's employer or from a reporter).

When forensic specialists participate with the media, however, they may make statements that violate principles of professional ethics. The most likely violation stems from the American Psychiatric Association's (APA) guidelines set forth in the Goldwater Rule, which prohibits certain types of commentary when psychiatrists share professional opinions with the public.

In this chapter, I extend my previous work (Cooke et al. 2014) by focusing considerable attention on recent developments in this area of forensic ethics. The analysis will consider perspectives from psychology and from the 2016 U.S. presidential election. I suggest several expanded methods of ethics-based frameworks to negotiate the dilemmas faced by professionals who interact with

the media. This methodology will guide the behavior of forensic specialists who consider providing commentary to the media.

THE GOLDWATER RULE

The creation of the Goldwater Rule followed a scandal from a 1964 publication in the magazine *Fact* and has been detailed by many authors (e.g., Cooke et al. 2014, Friedman 2008, Kroll and Pouncey 2016). Created in 1973, the Goldwater Rule refers to annotation 3 of section 7 of the Principles of Medical Ethics with Special Annotations Especially Applicable to Psychiatry (American Psychiatric Association 2009b), which are put forth by the American Medical Association (AMA) and represent ethics guidelines for psychiatrists. The Goldwater Rule reads as follows:

> On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.
>
> (AMERICAN PSYCHIATRIC ASSOCIATION 2009B, 9)

In the 1964 September/October issue of *Fact*, entitled "The Unconscious of a Conservative: A Special Issue on the Mind of Barry Goldwater," the anonymous opinions of over 1,800 psychiatrists were published commenting on Senator Barry Goldwater's psychological fitness to be president of the United States. This issue immediately preceded the November 1964 presidential election between the Republican senator Goldwater and President Lyndon Johnson.

The article in question included opinions selected by *Fact*'s editor Ralph Ginzburg from a poll of over 12,000 psychiatrists from across the country, whose names were provided by the AMA. Of the 2,417 respondents, 571 chose not to provide comments, 657 responded that Goldwater was fit to be president, and 1,189 responded he was unfit. None of the psychiatrists whose comments were published, however, had examined Goldwater, and none had permission from him to issue their comments publicly. Emphasis was placed

on two nervous breakdowns allegedly suffered by Goldwater, and there were statements warning that Goldwater might launch a nuclear attack if placed under a critical amount of stress as president.

The AMA and APA immediately condemned the remarks made in the *Fact* article after its publication (Friedman 2008). A legal battle ensued: Goldwater claimed the magazine made defamatory statements (*Goldwater v. Ginsburg* 1969, *Ginzburg v. Goldwater* 1981). In response to this "fiasco" (Stone 2008, 172), the APA created the Goldwater Rule "to protect public figures from psychiatric speculation that harms the reputation of the profession and of the unsuspecting public figure" (American Psychiatric Association 2016, 35).

ETHICS DILEMMAS

The scandal that created the Goldwater Rule and the ensuing debate continue to raise many ethics dilemmas. Some have criticized the rule as a denial of free speech. Others wonder if psychiatrists are permitted to give public lectures on the clinical aspects of notable figures, e.g., Hinckley or deceased presidents. Are there situations of such importance (e.g., for national security) when there is justification for breaking the Goldwater Rule? If a large volume of information is publicly available, including information from professionals who have examined the individual, then some argue that public comments can be made. Others justify the public discussion by weighing the professional and social interests that may be served by an analysis of the individual.

The debate also raises the question whether it is possible to separate personal opinions from professional opinions. Jeremy Lazarus, a past chair of the APA's Ethics Committee, provided the following answer: "It is important to remember that once identified as a psychiatrist, your public opinion on important public figures will be heard from you as a psychiatrist and not as an ordinary citizen" (American Psychiatric Association 2009a, 108). Describing one's comments as "personal opinions" instead of offering "professional opinions" might be a subtlety lost on the public.

Other psychiatrists questioned if adherence to the Goldwater Rule made it ethically impossible to engage in psychohistory or provide political-psychology profiles. If the Goldwater Rule is interpreted strictly to prohibit these practices, then it appears to contradict parts of sections 7.1 and 7.2 of the Principles of Medical Ethics with Special Annotations Especially Applicable to Psychiatry:

> Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/she speaks as an individual or as a representative of an organization.
>
> (AMERICAN PSYCHIATRIC ASSOCIATION 2009B, 9)

> Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.
>
> (AMERICAN PSYCHIATRIC ASSOCIATION 2009B, 9)

Friedman has further supported the role of psychiatrists in "educating the public about the current state of the psychiatric field" (Friedman 2009, 758). His experience as a regular contributor to the *New York Times* has shown how the public is "intensely curious about human behavior and the psychiatric profession" (757). It is no wonder, then, that the media would echo these curiosities and seek out mental-health professionals to provide explanations about human behavior and other matters that are in the national spotlight. Friedman emphasizes the inherent challenge with knowing how far to go when answering such questions and potentially leading to speculation. Others (e.g., Cooke et al. 2014) have also cautioned against the potential for public commentary by psychiatrists to overreach, speculate, and exceed a scientific foundation. Despite the inherent challenges and potential ethics dilemmas, Friedman echoes a commonly voiced opinion that "if we do not take a more active role in presenting and explaining our field to the public, others will do it for us" (2009, 758).

One difficulty is that when journalists turn to mental-health professionals to seek our opinions, forensic specialists may rush to be helpful (Cooke et al. 2014). Opinions shared in this public forum have the potential to cause harm, which may occur in the form of libel or slander. In the case of an active criminal investigation or trial, there is also the potential that such public comments could influence a jury. Even if the case is resolved and any appeals exhausted, the forensic specialist may still be criticized for "promoting her own social agenda" (Schumann 2013, 830).

Some psychiatrists have attempted to analyze the behaviors of individuals who have committed mass causalities. In 1990, the former CIA profiler and psychiatrist Jerold Post presented a public profile of Saddam Hussein to the

House Armed Services Committee (Post 1990). He believed that misunderstandings of Hussein's psychology were guiding policy and had dangerous implications, which could lead to further loss of life. In 2008, the APA Ethics Committee issued an opinion on profiling "historical figures" that is included in the "Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry," which opined that historical profiling does not conflict with ethical principles if done to "enhance public and governmental understanding . . . as long as the psychological profiling does not include a clinical diagnosis and is the product of scholarly research that has been subject to peer review and academic scrutiny, and is based on relevant standards of scholarship" (American Psychiatric Association 2016, 75). The opinion does not define "historical figure" or explain the reasoning used to arrive at this position.

More recently, some scholars have analyzed the behaviors and motivations of other mass murderers. In the analysis of two pseudocommandos (Knoll 2010), Aaron Alexis, the perpetrator of the Navy Yard massacre in 2012 (Lake 2014), and Anders Breivik, the mass murderer in Norway in 2011 (Rahman et al. 2016), the authors acknowledge the constraints of the Goldwater Rule and then argue the reasons that allow public, scholarly discourse of an individual who has not been personally examined.

Also relevant is commentary from psychiatrists regarding characters depicted in movies and television shows. Several books offer a compendium of movies featuring mental-health professionals at work or that depict mental illness (e.g., Gabbard 1999, Wedding 2005). These books are intended to be used for teaching and serve as a resource for medical educators. If the characters are based in fiction, then any analysis that is balanced and does not overreach may help educate the public to certain facets of mental illness. Psychiatrists and psychologists must be attentive to the possibility that some characters depicted in movies and television shows, however, are based on real people.

The debate has extended beyond the profession of psychiatry and pertains to all specialists. For example, the sixth edition of the *American College of Physicians Ethics Manual* provides the following guidance:

> Physicians should support community health education and initiatives that provide the public with accurate information about health care and should contribute to keeping the public properly informed by commenting on medical subjects in their areas of expertise. Physicians should provide the news media

> with accurate information, recognizing this as an obligation to society and an extension of medical practice. However, patient confidentiality must be respected.
>
> (SYNDER 2012, 89)

ETHICS DILEMMAS RELEVANT TO THE 2016 PRESIDENTIAL ELECTION

In the months leading up to the 2016 U.S. presidential election, there was much discussion as to the mental fitness of the leading presidential candidates. Almost every major media outlet ran stories about the profiles, character, or even suggested symptoms of Hillary Clinton and Donald Trump. Several lengthy psychological portrayals of Trump were published (e.g., Alford 2015, McAdams 2016). The justification for these portrayals is hardly a new phenomenon. In 1997, the psychologist and psychohistorian Elms (1997, 252) argued, "Throughout their vote-seeking careers, politicians regularly hold themselves up for public inspection, and I think professional psychobiographers have as much right and responsibility to inspect their qualifications for office as journalists and competing politicians."

The candidates also made comments about each other's fitness. For example, in response to comments Trump made about the North Korean dictator Kim Jung Un, Clinton said, "I'll leave it to the psychiatrist to explain his affection for tyrants" (Koerth-Baker 2016). Many psychiatrists were asked to provide commentary about the candidates; many declined (including this author). Some suggested that psychiatrists and psychologists have "publicly flouted the Goldwater Rule" (Carey 2016) by labeling Trump with a variety of problems, including grandiosity, a lack of empathy, and narcissism. As Appelbaum suggested, mental-health professionals may feel compelled to join this discussion because "they're persuaded they're saving the nation from a terrible fate" (Carey 2016). Many have argued they are able to do so given the presumed depth of material about the candidates provided by social-media comments (e.g., Twitter) and video clips.

One compelling argument that the depth of material in the public domain is insufficient to make psychologically informed commentary about political candidates is that media portrayals of public figures are potentially biased. We only know the candidates through the media lens. In defense of the Goldwater Rule, Appelbaum asserted that "the process of making a psychiatric diagnosis

depends on more than just observing somebody's behavior or listening to their words" and that with respect to identifying symptoms, ruling out substance use, and considering the deliberate persona portrayed by the individual, "none of that is discernible by watching somebody on TV or reading what they have to say in the newspaper" (*Diane Rehm Show* 2016). Furthermore, psychiatrists' opinions of presidential candidates are also likely to be biased. It is an irresponsible application of "duty to warn" for psychiatrists and psychologists to justify public comments about presidential candidates in an effort to save the nation.

The commentary reached a point where the former president of the APA felt compelled to weigh in. On August 3, 2016, Maria Oquendo wrote: "The unique atmosphere of this year's election cycle may lead some to want to psychoanalyze the candidates, but to do so would not only be unethical, it would be irresponsible." She cited the historical basis of the Goldwater Rule and practical implications and resulting stigma from psychiatrists who describe presidential candidates with a mental disorder as unfit or unworthy. In plain and direct language, she concluded: "Simply put, breaking the Goldwater Rule is irresponsible, potentially stigmatizing, and definitely unethical" (Oquendo 2016).

Oquendo's comments breathed new life into the media coverage of the 2016 presidential election from the perspective of analyzing the mental fitness of the candidates. Now, many stories highlighted the ethical dilemmas faced by psychiatrists contemplating offering these comments in light of the Goldwater Rule's restrictions and cautioned psychiatrists from participating in "armchair psychiatry." Stetka (2016) and Redinger et al. (2016) argued that diagnosing public figures via observations from the media represents poor diagnostic methodology in the absence of a personal diagnostic interview.

GUIDANCE FOR FORENSIC SPECIALISTS

Despite the inherent concerns and professional liability, there clearly are opportunities for forensic specialists to engage in activities with the media. Some argue that complete avoidance of the media is shirking a responsibility to society at large, which is one provision of the AMA principles of medical ethics. Whatever statements individual psychiatrists might make, however, should be measured, professional, factually correct, and intended to inform, educate, and alert the public to the seriousness of the issues. These interactions must

adhere to a method that relies on an integrated structure of ethics principles. We will now propose several methods for navigating these ethics dilemmas.

ETHICS-BASED ROLES

We have previously proposed a framework of performative roles (Cooke et al. 2014) representing an extension of the work by Griffith et al. (2010, 2011). These roles are frameworks that allow the professional to ask himself what objectives he wishes to fulfill in the interaction with the media, how he wishes to behave, what role he is qualified to play, and whether he is comfortable with the role. The ethics-based roles include the Teacher, the Storyteller, the Celebrity Commentator, the Hollywood Consultant, the Clinician, and the Advertiser.

The professional who adopts the role of the Teacher educates the public about mental illness. She may recommend resources for treatment and advances the field of knowledge through scholarship. This role is clearly supported by the Principles of Medical Ethics with Special Annotations Especially Applicable to Psychiatry, which encourages psychiatrists to share their knowledge with the public: "Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness" (American Psychiatric Association 2009b, 9). The Teacher must remain attentive to patient confidentiality, temptations for self-promotion, and the limits of one's knowledge. Speculation and unfounded commentary should be avoided.

The role of the Storyteller focuses on personal narrative. The mental-health professional may choose to disclose a personal or familial history of mental illness or substance use. Some have written about experiences in their medical training or practice. The Storyteller must decide for himself how much information to disclose and consider the potential impact on family, colleagues, patients, and potential expert-witness work.

The forensic specialist who plays the role of the Celebrity Commentator is invited to provide commentary about people in the national spotlight. These comments are typically based on speculation and personal opinions and lack an in-person examination of the subject. The Celebrity Commentator has the greatest potential to violate the Goldwater Rule, although some have argued (as described above, regarding the 2016 U.S. presidential election) that there are circumstances that permit exceptions to the rule and allow for professional commentary about public individuals.

The role of the Hollywood Consultant provides services and expertise or media productions. Mental-health professionals may be hired as consultants

for television shows involving persons with mental illness. This individual must remain attentive not to misrepresent the complexities of mental illness and not violate any confidential information about patients or forensic evaluees.

The role of the Clinician is adopted when the mental-health professional places his medical training and expertise directly in the media spotlight. He may act as a discussant on a talk show or provide televised interviews of individuals with mental illness or substance use. Here the ethics considerations are to maintain the fiduciary nature of the doctor-patient relationship: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and right" and "A physician shall, while caring for a patient, regard responsibility to the patient as paramount" (American Psychiatric Association 2009b, 3–4). He must also be mindful not to exploit the patient or breach confidentiality.

The final ethics-based role is the Advertiser. In this role, the specialist uses the media to market his services. This may be done to target clinical or forensic referrals. The Advertiser should consider the pitfalls of misrepresenting one's credentials and how patients or attorneys might perceive this information.

RISK-BENEFIT ANALYSIS APPLIED TO PUBLIC COMMENTARY

To apply a risk-benefit analysis to the act of a forensic specialist providing commentary on public issues and personalities, we must first identify the relevant stakeholders. First, there is the subject the specialist is speaking about. This might be an inanimate object (e.g., a novel antidepressant treatment or the prevalence of mental illness in prisons) or an actual person (alive or deceased) and the person's family. The next stakeholder is the profession of psychiatry, psychology, or medicine. Society at large is also a stakeholder, as it will hear the professional's comments and potentially be influenced by them. The last stakeholder is the professional providing the commentary.

Assume the comments from the mental-health professional have a scientific basis and are not speculative. Then, as the statements help provide education in a balanced manner, there would likely be a benefit to society at large. The profession benefits because the speaker's comments might decrease stigma or even alert individuals to the positive role of mental-health treatment. The impact on the subject and the family cannot be determined without more details, as it would depend, for example, on the status of any criminal investigation, trial, upcoming election, or other event. Expert commentary has the

potential to sway public opinion (Mayer and Leichtman 2012). Last, the statements have the opportunity to benefit the speaker as a member of the profession and to afford him public attention (potentially leading to future referrals or media invitations).

Now let us assume that the comments from the mental-health professional are speculative, overreaching, or inflammatory. Although this rhetoric may seemingly answer questions from society at large, the effect would obviously be negative. Similarly, the profession is damaged by having one of its members provide unfounded commentary. The subject of the commentary and family members may also be harmed. The effect on the speaker, however, is difficult to determine: although the comments may not be accurate or scientifically based, they would likely fill a need by the media to help push headlines; alternately, the speaker might look foolish or appear to have his own biases or agenda, which would likely affect his own personal and professional reputation.

OTHER ETHICS-BASED ANALYSES

Critics of the Goldwater Rule assert that ethical guidelines should simply be guidelines and not rigid rules. Individuals who feel compelled to provide public commentary may weigh their right to free speech over the potential harm to the subject. Others attempt to strengthen their position by providing a political profile instead of an expert or clinical psychiatric opinion. This distinction, however, may amount to a splitting of hairs. Similar subtleties that may be lost on the public would include commenting on the candidate's public persona instead of any psychiatric diagnosis or offering personal opinions (as a citizen) as opposed to professional opinions (as a psychiatrist).

Critics of the Goldwater Rule cite other examples when mental-health professionals appear to be offering diagnostic impressions of individuals they have not personally examined (and when these examples appear commonplace and acceptable by organized medicine). These examples include those done by third-party payers, some forensic cases, and historical psychobiographers. While there are ethics dilemmas for each of these examples, they still appear supported by the profession. For example, the APA has not spoken out against psychiatrists who perform record reviews to determine if patients in healthcare systems meet criteria for financial reimbursement. As a second example, the American Academy of Psychiatry and the Law's (2005) ethics guidelines emphasize conducting a personal examination

of the evaluee but allow opinions to be rendered based on other information if clearly stated that a personal examination was not conducted. These examples demonstrate seemingly acceptable exceptions to the Goldwater Rule.

From the perspective of psychologists, Mayer and Leichtman (2012) examined key issues that surround ethical commentary on public figures by mental-health professionals. They propose six areas of ethical consideration when deciding to comment on a public figure. These areas include having a good rationale for making the commentary, (e.g., free speech, obligation to educate and to warn public, and being in a position to set an example of a balanced judgment that others may follow), the intentions of the judge (e.g., to further education and to promote personal well-being and the well-being of others), deciding whether the public figure is suitable to comment on (e.g., respect for persons—especially the special vulnerability of certain populations), the form of psychological judgment (e.g., holistic versus particularistic comments, positive versus negative commentary, and commenting on a specific individual versus a small group), having a reasonable scientific basis for one's judgment (e.g., making scientific assessments at a distance, influence of speculation and opinion, and drawing erroneous conclusions), and the communication skills of the judge (e.g., issues of voice, clarity of the message, tradeoffs between tact and informativeness, and distancing of the target).

Kroll and Pouncey (2016) argued that the Goldwater Rule presents conflicting problems, including the right to speak one's conscience regarding concerns about the psychological stability of holders of high office and competing considerations regarding one's role as a private citizen or as a professional figure. They challenged the Goldwater Rule by questioning the APA's position that the standard for psychiatric assessment includes an in-person interview, by arguing both that psychiatrists have an obligation to protect the privacy of psychiatric patients but not the public perceptions of the psychiatric profession and that psychiatrists have a positive obligation (and sometimes right) to speak publicly. They conclude that the Goldwater Rule was an excessive response by the APA to an embarrassing moment for American psychiatry but that its real purpose (in their opinion), to "prevent individual psychiatrists from misrepresenting or embarrassing the psychiatric profession, possibly at the expense of personal, professional, or social values" (Kroll and Pouncey 2016, 233), is unreasonable. In a similar manner, Ghamei (2016) described the Goldwater Rule as "necessary, but draconian."

RECOMMENDATIONS

In this chapter, we have described the complexities inherent in the practice of forensic specialists' interacting with the media. This venture involves a delicate balance of maintaining respect for persons and not speaking with malice, conveying personal versus professional opinions, upholding the reputation of the profession, promoting public policy, adhering to social responsibility, and preserving the strict confidences of patients. There are many risks incurred by mental-health professionals related to the responsible manner in which they may interact with the media. Public expressions of opinions by a forensic specialist might lead to ethics violations beyond a Goldwater Rule infraction. Beneficence, truth telling, and respect of persons are the tenets most vulnerable to infringement.

In addition to violations of professional ethics, professionals risk civil action when making opinions public. If the psychiatrist or psychologist has not conducted an examination and later speaks negatively about a person, he may be liable for invasion of privacy or defamation of character. A psychiatrist or psychologist who has not been granted the authorization to speak publicly about a patient could face a lawsuit for breach of confidentiality based on a common law or statutory right to confidentiality. For example, the Health Insurance Portability and Accountability Act (HIPPA) of 1996 (United States) provides federal protections for personal health information held by covered entities and gives patients certain rights with respect to that information.

The lure to express one's opinions publicly is often enticing. The 2016 U.S. presidential election reminds us that there are many opportunities for forensic specialists to interact with the media. One must recognize that this practice is ethics based (e.g., Cooke et al. 2014). If a psychiatrist or a psychologist decides to interact with the media, one must ask if the subject of the discussion is a patient. If yes, then the expected ethics constraints apply: specifically, confidentiality and autonomy. If the subject is not a patient, then a different set of ethics principles apply: the mental-health professional must be objective, tell the truth, and be circumspect about the situation without overreaching or exaggerating—discussing issues in general without specifically commenting on the person who is in the public spotlight. In other words, leave the role of speculation to the media. If no one in particular asks the professional to talk about a subject, one must reflect and ask what is driving the desire to express one's opinions publicly.

Psychiatrists must remember that despite the criticism of the Goldwater Rule, this ethics guideline remains active. The former president of the APA

has spoken out defending it and chastising those who choose to violate this rule. Psychologists, although not bound by the ethics guidelines of the APA, must decide if these statements provide guidance for them.

If a forensic specialist decides to proceed with this venture, then we recommend careful consideration. The media often allow sloppy analysis of people who do bad things or who are unpopular. Commentary that joins the fray and that is unfounded in reality, however, should not establish the benchmark for competent analysis. Specialists should inform the audience of their biases, qualifications, and limitations (Schumann 2013). Using psychiatric terms in such a loose fashion without interviewing the individual worsens the stigma of mental disorders. It threatens to make the terms "cheap and ubiquitous, fueling misperceptions" (Klitzman 2016). When these are used without scientific basis, then anyone can pejoratively toss them around without the proper training or methodology.

Instead, forensic specialists who choose not to shy from this adventure can rise to the challenge of social responsibility and fill an obvious need to educate and inform the public on the nature of mental illness and human behavior without speaking specifically about the individual. The task of educating the public is supported by the Principles of Medical Ethics with Special Annotations Especially Applicable to Psychiatry. Mayer and Leichtman (2012, 12) advised, "In a perfect world, professionals' commentaries on public figures' personalities or mental health would be dispassionate, free of personal biases, and informed by science, experience, and the realm of available information." Much has changed since the scandal that led to the Goldwater Rule, including the amount of information available about individuals in the national spotlight.

We have proposed an ethics-based methodology that will help forensic specialists interact with the media. These methods employ several perspectives that will prepare the professional to decide whether to make public comments and how far to take the commentary. The psychiatrist or psychologist may utilize the ethics-based performative roles, a risk-benefit analysis, or consider the criticisms of the Goldwater Rule and justifications for violating this ethics rule. Any media-related opportunities should be carefully considered, as they require complex analysis.

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17

ETHICAL DILEMMAS FOR FORENSIC PRACTITIONERS WORKING WITH ASYLUM PETITIONERS

Chinmoy Gulrajani and Maya Prabhu

THE GLOBAL REFUGEE CRISIS is at its worst since World War II. UNHCR estimates that at the end of 2015 there were 65.3 million individuals forcibly displaced worldwide. More than half of these came from just three war-torn countries: Syria, Afghanistan, and Somalia. While the majority of the world's refugees were hosted by developing countries in 2015, a small percentage of those displaced persons made their way to the United States to make a claim of asylum. The United States was one of the largest recipients of asylum claims, at 172,700, trailing only Germany (UNHCR 2015). Asylum is granted to 20,000 to 30,000 individuals in the United States annually (DHS 2015), though there is no cap to the number that can be admitted yearly.

Asylum seekers bear the burden of showing they cannot return to their home country because of a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. As a signatory to the United Nations Convention on Refugees (1951), the United States has a legal commitment not to return individuals to countries where they may be persecuted (the principle of refoulement). Nonreturn may take place under the status of a refugee, an asylee, withholding of removal (avoidance of deportation), or by claiming relief under the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (UN 1984). Asylum seekers and refugees must meet the same criteria; however, asylum seekers are already physically on U.S. soil or at a port of entry; refugees are outside U.S. borders.

Forensic psychiatrists are frequently called upon by immigration attorneys to evaluate their clients. As the number of asylum claims has increased, the role of forensic psychiatrists in these cases has also increased exponentially. Additionally, their role has expanded given recent opinions in cases such as *In*

the Matter of M-A-M (defining test for *pro se* competency in immigration proceedings) and the *Franco-Gonzales v. Holder* class-action lawsuit (ordering that immigrants with serious mental disabilities in California, Arizona, and Washington have a right to legal representation if they are determined incompetent from a mental disorder or defect). This chapter will consider the ethics of forensic psychiatric involvement in asylum claims.

LEGAL FRAMEWORK FOR ASYLUM SEEKERS

The process of seeking asylum is a multistep and onerous one for applicants. One initial hurdle is the need to apply for asylum within a year of arriving in the United States. Otherwise, applicants may be barred from asylum unless they can demonstrate changed or extraordinary circumstances that would allow them a waiver. The adjudication process also varies according to applicants' legal status at the time of application. If the applicant is in the United States legally (for example, on another kind of visa), is not in the middle of removal proceedings, or is admitted at the port of entry, he or she may apply "affirmatively." Affirmative applications are evaluated in a nonadversarial proceeding by an asylum officer from the Department of Homeland Security, in which applicants must satisfy a "credible-fear" test. If the affirmative-asylum claim is initially denied, individuals can appeal the decision through the Department of Justice's Executive Office for Immigration Review (EOIR). Applicants must apply "defensively" before an immigration judge if they are in removal proceedings, placed in detention, or arrested for a crime, among other circumstances.

Asylum decisions are based on information that may include country conditions, corroborative documentation, and the testimony of the asylum seeker. The credibility of the applicant's testimony is crucial at each stage of the process. Asylum officers or judges may consider factors such as the applicant's demeanor, inconsistencies in the applicant's testimony and supporting documents, and gaps in testimony. Gaps in testimony may also be the basis for an adverse finding (*Ali v. Gonzales, Afful v. Ashcroft, Pan v. Gonzales*). Asylum seekers also undergo a process of background security checks and fingerprinting, which involves multiple agencies. Bars to successful claims may include firm resettlement elsewhere, past conviction of a "particularly serious crime," commitment of a "serious nonpolitical crime" outside the United States, involvement or incitement with terrorism, persecution, being a

security threat, or having a spouse or child who is inadmissible for the just-stated reasons (USCIS).

Over the last five years, as the number of asylum claims has increased, so has the number of denials. The overall asylum-denial rates in FY 2016 was 57 percent, and the number of cases awaiting resolution before the immigration courts in November 2016 was a staggering 526,175, up from 262,799 in December 2010 (TRAC Immigration Backlog Tool). The most important factor that determines whether an asylum seeker's claim will be accepted or rejected is legal representation (TRAC). For example, in 2015 a represented asylum seeker was five times more likely to be granted asylum compared to an unrepresented petitioner. Since asylum seekers are not citizens of the United States, in most jurisdictions they are not entitled to legal representation, though they are allowed to seek legal counsel. In cases that are represented, legal help is usually offered pro bono by large law firms, human-rights advocacy groups, and immigration clinics at law schools, where student attorneys provide representation under supervision of faculty.

THE ROLE OF THE FORENSIC PSYCHIATRIST IN ASYLUM CASES

Involvement in immigration cases begins when an attorney representing an asylum seeker has doubts or questions about his client's mental health. An initial psychiatric consultation with the attorney is useful in obtaining preliminary information about the asylum seeker's symptoms and to get a detailed account of the attorney's concerns. This in turn shapes the narrow question that a psychiatric consultation might answer. For example, if an acutely ill client is unable to communicate effectively with his attorney on account of the client's symptoms, a psychiatric evaluation may help determine if the client has the capacity to proceed in the case.

Most often, however, psychiatrists are called upon by attorneys to explain the effects of trauma in their clients' lives and to formulate how a history of trauma affects clients' behavior and ability to function. Since exposure to trauma can lead to deficits in memory and recall, a meticulous psychiatric evaluation can at times help explain inconsistencies in an individual's report of significant events in his life.

An accurate cultural formulation is an important part of a comprehensive evaluation of an asylum seeker. A psychiatrist ought to be able to communicate

an integrative narrative of the individual's history by placing it in the appropriate cultural context. At a minimum, culture influences the expression of symptoms of psychological distress. Additionally, Kirmayer et al. (2007) remind us that the meaning of traumatic life events, which may be germane to the asylum application and to the reasons for flight, may be understood better through exploration of the applicant's background. For a more complete guide to a cultural formulation in the forensic-evaluation context, the authors of this chapter refer readers elsewhere (Aggarwal 2012, Griffith 1998).

A detailed mental-health evaluation may uncover attempts made at exaggeration or feigning of symptoms by the evaluee in an attempt to bolster his claims. In such cases, the psychiatric consultation should be suspended until there is communication of the finding of malingering to the attorney. The American Academy of Psychiatry and the Law (AAPL 2007) reminds evaluators that when instruments to assess malingering are used, especially with an interpreter, it "may be misleading to interpret test results from evaluees of other cultures according to norms established by administering the tests to North Americans." Conversely, in situations where malingering can be definitively ruled out, the psychiatrist may be able to comment on the authenticity of an individual's account of his past.

Deportation of an individual already residing in the United States can be a hardship not only for the individual but also his spouse, children, and other family members. Under 8 USCA §1229(b), the attorney general has discretion to cancel deportation where it would result in "exceptional and extremely unusual hardship to the alien's spouse, parent or child, who is a citizen of the United States or an alien lawfully admitted for permanent residence." In the case of *In re Monreal-Aguinaga*, the Board of Immigration Appeals has defined "exceptional and extremely unusual hardship" as "hardship that is substantially beyond that which would ordinarily be expected to result from his deportation." On occasion, psychiatrists are called upon to render their opinion regarding the hardship faced by the deportee's family members in the event of deportation. These evaluations require a meticulous assessment of all the family members, not just the petitioner, and also an objective measurement of emotional distress and socio-occupational disruption that deportation might cause the deportee's family members remaining in the country.

Psychiatrists are in a position to assist attorneys, clients, and adjudicators in a variety of other ways. For instance, psychiatrists are able to identify evaluees whose mental state is decompensating and provide appropriate treatment referrals in the community in a timely manner. Similarly, psychiatrists can also

offer an opinion on the likely effects of repatriation on the mental health of the asylee and teach effective methods of obtaining trauma details to collaborating attorneys (Meffert et al. 2010, 486).

ETHICAL CONSIDERATIONS

The general framework for the ethical practice of psychiatry is laid out in the medical code of ethics set forth in the Principles of Medical Ethics of the American Medical Association with Annotation Applicable to Psychiatry (APA 2013). These principles stress the importance of providing competent medical care with compassion and respect for human dignity. Under the code, psychiatrists are required to uphold the standards of professionalism, be honest in their interactions, and respect the law. Other areas of import include the safeguard of patient confidences and privacy, commitment to advance scientific knowledge, and the duty to participate in activities contributing to the betterment of community health.

For forensic psychiatrists, these principles are supplemented by the Ethics Guidelines for the Practice of Forensic Psychiatry adopted by the American Academy of Psychiatry and Law (AAPL 2005). The AAPL guidelines recognize that unlike the treatment setting, psychiatrists in a forensic role are called to practice in a manner that balances competing duties to the individual and to society. However, the guidelines emphasize that forensic psychiatrists remain bound by the underlying ethical principles of respect for persons, honesty, justice, and social responsibility. In addition, the guidelines highlight four ethical areas specific to the practice of forensic psychiatry: respect for the individual's right of privacy and the maintenance of confidentiality; provision of proper informed consent as applicable; adherence to the principles of honesty and striving for objectivity; and claiming expertise only in the areas of actual knowledge, skills, training, and expertise.

There are no separate ethical guidelines for asylum evaluations. Forensic psychiatrists performing these evaluations operate under the same broad ethical framework laid out in the section above. However, forensic psychiatric evaluations in immigration cases are unique in several ways, leading to novel ethical concerns. First, as noted above, cross-cultural competency is of paramount importance, as the evaluee in a majority of cases is from a foreign, non-English-speaking culture. Hence psychiatrists practicing in this area should be comfortable negotiating a wide array of cultural and linguistic barriers.

Second, the psychiatrist must be adept at eliciting a detailed history of trauma, since sequelae of post-traumatic stress occur at a higher frequency in this population. Further, a history of intense trauma can provoke strong countertransference in the evaluator. Hence maintaining objectivity, in the face of both positive and negative countertransference reactions toward the evaluee, can pose a challenge. Fourth, resettlement in the United States is a significant incentive, and fabrication of facts and/or of symptoms is encountered occasionally; the evaluator should maintain a high index of suspicion for malingering, as he is often asked to provide an opinion regarding the authenticity of the individual seeking asylum. Fifth, many psychiatrists are not paid for their services in asylum-related cases, and altruism plays a major role in case selection (Meffert et al. 2010, 485). Finally, legal standards applicable in immigration cases are unique and different from standards adopted in other criminal or civil courts, albeit with some similarities. Therefore, it behooves psychiatrists claiming expertise in asylum cases to be well versed in existing and emerging legal standards as they pertain to immigration courts.

While no specific ethical guidelines are available, some best practices for working with asylum seekers are underscored in specific manuals for physicians that address working with torture victims, as many asylum seekers unfortunately also are. The UN's *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment* ("Istanbul Protocol") reminds evaluators that the "overall goal of a psychological evaluation is to assess the degree of consistency between an individual's account of torture and the psychological findings observed during the course of the evaluation" (para. 261). It calls for the assessment and formulation of a clinical diagnosis to be made always "with an awareness of the cultural context," which includes an awareness of "culture-specific syndromes" and "native language–bound idioms of distress," which are of paramount importance for conducting the interview. The Istanbul Protocol identifies the assistance of an interpreter as "essential" when the interviewer has little or no knowledge of the applicant's culture (para. 262).

As with general guidelines, the Istanbul Protocol notes that the interview may result in retraumatization, which the interviewer should take steps to mitigate. Although the protocol recommends avoiding an approach in which the clinician is inactive and says little, the authors of this chapter caution that this refers to the style of interaction with the subject rather than a comment on the need for honesty and objectivity in the assessment.

The "Physicians for Human Rights' Guide to Medical and Psychological Evaluations of Torture" (PHR 2012a) also reinforces the importance of ethics

guiding health professionals in their work. Its "Model Medical Curriculum" (PHR 2012b) notes that there are "three areas in which the health professional must be particularly cognizant of specific ethical considerations. The first is the duty to the patient, the second is the clinical independence of the health professional and the third is in the production of medical records, reports and testimony."

The following vignettes demonstrate that while asylum evaluations are clinically complex given a number of cross-cultural challenges, the ethical issues can be addressed with standard ethical frameworks.

VIGNETTE 1

You are a female psychiatrist in practice in an urban city. You're asked to evaluate Ms. K, a thirty-two-year-old widowed refugee from a civil war–torn African country on request of her attorney. The attorney explains that Ms. K has been in the United States for a little over two years and may suffer from symptoms of PTSD. He requests a mental-health evaluation to explore if symptoms of mental illness may have prevented Ms. K from filing her asylum petition within the one-year deadline set by the USCIS.

During your evaluation Ms. K provides a horrifying narrative of her torture and exploitation in her home country. You learn that she hails from a minority tribe in her community that was at war with the majority tribe. Ms. K informs you that one night members of this opposing tribe forcibly entered and looted her family home and killed her husband and child. She reports that she was abducted and held captive in a small cage-like room over the next several weeks, where she was repeatedly physically and sexually tortured. One day she was able to escape and flee on foot to the nearest big city, 150 miles away. Along the way she developed ulcers in her feet, suffered severe malnutrition and dehydration, and nearly died. On reaching the big city, she sought refuge with a women's organization that helped organize her passage to the United States on a temporary-stay visa.

In the United States she started working as a live-in babysitter for a family friend who in exchange provided her with food, shelter, and clothing. She reports to you that her initial few months in the United States were difficult, as she had few resources or supports and was recovering from significant losses. She provides a history of symptoms consistent with depression and post-traumatic stress during this period.

Ms. K informs you that it took her almost two years to adapt to life in the United States. She reports that she had no idea that she had to file for asylum formally during this time and only sought legal help after she received a notice from the USCIS. Thereafter, her attorney informed her that she had missed the one-year deadline for filing an asylum petition and that the only legal remedy would be by demonstration of extenuating circumstances (for example,

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debilitating medical or physical illness) that might have prevented her from filing within the deadline.

While there is little doubt that Ms. K was suffering from symptoms of major depression and PTSD during the first few months of her arrival into the United States, it is unclear to what extent these symptoms contributed to her inability to file for asylum within the one-year deadline. You do not doubt Ms. K's credibility and find yourself empathizing with her repeatedly. You also know that if in your report you conclude that she was prevented from filing her petition within the one-year deadline on account of debilitating symptoms of depression and PTSD, there is a good chance that this explanation will suffice and her asylum petition will be accepted.

DISCUSSION

The vignette above exemplifies how intense feelings of empathy toward an asylum seeker can affect the forensic psychiatrist's objectivity. According to the American Academy of Psychiatry and Law (AAPL), honesty and striving for objectivity are the two cornerstones of ethical practice in forensic psychiatry. According to Dietz (1996), bias in forensic psychiatric evaluations can arise from two sources: countertransference and a failure to maintain appropriate professional boundaries. Further, Dietz notes that the forensic evaluator may not be aware of the several influences, distractions, and temptations that can affect his objectivity.

Working with victims of torture and political oppression in the therapeutic setting can induce a wide array of feelings in a therapist, including helplessness, vulnerability, despair, overidentification, ambivalence, and fear (Comas-Diaz 1990). Adler (1972) observed that when working with traumatized individuals, therapists may display countertransferential regression, often feeling that they literally have to rescue and comfort the patient. According to Adler, the patient demands and expects rescue from the omnipotent parent, and the therapist, like a parent, feels a requirement to respond. Therefore, the very act of helping the victims becomes an emotional way of containing the therapists' own terror and feelings of helplessness. When both the psychiatrist and defendant belong to the same racially or culturally defined minority, some psychiatrists may also overidentify with defendants at the expense of objectivity (AAPL 2007).

Even though the principal purpose of a forensic psychiatric evaluation is not therapeutic, when eliciting a history of trauma, forensic evaluators are susceptible to myriad countertransference reactions, including denial or disbelief of their claims, judgment of their actions, feeling burdened by the responsibility of the evaluation, and over/under pathologizing the symptoms of their evaluee

(Prabhu and Baranoski 2012). Intense positive or negative feelings toward the evaluee can subconsciously affect the objectivity of the forensic psychiatrist, which then manifests as a biased opinion. Meffert et al. (2010), De Jesus-Rentas (2010), and Prabhu (2012) have all cautioned against this bias. Meffert et al. (2010) recommend that forensic evaluators remain particularly vigilant about their own desires for the outcome; De Jesus-Rentas (2010) has taken the position that the ethical forensic examiner should not be an advocate for any particular legal goal.

VIGNETTE 2

You are a forensic psychiatrist working in an academic medical setting. In addition to your clinical responsibilities on an outpatient general-psychiatry team and teaching and scholarship responsibilities, you maintain a small private practice of forensic cases. Over the years, you have developed expertise in gender-based asylum claims. Because of your expertise, you are often asked to take on both paid and unpaid asylum cases.

In recent years you have received an increasing number of requests to take on high-profile asylum cases pro bono. You are flattered by some of these requests; many of these have the potential to set legal precedent and would involve working with nationally and internationally recognized legal-advocacy groups, which could bolster your academic reputation. However, at times you are feeling overwhelmed with the numbers of requests you are receiving. At the same time, with all of the media coverage on the "migration crisis," you conclude that it's your responsibility to "do your part."

In an effort to ease the workflow, you have tried to involve colleagues and trainees in your work. This has helped somewhat, but there are always many more requests pending. You continue to be committed to this form of social engagement but are unclear about how to balance your commitments and are considering limiting the amount of time spent on each asylum case in order to keep up with the work.

DISCUSSION

The vignette is intended to remind forensic evaluators of a number of principles. The first concerns the importance of maintaining one's usual standard of practice regardless of the paying status of the client and the workload. According to the American Medical Association (AMA 2013, 10), "when the psychiatrist's outside relationships conflict with the clinical needs of the patient, the psychiatrist must always consider the impact of such relationships and strive to resolve conflicts in a manner that the psychiatrist believes is likely to be beneficial to the patient." There is little published data about how

physicians approach their pro bono work. However, there is some data that indicates that physicians are sensitive to reductions in income and will make adjustments to practice style, for example, by increasing reimbursable services in some areas to offset losses in another (Jones et al. 2005).

Even where the evaluator is cognizant of these vulnerabilities, managing a large caseload of both paid and pro bono work can be a challenge regardless of the intensity of the material. While psychiatrists are encouraged to engage in "activities contributing to the improvement of the community and the betterment of public health" (AMA 2013, 9), it does not follow that this requires taking on a large caseload for free. Some authors have suggested pro bono efforts can include "speaking to groups or sharing professional information" (ACA 2016, 10). "The requirement for social engagement speaks to sharing knowledge and expertise in ways that benefit others without posing an unreasonable burden on the evaluator" (Meyers 2014). While it is not uncommon for cases to be used for teaching and writing purposes, the AMA cautions physicians to disguise details adequately in order to preserve the anonymity of the individuals involved (AMA 2013, 6).

VIGNETTE 3

You are in the process of conducting a forensic psychiatric evaluation of an asylum applicant. He was able to enter the country lawfully on a medical humanitarian visa and is receiving surgical treatment for injuries sustained during his country's civil conflict. The applicant lived for almost three years in a UNHCR refugee camp after having fled his village from violent militia. Before the war, he was a subsistence farmer. He is being housed by a church group, which has helped him find the legal counsel that is assisting him with his asylum application. You were not able to find a translator who speaks his specific dialect, but he and the translator are communicating through a second language they both know. You have seen him once shortly after he was discharged from the hospital and thoroughly reviewed with the applicant, the nature of the forensic evaluation, how it might be used in his legal application, your role as a consultant, and the limits of confidentiality. The applicant is pleased to be in the United States but seems somewhat overwhelmed by the complexity of the medical system and the asylum process. Until he was seen by a UNHCR physician, he had only ever seen a local herbalist and relied on his animist beliefs to manage his medical problems. Nonetheless, he indicated through the translator that he is agreeable to participating in the evaluation.

On your second interview with the applicant, he is noticeably despondent about setbacks in his recovery and possibly the permanent loss of vision in one of his eyes.

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You become worried enough about his mood that you arrange an urgent assessment by Acute Services in the same facility that day, where he continues to be seen for ongoing mental-health care by a psychology fellow who is eager to learn about cross-cultural issues. The applicant's mood has sufficiently improved so that you are able to complete your evaluation. However, over the following months, when he visits his therapist, he drops in to see you as well, sometimes just to say hello and sometimes to ask for advice about how to navigate various medical issues. On one occasion, the applicant brings his wife to meet you and asks if you can "be her American doctor," as she also experiences mental-health symptoms related to their experiences in their home country. He and his wife repeatedly express gratitude for "your help," and you find yourself making time for their questions. When the psychology fellow asks for consultation about the cross-cultural complexities, you wonder whether you have taken on more roles than you had anticipated.

DISCUSSION

This vignette demonstrates two common problems encountered in asylum cases that can lead to ethical pitfalls: deficits in cultural competence and dual-role conflicts. In the vignette, the evaluee who initially visits the psychiatrist for a forensic evaluation starts attributing the role of treater to the evaluator. Since the evaluee is from a different culture and unfamiliar with the dominant culture in the United States, the onus of recognizing this shift in roles lies on the psychiatrist. The psychiatrist, who is not well versed with his evaluee's cultural practices, fails to recognize that he has gone from becoming an objective evaluator to a treater and advocate. The vignette also demonstrates that while cultural differences between the evaluator and the evaluee may be overt, in many cases they can affect the interaction in subtle ways that require evaluators to remain vigilant for such influences.

This vignette also illustrates the challenges of using interpreters. Cultural competence not only refers to a necessary skill for the evaluator but for the interpreter. The interpreter's ability to understand not only the evaluee's statements but also the culturally unique meanings attached to those statements can be invaluable in a forensic assessment (Wagoner 2016; see Maddux 2010, on the use of interpreters in forensic evaluations). While it may be ideal to use certified court interpreters who are licensed and tested by the state, this may be unrealistic for many dialects. In this vignette, the evaluee's primary language was unable to be accommodated, which additionally raises the likelihood of misunderstandings about the nature of the evaluation and relationship

on the part of the evaluee. It may also result in distortion of communication on the part of the evaluator (Bauer 2010, 772).

The second problem, which is closely tied to the first one in the above example, is that of dual-role conflict. The ethical problems associated with donning the role of both expert witness and treating physician are now recognized (Appelbaum 1997). However, in the traditional setting, it is the treating psychiatrist who often extends his services to serve also as expert witness for his patient. Strasburger, Gutheil, and Brodsky (1997) have cited various reasons for this: the retaining attorney may not be aware of the incompatibility of these roles and assumes that the treating psychiatrist would also make the best expert for the case; the clinician, in the grip of altruism, may endorse this idea; or the attorney may simply want to save money for the client by hiring the psychiatrist as the forensic expert. These situations are problematic because a treating psychiatrist and a forensic examiner have conflicting loyalties and duties, one to the patient and the other to the hiring agency. These conflicts in turn affect the physician-patient relationship and also have the potential to impact the objectivity of the forensic opinion. However, there is little guidance in the existing literature on situations where the converse happens (as in the vignette), that is, when the forensic evaluator takes on the role of the treating psychiatrist. We foresee at least two ethical challenges in these situations. First, the added burden of supporting the evaluee's treatment needs in the above case has the potential to compromise the quality of services the psychiatrist provides, not only as a forensic examiner but in other professional roles. Second, assuming the role of advocate for the patient and family can compromise the forensic evaluator's objectivity and also have a significant negative affect on credibility in court as a neutral expert.

CONCLUSIONS

Asylum evaluations can be a rewarding and challenging area of practice in forensic psychiatry. For many, it can be a way to engage in work that feels connected to larger humanitarian causes, especially in the context of a well-documented postconflict migration crisis. Asylum evaluations may also be an opportunity to hone cross-cultural skills and language skills and are a ripe area for education and training with residents and fellows. As this chapter begins to illustrate, however, asylum evaluations are rendered ethically arduous by virtue of complex transferences and countertransferences or by

dual-role challenges. Our recommendations are for evaluators to seek supervision preemptively and proactively before dilemmas arise and when in doubt to return to ethical first principles. With the expanding global refugee crisis, this is a growing area of work for forensic psychiatrists, one that shows no signs of abating. Therefore, it is has become essential for forensic psychiatrists working in this arena to avoid the ethical pitfalls highlighted in this chapter and maintain the same standards of professionalism while working with asylum seekers as they do in all other domains of forensic practice.

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ADDRESSING ETHICS DILEMMAS IN VIOLENCE-RISK ASSESSMENT

A Forensic Psychologist Perspective

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CURRENTLY, THE ASSESSMENT OF RISK of violence remains an important public-safety issue within mental-health practice, particularly within forensic clinical practice. Risk assessment provides a critical foundation not only for assessing risk of violence but for the formulation and implementation of an appropriate treatment plan to reduce the risk and untoward outcomes for both the patient and others. There are multiple arenas where forensic mental-health professionals conduct violence-risk assessments. These include cases focusing on criminal disposition and sentencing as well as on civil commitment. In addition, risk assessments are used in situations when an individual with mental illness is being considered for parole/discharge into the community from a correctional facility or a psychiatric hospital. Finally, large organizations may need risk-assessment evaluations regarding security concerns of their employees or others.

Violence-risk assessments conducted by forensic professionals can bring two competing interests into conflict: the duty to protect the public and the duty to protect the individual's civil liberties. These two duties conflict in the arena of violence-risk assessment when the interest of one party occurs at the cost of the other's interest. The importance of "doing no harm" is found throughout the American Psychological Association's Ethical Principles and Code of Conduct (2010). However, the APA Ethics Code does not offer clear direction as to which party's interests should prevail; rather, it merely cautions against condoning unjust practices and emphasizes the use of reasonable judgment.

A number of concerns in ethics arise from violence-risk assessments, given the implications of such evaluations in terms of the individual's restriction of liberty and potential stigmatization associated with the "violent" label. Ethical

conduct, as it is formulated by the American Psychological Association, has two elements: principles that represent aspirational guidelines toward an ethical course of professional conduct and standards that are a set of enforceable rules of conduct. Forensic psychiatrists and forensic psychologists have formulated separate ethical guidelines of conduct from those of general clinical practice (AAPL 2005, APA 2013). Both specialty guidelines have overlapping core areas related to bias, external influences, and awareness of the limitations related to the methods employed and opinions offered. The psychological standards discussed in this chapter may have cross-professional relevance and can be applied to the practice of forensic psychiatry.

This chapter will explore broad issues of ethics inherent to violence-risk assessments, factors that may influence/affect an expert's opinions, and guidelines for ethical forensic violence-risk assessments.

ETHICAL ISSUES INHERENT TO VIOLENCE-RISK ASSESSMENTS

Two general issues inherent to violence-risk assessments are how they are conducted and the impact of the assessment on the examinee.

LOPSIDED RISK ASSESSMENTS: OVERRELIANCE ON STATIC AND STATISTICAL RISK FACTORS TO THE EXCLUSION OF DYNAMIC AND PROTECTIVE FACTORS

The American Psychological Association's "Specialty Guidelines for Forensic Psychology" (Forensic Psychology Guidelines) recommend in guideline 1.02 that forensic practitioners strive for "accuracy, impartiality, fairness, and independence . . . and . . . be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact" (APA 2013, 8–9). What would represent an unjust practice and unreasonable judgment within violence-risk assessment? Biased assessments would be one example. The APA Ethics Code cautions clinicians to consider potential biases. How can violence-risk assessment be influenced by bias? An obvious example is a bias based on characterizing individuals according to their diagnosis; for example, all individuals suffering from schizophrenia are violent. A more subtle bias is what Rogers (2000) has called clinicians' "uncritical" acceptance of risk-assessment practices, namely, an

assessment driven only by a review of factors associated with a negative outcome (aggravating factors). Rogers characterized such evaluations as "one-sided" risk assessments that are exclusively or heavily reliant on static risk factors (aggravating factors that do not change) to the exclusion of protective factors (mitigating factors that reduce the risk of violence and dynamic factors that can change). One-sided risk assessments may be inaccurate and can lead to individuals' being identified at greater risk of violence than they actually are, thus leading possibly to an initial involuntary psychiatric commitment or longer terms of involuntary psychiatric or prison confinement.

Rogers's recognition of a clinician's uncritical embrace of focusing on static risk factors was written in 2000, yet it remains a problematic issue even today, as this practice is a prominent and highly weighted methodology used in forensic violence- and sexual violence–risk assessments (Weinberger et al. 2018). Why is this? Actuarial risk assessments, which are based on scoring the presence or absence of a small number of statistically identified risk factors from a group of individuals, have gained popularity in forensic assessments because they give the appearance of impartiality and quantification, that is, risk percentages for defined periods of time (Sreenivasan et al. 2010).

A historical context helps us understand the attractiveness of actuarials. In the 1970s, research findings reported that the identification of dangerousness based on clinical judgment was not predictive of future aggressive or assaultive behavior (Steadman and Cocozza 1978). This led to a conceptual change away from "dangerousness" to "risk" as the evaluation focus. Unlike "dangerousness," which was viewed as a fixed characteristic about the individual or as "categorical" (e.g., yes or no), "risk" was regarded as a continuum and dependent on the presence of many factors that were external, subject to change, and not characterologic (Nilsson et al. 2009, Szmukler and Rose 2013). Initially, risk assessments were unstructured and relied heavily upon an examiner's clinical experience and the weighing of variables derived from a clinician-idiosyncratic basis. Not surprisingly, the reliability and validity of such assessments were marginal at best or outright inaccurate.

In response, during the early 1990s there was a move to find an evidence-based methodology that identified statistically based risk factors. Borrowing the methodology from the insurance industry, which uses large datasets to identify whether an individual is a good or bad risk for being insured, actuarials for violence risk were developed. These risk-assessment instruments (such as the VRAG, the Static-99, and the RRASOR) were atheoretical and constructed using a small number of static predictors or historical variables that

were statistically identified as correlated with violence risk. The risk factors were based on data from large groups of individuals (e.g., violent offenders released from a jurisdiction or country in a certain year). Moreover, these risk instruments listed a defined set of static variables (e.g., age, prior history of arrest, history of violent crimes) to predict a defined outcome (e.g., criminal violence) at a defined period (e.g., five years or ten years), using criminal-history records as the outcome. Typically, the higher the score on the instrument, the higher the risk. Actuarials had the benefit of being "objective" in that the clinician could not assign a weight to the variables based on the expert's clinical experience. However, they were also problematic. The variables were fixed and did not assess individual change or current functioning. Moreover, the statistical probabilities for risk were unstable when norms were used for those who were not from the original sample, for instance, using Canadian risk percentages based largely on Caucasian samples and applying them to an American ethnic minority (Sreenivasan et al. 2010).

Actuarials are composed of static risk factors that do not take into account changes in the individual; nor do they address protective factors. Rogers (2000) highlighted the dangers of reliance on static risk factors by noting the study by Silver, Mulvey, and Monahan (1999), which examined risk factors for violence among discharged psychiatric patients. Notably, Silver and colleagues found that being African American versus Anglo American increased dramatically the risk for violence on discharge. But it was a dynamic moderating factor, poverty, which was the predictive variable, not race, which, when financial status was examined, had no impact on violence. Another limitation of actuarials is the fixed nature of the risk factors, which allows for no mechanism to assess change and limits the ability to target the individual's problem areas in treatment (Wong and Gordon 2006). These limitations prompted increased interest and research into the development of another risk-assessment methodology: structured professional judgments (Douglas et al. 2014, Roychowdhury and Adshead 2014).

SPJs use research-based risk factors that include both static (fixed) and dynamic risk-factor predictors, but they also require clinical judgment. Unlike actuarials, SPJs focus on the areas of risk most relevant to the person being evaluated (Roychowdhury and Adshead 2014). The APA's Forensic Psychology Guidelines urge forensic practitioners to strive for accuracy and fairness. SPJs offer a methodology by which to do so. They are also consistent with the APA Ethics Code in relation to concern for the cultural and contextual specificity of violence risk. In general, SPJs are considered a more ethical approach to risk

assessment (Roychowdhury and Adshead 2014). They focus on risk areas that are most relevant to the person; they also include protective and moderating factors that reduce risk. Prevention rather than prediction is the objective. In addition, SPJs can be conducted within an interdisciplinary team context and where a dissenting voice (often one who argues for reduced risk) can be heard. Patient input is also solicited, upholding the principles of respect and autonomy. Moreover, attributing less reliance on false positives will reduce the harmful effects of risk management for the patient (Roychowdhury and Adshead 2014). Finally, SPJs focus on the prevention of aggressive and assaultive behavior, which is cited as critical to the treatment and management of assaultive conduct (Abderhalden et al. 2008, Anderson and West 2011). All these elements comport with the APA's Ethical Standard 9.02, "Use of Assessments," by employing "assessment instruments whose validity and reliability have been established for use with members of the population tested" (APA 2010, 12).

STIGMA OF LABELING

It is not uncommon for people with mental illness to be perceived as threatening and dangerous; consequently, such beliefs can result in stigmatization and discrimination (Martinez et al. 2011). Risk-of-violence assessments are conducted frequently on individuals who have psychiatric diagnoses. In fact, some believe that offenders with mental illness are more dangerous than other people who have committed similar crimes, despite questionable scientific evidence (Nilsson et al. 2009). These assumptions regarding a link between mental illness and violence are not supported by research findings, which have demonstrated that "the vast majority of individuals with a mental illness and no concurrent substance use pose no greater risk of violent behavior that those without M/SU illnesses" (Institute of Medicine 2006, 100). Yet the perceptions and assumptions continue, with the individual experiencing the double stigma of being labeled as mentally ill and violent. Often these labels produce dehumanizing responses toward the person by others (Martinez et al. 2011). As a result of these reactions, "labeled" individuals may also develop negative feelings about themselves and feel discouraged to obtain help, disclose information, or remain in treatment. Rogers (2000) described violence-risk assessments as having the potential to exert a "corrosive effect" on the clinician's perception of the patient, which can create the climate for negative countertransference.

The "Report of the APA Task Force on Implementation of the Multicultural Guidelines" advises psychologists to understand stigma and how it may

affect a person's psychological processes (APA 2008). In addition, the APA's "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" state that psychologists should be "encouraged to understand the stigmatizing aspects of being a member of a culturally devalued 'other group'" (APA 2002, 26). The APA Task Force also recommends that psychologists become more "knowledgeable about the history, worldviews, and values of groups other than their own" (APA 2008, 7). Thus, forensic psychologists need to take into account cultural diversity and the influence it may have on their forensic assessments and analyses.

There are several considerations regarding ethics and stigmatization relevant to identifying someone as having a mental illness as well as posing a risk of violence. In light of the serious social consequences, such as discrimination and infringement on civil liberties, forensic professionals need to conduct an accurate and impartial evaluation and report. There are many factors that may play a role (intentional or not) in influencing the forensic examiner's findings and opinions. Therefore, the examiner should be aware of these and take measures to minimize their effect.

FACTORS THAT MAY INFLUENCE THE EXPERT'S OPINIONS

The APA's Forensic Psychology Guidelines state that forensic practitioners should recognize the adversarial nature of the legal system and to that end weigh all the data (APA 2013). The guidelines underscore forensic psychologists' need to consider rival hypotheses impartially so that their opinions may be unbiased. The value of being unbiased, comprehensive, and as accurate as possible is emphasized. Yet the legal context of forensic assessments may lead to the examiner's having to rely on incomplete data to formulate opinions; for example, the individual may decline to participate in the evaluation, external sources of information may be limited, there may be pressures exerted by the appointing party, and there may be examiner bias based on personal experience or reaction to the examinee's crime.

THE EXAMINEE'S WILLINGNESS TO PARTICIPATE AND DISCLOSE INFORMATION

There are many instances when individuals may understandably not wish to participate in an evaluation to determine their level of violence risk if the conclusions may be disclosed to the trier of fact or a deciding board. Examples

may include an examinee facing capital punishment or a potentially lengthy sentence for criminal charges based on violent offenses, a life-term prisoner seeking a parole hearing, or a prisoner facing a Sexually Violent Predator commitment. Consequently, the forensic professional should bear in mind several issues.

The ethics regarding direct communication to the examinee of the nature and purpose of the evaluation as well as the limits of confidentiality are found in both the APA Ethics Code and the Forensic Psychology Guidelines. Informed consent consists of providing the examinee with as much information as possible, using language the person can understand, about the risks and benefits of the forensic psychological violence-risk evaluation (APA 2010, 2013). This would include the purpose of the evaluation, what the evaluation will consist of, the limits to confidentiality, the foreseeable uses of the information obtained, the involvement of third parties, the right to decline participation and the foreseeable consequences of doing so, the potential benefit—as well as harm—if they do participate, and the opportunity to ask questions and receive answers (Ethical Standard 9.03; Forensic Guideline 6.03). In addition, examinees should be informed about what information (e.g., records, interviews with collaterals, risk-assessment approach used) other than that disclosed by them may be considered by the examiner. Forensic specialists should be careful not to delve too deeply into the legal information pertaining to the evaluation, given that they are not the examinee's attorney, may not have legal expertise, and may not know all of the possible legal ramifications relevant to the case.

Another essential disclosure that forensic professionals should make to the examinee is an explanation of their "evaluative" role and an emphasis that they are not acting in a therapeutic capacity. Most examinees are inclined to see psychologists and other mental-health specialists as professionals who are there to help them. If the forensic role is not defined clearly, the examinees may reveal unknowingly more information than they ordinarily would if they had a better understanding. This inclination by the examinee can be more pronounced if the forensic specialist uses empathic techniques during the interview (Shuman and Zervopoulos 2010).

What should a forensic psychologist do when the examinee is incompetent to give informed consent? The APA Ethics Code (Ethical Standard 3.10) and the Forensic Psychology Guidelines (Forensic Guideline 6.03.03) address situations when the individual is incapable legally of giving consent. They state that

> psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.
>
> (APA 2010, 6; 2013, 13)

Finally, it should be noted that it is not unethical for a forensic psychologist to conduct a psychological evaluation over the objection of examinees and without their consent if the examinees are ordered by the court to participate (Ethical Standard 3.10, 9.03; Forensic Guideline 6.03.02). The Forensic Psychology Guidelines state that "If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider a variety of options including postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee's unwillingness to proceed" (APA 2013, 13).

SOURCES OF INFORMATION

A thorough violence-risk assessment depends not only on the information provided by the examinee but also on collateral material. The more complete and unrestricted access examiners have to collateral information and third-party sources, the higher degree of objectivity and confidence forensic professionals may have regarding their opinions. Forensic Guideline 8.03 acknowledges that the forensic psychologist should "strive to access information or records from collateral sources with the consent of the relevant attorney or the relevant party, or when otherwise authorized by law or court order" (APA 2013, 14).

Despite this, it is not uncommon for attorneys to limit the data provided to the examiner. Defense attorneys may restrict access intentionally and select only those documents they want the examiner to review. In fact, a study conducted by Gutheil, Commons, and Miller (2001) found that 49 percent of respondents to a survey experienced situations where attorneys who retained them withheld important data from the expert. The authors suggested that attorneys may withhold material because they do not want the opposing attorney to gain access to data that otherwise would be legally inadmissible. Other reasons mentioned include the financial cost either of reproducing the records

or paying for the time it will take the expert to review the material. Withholding material may also be an attempt by attorneys to protect their client from being viewed negatively. Moreover, case material may not be provided because the attorney does not understand the data's importance to the forensic specialist.

More specifically, it is not unusual for material to be withheld in violence-risk evaluations. This, however, can compromise the examiner's ability to conduct a reliable and valid assessment because of the importance of records, particularly those regarding the examinee's mental health and criminal history. Irrespective of the attorney's underlying reasons for not providing the examiner with relevant sources of information, it is incumbent upon forensic professionals to explain to the attorney why the data are important to the assessment and its influence on their opinions, or whether they can even perform the forensic evaluation.

There are many instances when forensic specialists do not have access to all the relevant sources of information, independent of the attorney's restrictions, for example, situations when the records cannot be located or third parties do not return telephone calls. Regardless of whether the attorney played a role in the limitation of data, forensic specialists have a professional and ethical duty to acknowledge in their report and testimony how this affected the scope and certainty of their opinions.

ATTORNEYS' AND OTHERS' INFLUENCE ON THE RETAINED EXPERT

Two major sources of potential bias are the influence of others and the personal biases of the forensic expert. Attorneys may attempt to influence the forensic professional's opinions by controlling the expert's access to data sources. Attorneys can also select experts whom they believe will submit a positive opinion for their side. Often, these strategies reflect attorneys' ethical duty to be an advocate for their client and present the most favorable evidence. Given the adversarial nature of the criminal-justice system, attorneys' allegiance and advocacy can be evidenced in their behavior regarding the expert, which can range from subtle suggestion to overt coercion (Gutheil, Commons, and Miller 2001). For example, an attorney presents the facts of the case to the forensic professional in a way that may influence the expert to accept the attorney's position, or the attorney plays on the expert's ego by being complimentary and solicitous. At the other extreme, an attorney may go so far as to threaten to tarnish the expert's reputation to others or file a complaint to the expert's professional board if an unfavorable opinion is rendered.

Another means by which an attorney can influence experts is by telling them that they are a part of the team. This may create a sense of loyalty wherein experts would be reluctant to disappoint the team, or they may believe that they have a vested interest in the outcome. This is particularly true when there is the lure of financial incentives (for example, future work).

The expert's subjectivity can also be exploited. For example, attorneys might emphasize issues in the case that are important to the expert, such as the welfare of the examinee or the safety of the community. This tactic is not unusual and may be appropriate given the nature of attorneys' advocacy for the side they represent.

Sometimes attorneys do not have to engage in tactics to influence the expert because they have retained someone who is already biased. Biased forensic experts exist across many professional disciplines and are often perceived by others, including attorneys and judges, as "hired guns." Unfortunately, experts' inclination to favor the side that retains them may result in a form of advocacy that compromises the credibility of their evaluation and opinions. A field study by Murrie et al. (2013) was conducted on forensic mental-health professionals (predominantly psychologists) scoring risk-assessment instruments (PCL-R and Static-99R) for Sexually Violent Predator commitments. Prior to their review of the case and scoring the instruments, the mental-health professionals were led to believe that they were part of a team consulting for either the defense or the prosecution. The study found that their risk-assessment scores reflected the side that retained them, despite the fact that the same cases were used by both groups. This allegiance was not attributed to any chance or preexisting differences between the groups or to any manipulation by the confederate who acted as the defense or prosecuting attorney. Rather, it appeared to be the result of "adversarial allegiance."

Forensic specialists are not part of the legal team; they are independent consultants. As such, they should be cognizant of "allegiance" and guard against compromising their identity and role as professionals practicing independently and with integrity in an objective forensic science.

Not all violence-risk assessments are initiated by attorneys in judicial matters. Forensic professionals' expertise can be enlisted by organizations where they are employed, such as psychiatric hospitals and governmental agencies (e.g., Veterans' Affairs, county or state departments of health/mental health, county law-enforcement agencies, jails, and prisons). In these cases, issues of the examinee's welfare as well as the organization's needs (maintaining order, upholding legal standards, employee/community safety) are in play. It

is imperative that the forensic specialist be a neutral examiner and resolve any conflicts of interest. Allegiance to either side (clients or employees versus the organization) jeopardizes the integrity of the evaluation. Clearly, it is best that forensic specialists avoid multiple relationships and not evaluate anyone with whom they have or had a professional relationship. The same pressure and influence exerted on the forensic specialist by attorneys can be applied by these agencies as well, who may have their own agendas regarding the examinee. Indeed, there may be even more pressure because of the employment status of the examiner.

THE EXPERT'S SUBJECTIVE BIAS

In addition to the biases that expert witnesses are believed to have because of the attorney's influence or their remuneration, there can be bias within the character of the expert. Such bias can be a product of professional training, personal beliefs and reactions, historical background, and personality characteristics. In the context of violence-risk assessment, it is important to recognize how the personal biases of forensic professionals affect their opinions related to the individual's civil-liberty rights and the safety of the community. There are many factors that may elicit these biases.

Therapeutically oriented clinicians may have a difficult time limiting their bias when conducting forensic evaluations. Seymour Pollack (1982, 29), one of the pioneers of modern forensic psychiatry, wrote: "This bias acts both covertly and overtly to subvert the objective and impartial application of psychiatry to the purposes of justice." The desire to help the examinee influences forensic examiners in arriving at an opinion that they believe is protective of the individual. This may be most apparent in a death-penalty case or one that carries a lengthy sentence. In addition, a therapeutic orientation is often accompanied by an empathic approach, which, as discussed earlier, might encourage the examinee to be more disclosing and possibly reveal potentially damaging material that otherwise might not have been divulged. In addition, the therapeutically oriented examiner may be more inclined to find a way in which the examinee can receive treatment, sometimes, perhaps, at the cost of the individual's liberty. For instance, the forensic specialist may apply liberally the standard for competency to stand trial so that the defendant with a mental illness is placed and treated in a mental-health facility, even in cases where legal exoneration for the alleged offense is likely. Therapeutically oriented forensic

professionals can also confuse the examinee as to the actual role of the examiner (therapist or forensic evaluator).

Not all forensic mental-health professionals are therapeutically biased. Some may have a "prosecution" orientation, which carries over to influence their opinions, applied either generally or to specific individuals. In these cases, the examiner may be more condemning of the individual's behavior rather than excusatory. For example, the examiner may be suspicious of and judgmental against individuals who minimize their criminal history, or the examiner may have a negative reaction to those who have committed serious sexual offenses or offenses that include horrifically brutal behavior.

Both types of "orientations" (defense and prosecution) can also reflect the political or ideological preferences of the expert. Those who seem to emphasize the interests of the individual over the community may be more liberal than those who are more socially conservative and inclined to favor community safety.

Personal experiences also have the power to color an examiner's opinions. Examiners who were crime victims may be susceptible to bias against the criminal defendant, particularly if the defendant is charged with offenses involving physical harm. Moreover, forensic clinicians who have encountered aggression by a previous examinee may have enduring emotional reactivity. A study by Leavitt et al. (2006) involved sending to a group of forensic psychologists and psychiatrists in Massachusetts a questionnaire focusing on their professional experience with threats, acts of harassment or intimidation, and acts of physical aggression. Of the 54 percent who responded (85 percent were psychologists), 85 percent of the forensic clinicians had been harassed or intimidated, 65 percent had been threatened, and almost 50 percent had experienced actual physical aggression. There was no difference of aggression regardless of whether the acts occurred in the respondents' forensic or nonforensic practice. The emotional recovery for about a third of the respondents lasted from several hours to several months, and many employed subsequent safety precautions in their practice and with respect to their home address and telephone number.

The emotional reactions clinicians have to being a target of aggression or violence by a forensic examinee or others can be serious and long lasting (Anderson and West 2011, OSHA 2004). Thus, the possibility exists that forensic professionals who have been threatened or assaulted may not approach the forensic evaluation with the necessary objectivity. However, an examiner's

subjectivity is not limited to forensic professionals who have been victims; it may manifest based merely on the circumstances of the case.

When conducting a violence-risk assessment, it is likely that the examinee engaged in some type of harmful behavior, which may evoke within the examiner feelings of fear or outrage. Or the case may involve an examinee who strongly endorses hate toward people who belong to "protected classes," such as minorities, religions, or ethnicities. Although the negative emotional reactions by the forensic examiner may be understandable, it is also possible that they will result in an implicitly biased evaluation that is not well supported. An example could be an evaluation that relies only on risk factors and excludes consideration of protective factors.

Another set of biases that may arise in risk assessments are those related to the examiner's inclination to avoid a personally negative outcome. Political and community pressure may be an influencing source. For instance, the potential release of a person committed as a sexually violent predator from a locked treatment facility to the community can arouse much publicity and negative response. Although the forensic professional should not be swayed by such reactions, high-profile cases of any type may induce the expert to offer an opinion of a moderate to high risk of violence rather than low or no risk, which could result in controversy impugning the examiner's reputation. In addition, the fear of a potential civil-liability lawsuit can influence the expert's opinion. That is, the forensic specialist may be disposed to submit an opinion that the examinee is more likely than not to harm others in order to take a prophylactic measure against possible liability for an inaccurate risk assessment in case the examinee were to engage in any future violence.

It would be naïve to assume that forensic specialists are immune to bias. Ethical concerns, however, emerge when psychologists do not address the attitudes and beliefs they hold that can have a detrimental effect. The APA ethical principle "Beneficence and Malfeasance" indicates that psychologists "take care to do no harm" (APA 2010, 3). In addition, the principle "Justice" states: "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases . . . do not lead to or condone unjust practices" (APA 2010, 3–4). Ethical Standard 3.04, "Avoiding Harm," has psychologists "take reasonable steps to avoid harming their clients/patients . . . and to minimize harm where it is foreseeable and unavoidable" (APA 2010, 6). Although Ethical Standard 3.06, "Conflict of Interest," indicates that psychologists refrain from engaging in professional behavior when their objectivity is impaired, the

APA Ethics Code also recognizes that psychologists may not always be aware of the issues that could interfere with the performance of their professional work. Consequently, psychologists should be more finely attuned to their potential for subjective findings and opinions and may well seek consultation or assistance (with confidentiality preserved) in regard to performing their evaluation competently and properly. Bias is also addressed under Forensic Guideline 1.02, "Impartiality and Fairness," wherein forensic psychologists "strive to be unbiased and impartial" (APA 2013, 9).

Another consideration that can skew forensic psychologists' opinions is their competence, both in terms of risk assessment and familiarity with the examinee's culture. The APA Ethics Code and Forensic Psychology Guidelines stress that psychologists perform their professional work within the boundaries or scope of their competence. When conducting a violence-risk assessment, forensic psychologists must have not only the training, knowledge, and experience in conducting these evaluations—and must continue to maintain their competencies—but they must also have an understanding of how the examinee's race, ethnicity, and culture (among other factors) may affect risk assessment (Ethical Standards 2.01, 2.03; Forensic Guidelines 2.02, 2.08).

GUIDELINES FOR ETHICAL FORENSIC RISK ASSESSMENTS

One of the most important elements in the American court system is the credibility of the expert witness. This can be viewed in terms of the expert's trustworthiness and knowledge (Wechsler et al. 2015). Credibility is also enhanced if experts communicate their knowledge meaningfully and honestly. This includes the ability to describe technical and complicated information in an understandable way to a layperson. Therefore, it is vital that forensic professionals have the competence to perform and interpret violence-risk assessments, which can be highly complicated and confusing.

As noted earlier, the APA Ethics Code holds that psychologists should practice only in areas where they are competent and not exceed the boundaries of their competence (Ethical Standard 2.01). Moreover, the Forensic Psychology Guidelines state that forensic psychologists properly represent their competencies to all recipients of their services (Forensic Guideline 2.03).

As mentioned previously, biases and attitudes can affect the competence and ultimately the trustworthiness of the expert. Thus, in comportment with

Forensic Guideline 2.07, forensic psychologists "may take steps to correct or limit such effects, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations" (APA 2013, 10). Increasing one's awareness of biases can be accomplished by consulting with colleagues, continuing education and training, being introspective about one's biases, and learning how others successfully manage their biases (Neal and Brodsky 2016).

AVOID ONE-SIDED RISK ASSESSMENTS

Attention must be paid to the manner in which violence risk is assessed. Often, the evaluation focuses on static risk factors. A comprehensive and ethical assessment must evaluate all relevant factors, not just static risk factors. Among these are protective factors and moderator and mediating effects, which can include the influence of one's culture or ethnicity (Rogers 2000, Roychowdhury and Adshead 2014). Recognizing the examinee's strengths reflects a more thorough evaluation and respects the individual's dignity.

CONDUCT RISK ASSESSMENTS THAT ARE RELIABLE AND VALID

Both the APA Ethics Code (Ethical Standard 9.02) and the Forensic Psychology Guidelines (Forensic Guideline 10.02) state that "Psychologists [Forensic practitioners] use assessment instruments whose validity and reliability have been established for use with members of the population tested [assessed]. When such validity or [and] reliability has [have] not been established, psychologists [forensic practitioners consider and] describe the strengths and limitations of test results and interpretation [their findings]" (APA 2010, 12; 2013, 15). Using accepted methods in data collection increases the reliability of the information considered. This includes checklists, techniques, and other data-gathering methods that have been researched and vetted by forensic psychologists. Moreover, forensic psychologists must be aware of their jurisdiction's laws (statutes and case law) and whether these address how the risk assessment should be conducted.

INCLUDE EXAMINEE'S INPUT

Another important aspect is the consideration of the examinee's input to the assessment process. Information and data contributed by the examinee that may support reduced risk should be considered by the forensic psychologist. In

addition, the examinee should be given feedback about the assessment results, unless the forensic psychologist is prevented from disclosing this information (for example, an organization using risk assessment for security screenings), in which case the person should be informed of this preclusion in advance (Ethical Standard 9.10, Forensic Guideline 10.05). These concerns of ethics acknowledge the examinee's involvement and personhood as well as contribute to a more balanced, informed, and objective assessment approach.

PROVIDE RATIONALE FOR OPINIONS

Forensic mental-health reports often include the clinical data addressing the psychological-legal issues and the expert's opinions. Frequently, however, little or no reasoning is included in the report as to how the forensic clinician derived the opinions (that is, the logical link between the data and their relevance to the opinions). Elucidating the relation of the data to the opinions is critical; indeed, it could be argued that this reasoning is more important than the opinions. Forensic Guideline 11.04, "Comprehensive and Accurate Presentation of Opinions in Reports and Testimony," addresses the importance of providing the reasoning underlying the forensic psychologist's opinions (APA 2013). The reasonableness as well as the certainty of the psychological-legal opinions are based not solely on meaningful data (e.g., accurate, unbiased, sufficient, corroborated, and relevant) but on reasoning that is argued soundly. Throughout the Forensic Psychology Guidelines, there are statements on how forensic psychologists should handle limitations or concerns regarding the data; these include forensic psychologists explaining what effect this has in relation to their reasoning and opinions. This is not only practice guided by ethics; it also increases the credibility of the examiner and his or her evaluation and opinions.

The reasoning process should also take into account the consideration of alternative possibilities—one of the most important approaches in conducting an ethical forensic mental-health evaluation. Seymour Pollack (1982, 42) compared this forensic approach to that of "the medical tradition of differential diagnosis, a clinical approach in which various medical possibilities are considered and evaluated, and all other judgments are set aside in favor of the clinical judgment that holds the highest level of confidence." By using this approach, forensic specialists expose their reasoning in how they considered other interpretations and arrived at their final opinions. In addition, this process of reasoning can uncover and resolve any issues that may weaken the final

opinions. The use of alternative hypotheses is addressed in Forensic Guideline 9.01: "When performing examinations, treatment, consultation . . . forensic practitioners seek to maintain integrity by examining the issue or problem at hand from all reasonable perspectives and seek information that will differentially test plausible rival hypotheses" (APA 2013, 14–15). This method also better prepares the forensic professional for cross-examination.

The opinion making involved in violence-risk assessment requires the consideration of many factors and well-reasoned opinions. Consequently, the process should not be rushed; nor should it rely on limited data. Quick and easy assessment approaches are not recommended, given the ramifications to both the examinee and the community.

CONCLUSIONS

The assessment of risk of violence is fraught with ethics concerns, not only because of the potential ramifications for the individual and society but because of confounding elements related to the process itself (bias, intentional limitation of access to data, and pressure exerted by external sources). Forensic professionals should be aware of how such influences, which have no relation to risk assessment, can affect their clinical findings and forensic opinions.

The type of violence risk–assessment approach used by forensic professionals is another important issue to consider. Forensic specialists have an ethical and professional obligation to be familiar with and remain knowledgeable about current research findings in their areas of practice. The categorization of "best-practice" methods is evolutionary, particularly in violence-risk assessment. Presently, SPJ is viewed as the most balanced, reliable, valid, and generalizable approach as well as the most sensitive to concerns of ethics (Roychowdhury and Adshead 2014). Among other issues, SPJ requires that the examiner's decision making be explained; this forces the clinician to link data with opinions. In addition, the items included in SPJ tools rely heavily on scientific research and the professional and legal literature; consequently, the factors that support risk of violence can change and should be updated (Guy, Packer, and Warnken 2012). Such characteristics contribute to its attributes of science and ethics.

Forensic professionals practice in a specialty that can arouse controversy. Assessing risk of violence may prompt even more reaction and debate, thus

reminding us of our obligation to base our professional practice and expertise on sound principles, scientific knowledge, and ethical conduct.

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19

FORENSIC-ETHICS CHALLENGES IN THE PSYCHIATRIC TREATMENT OF CHILDREN

Thomas J. McMahon and Christy Olezeski

DESPITE ADVANCES IN SOCIAL and economic policy designed to limit the adverse effects of poverty on the well-being of children, more than 14 million children in the United States continue to live in poverty as the consequences of the Great Recession persist (Proctor, Semega, and Kollar 2016). A report from the U.S. Census Bureau recently prepared by Proctor, Semega, and Kollar (2016) indicated that, although the economic status of the low-income American family is slowly improving, almost 20 percent of the population under eighteen years of age lives in poverty. Overlapping populations of children with specific demographic characteristics seem to incur the greatest risk. Generally, children living in the southern region of the country, children living in the inner city, and children living in rural areas are more likely to be affected. Children of African American, Hispanic, and Native American heritage are at greater risk than children of European and Asian heritage, and children living in a household headed by a single female parent, foreign-born children, children with a disabled parent, and children living with a parent who did not graduate from high school are also more likely to be living in poverty (Proctor, Semega, and Kollar 2016).

Children living in poverty referred for psychiatric evaluation of emotional-behavioral difficulty typically enter the publicly funded system of care with a configuration of short- and long-term threats to their physical and psychological health (Pascoe et al. 2016). Concentrated in rural and urban settings plagued by a complex array of social problems (Pascoe et al. 2016; Proctor, Semega, and Kollar 2016), children seeking psychiatric services in the public sector typically live in fragile family systems. Data from the Comprehensive Community Mental Health Services for Children and Their Families Program (USDHHS 2013) and other federal initiatives characterize the children

being referred to the publicly funded system of care. Although most children are in the custody of a biological relative, typically their biological mother, relatively few are living with both biological parents. A significant number of children are separated from both their biological parents. Regardless of whom they live with, children referred for psychiatric services frequently come with a family history of psychiatric and substance-use problems and exposure to an average of four to seven traumatic life events. Exposure to emotional, physical, and sexual abuse is common. Exposure to physical, emotional, educational, and medical neglect tends to be even more common.

Federal data (USDHHS 2006) also suggest that, diagnostically, internalizing difficulty, characterized by anxiety, depression, and somatic preoccupation, appears to be as common as externalizing difficulty, characterized by angry affect, oppositional-defiant behavior, hyperactivity, aggressive behavior, and conduct problems. Many children present with both the internalizing and externalizing difficulty that some researchers (e.g., D'Andrea et al. 2012) characterize as the sequelae of repeated exposure to the interpersonal trauma so common within this population. Suicidal thoughts, deliberate self-harm, and suicidal behavior are common. Although most typically present with low-average to average intelligence, children with attentional problems, specific learning problems, intellectual disability, and autism-spectrum disorders are disproportionately represented in the publicly funded system of care. Problems with school attendance, academic performance, and classroom behavior are very common. Children entering this system of care also present with disproportionately higher rates of asthma, allergy, and obesity. Running away, substance use, early sexual activity, and legal offenses are not unusual among these adolescents (USDHHS 2006). Given this configuration of challenges, it is not surprising that children seeking psychiatric care in the public sector are also usually involved with pediatric, special education, child welfare, family court, juvenile justice, or other human-service systems (Masi and Cooper 2006, Stagman and Cooper 2010).

FORENSIC-ETHICS CHALLENGES IN CLINICAL PRACTICE WITH CHILDREN

For clinicians working in the public sector, forensic-ethics challenges involve questions about ethical practice with children at the interface of clinical and legal or quasi-legal systems. Although clinical work with children always

involves some generic ethical issues arising from the status of children as minors (Ascherman and Rubin 2008, Belitz and Bailey 2009), service delivery to children living in poverty can involve some specific, complex ethical questions that emerge from their concurrent involvement in systems of care governed by complex codes of law and regulation. Moreover, children receiving psychiatric services in the public sector are, as noted above, typically living in fragile family situations where parental capacity to provide for the care of children is often compromised by unstable sexual partnerships, substance abuse, psychiatric difficulty, legal problems, economic stress, and related problems. Frequently, ethical dilemmas occurring at the interface of these human-service systems are further complicated by questions about the authority and capacity of an adult to act in the best interests of a child as a legal guardian.

When working with this population of vulnerable children, it is inevitable that clinicians will face ethical challenges involving forensic issues. Although professionals writing about the ethics of clinical practice (e.g., Greenberg and Shuman 1997, 2007; Strasburger, Gutheil, and Brodsky 1997) frequently distinguish between clinical and forensic roles, the boundary between the two concepts can, under some circumstances, become somewhat blurred. When this occurs, clinicians must have a conceptual framework to guide decision making so that, when they interface with other systems, they can function effectively in a clinical role without being drawn into an inappropriate forensic role (Greenberg and Shuman 1997, 2007; Strasburger, Gutheil, and Brodsky 1997). Consequently, the goal of this chapter is to examine forensic ethics from the perspective of professionals providing clinical services to children whose emotional-behavioral difficulties are likely to be complicated by the social problems commonly associated with poverty.

Drawing upon our experience administering outpatient psychiatric services to children in an academically affiliated community mental-health center, we outline fictionalized clinical vignettes of real ethical dilemmas to illustrate some of the ways professionals may encounter questions about forensic ethics in a clinical setting. Drawing upon ethical guidelines, the ethics literature, and practice parameters, we then outline some conceptual issues for professionals working with children to consider when faced with ethical challenges involving forensic issues, and we propose some potential solutions to the challenges outlined in some of our clinical vignettes. Finally, we conclude the discussion by proposing that professionals who work with vulnerable children in

a publicly funded setting must cautiously adopt a forensically oriented, child-centered approach to service delivery that allows them to advance, with caution, the best interests of children across systems of care.

CLINICAL VIGNETTES OF ETHICAL DILEMMAS INVOLVING THE LEGAL DIMENSIONS OF PRACTICE

CASE 1

A maternal grandmother requests a psychiatric evaluation of her fourteen-year-old granddaughter, who has been living with her for more than two years. Although the grandmother indicated that she is the child's legal guardian at the time of referral, careful review during an initial appointment indicates that her guardianship was never established in dependency or probate court. The child's biological mother has a chronic, recurrent substance-use disorder, and her whereabouts are unknown. From the information provided by the grandmother, the biological mother appears to be the child's legal guardian. The child's biological father is reportedly incarcerated in another state, and as best as it can be determined, paternity was never established. The child is arguing with teachers and fighting physically with peers in school. She has been suspended from school twice in the previous sixty days, and the principal is threatening to expel her if she cannot control herself in school. The child requested that her grandmother secure her counseling so she can talk about the anger she has toward her parents for abandoning her. She appears to be appropriately concerned that she will harm a peer seriously in a fight if she does not get her temper under control. The clinician finds the program director and asks whether the clinic should somehow admit the child or defer her admission until the grandmother establishes legal guardianship through dependency or probate court.

CASE 2

During the psychiatric evaluation of a nine-year-old boy, his biological mother informs a clinician that, although they were not married, a previous boyfriend was listed as the child's biological father on his birth certificate, but he is not presently interested in being involved in the boy's psychiatric assessment and treatment. When the clinician asks for contact information for the biological father, the mother refuses, indicating that she does not want him involved even if he is willing to do so. She insists that her new boyfriend of several months be involved as a surrogate father and threatens to end the evaluation if the clinician insists on contacting the biological

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father. When interviewed alone, the boy indicates he last saw his biological father during the previous school year. He indicates that he misses his biological father and has not seen him since his parents had a fight over child support. He also indicates that he does not feel very close to his mother's new boyfriend, who, from the boy's perspective, is always telling him what to do. When outlining the psychosocial history for the child and adolescent-treatment team at the clinic, the attending psychiatrist asks whether the clinician should honor the mother's request and proceed without contacting the biological father or insist that the biological father be included, which risks having the mother end the initial assessment.

CLINICAL VIGNETTES OF ETHICAL DILEMMAS INVOLVING COMMUNICATION WITH LEGAL AND QUASI-LEGAL SYSTEMS

CASE 3

A clinician has been working for an extended period of time in individual psychotherapy with a ten-year-old girl who has finally been removed from the care of her biological mother following substantiation of educational neglect. The child had missed more than 50 percent of the last three school years. Over more than twelve months, the clinician has carefully documented a psychological process by which the child's mother insists, in the absence of convincing evidence, that the child is too sick to be in school. The mother either keeps her home for the day or goes to the school to remove her early to keep an appointment with a physician. Over time, the mother has repeatedly outlined a long list of nonspecific medical symptoms that she believes indicate the child is ill with a number of chronic conditions. Medical records provided by the child's pediatrician and the several specialists repeatedly indicate that the child is healthy. Individual psychotherapy for mother and child, along with family therapy, have not, even in the face of close monitoring by child-protective services, contributed to substantial improvement in school attendance.

Shortly after the child's removal from her mother's care under an order of temporary custody, the caseworker and assistant attorney general representing child-protective services request a full written report of the clinic's assessment and treatment of the child for use in a petition for commitment of the child to the care of the state. They specifically request a summary that includes reference to the *DSM-5* concept of Factitious Disorder Imposed on Another, they ask for confirmation of the child's psychiatric diagnosis, and they ask for a clear statement about the prognosis for improvement if the child returns to the mother's home. They also ask the clinician to testify voluntarily at the child-welfare hearing, arguing that the clinician may be the only one who can explain the psychological process occurring

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between mother and child. When the clinician expresses concern about doing so, the assistant attorney general suggests that, if necessary, a subpoena will be issued to ensure the clinician appears in court to testify. Angry that child-protective services has taken custody of her daughter, the child's mother calls the next day to request that the clinician continue to see her child while she is in foster care, but she also asks that the clinician stop communicating with child-protective services except to schedule appointments through the foster mother. Confused by the competing demands, the clinician asks for a meeting with the program director and risk manager to determine whether the clinic is to honor the request from child-protective services or the request from the mother.

CASE 4

A thirteen-year-old boy in the custody of child-protective services living with an aunt and uncle tells his caseworker and then his clinician that he would like to visit his father in prison. The boy was removed from the care of his mother when she could no longer care for him because of the disabling effects of a chronic medical illness and her misuse of opioids prescribed for chronic pain. He was placed in relative foster care with his aunt and uncle because his father was not considered an appropriate alternate caregiver. The father's involvement in illegal activity ultimately led to his conviction and incarceration for possession of illicit drugs and stolen firearms with intent to sell. The child has been functioning well at home, in school, and in the community. In his individual psychotherapy, he has completed a trauma-focused protocol, where he has insightfully constructed a narrative that outlines the shortcomings of his parents and events leading to his removal from the care of his mother. Although not a very good role model, his father has maintained contact with him, has been writing him letters, and has been calling his son once monthly when the child is with his caseworker. The caseworker and casework supervisor are ambivalent about allowing the child to visit his father in prison. The aunt and uncle are adamantly opposed. The child has been unwavering in his desire to see his father to talk with him about some questions that emerged when constructing his trauma narrative. The child has constructed his list of questions with his clinician and insists that he wants to ask his questions in person rather than by letter or telephone. Unable to decide, the caseworker and casework supervisor ask the clinician to write a letter indicating that the clinic believes it is in the child's interest to visit his father. Aware that the adults are debating his request, the child independently asks his clinician to help him visit his father at least once. The clinician comes to a meeting of the child- and adolescent-treatment team and asks if it is appropriate to write a letter, acknowledging that doing so might alienate the aunt and uncle, who are the child's primary source of family support, but failing to do so may compromise the clinician's long-standing positive relationship with the child. Another member of the clinical team points out that, given the ambivalence of the casework staff, the content of any letter will probably determine what happens for the child.

CLINICAL VIGNETTES OF ETHICAL DILEMMAS INVOLVING A POTENTIAL CONFLICT BETWEEN CLINICAL VERSUS FORENSIC ROLES

CASE 5

The local juvenile court refers a fourteen-year-old boy for evaluation and treatment of behavioral difficulty at home and school after his father abandoned him and his mother to live with his new, pregnant girlfriend. His mother is significantly depressed and struggling financially. Ongoing problems include oppositional-defiant behavior at home and school, failing grades, truancy, and experimentation with marijuana. By state statute, the school had to report his truancy to the juvenile court, and the boy was placed in a diversionary program with monitoring by a juvenile-probation officer. The conditions of his accountability to the court specify that he secure counseling, attend school daily, stop smoking marijuana, adhere to his mother's curfew, and avoid further legal difficulty. His clinical assessment indicated that, although occurring rather early in adolescence, the child's use of marijuana may not represent anything more than normative experimentation, and he readily agreed to provide a urine sample for toxicology on a random basis if asked. Shortly after his admission to the clinic, the teen's juvenile-probation officer requested that the clinician collect a urine sample for drug screening at least once monthly and forward the results to the court. Sensitive to the potential problems, the clinician asks the program director if the clinic has a policy on conducting drug screenings when clients are involved with the juvenile-justice or child-protective systems.

CASE 6

A socially and emotionally immature seventeen-year-old girl with mild to moderate learning problems has, over an extended period of time, made significant progress in individual psychotherapy, which has focused on the development of her capacity for emotional regulation, her social skills, and her self-esteem. With the support of her mother and her school, she is preparing to graduate from high school and transfer from the Child and Adolescent Service to the Young Adult Service, where she can get continued support negotiating the demands of early adulthood. The client is excited about entering this specialized young-adult program and is expressing an interest in making new friends, beginning a vocational internship, finding a boyfriend, and learning the daily- and community-living skills she will need to move into her own apartment. Just prior to her transfer to the new program, her mother begins a family session to discuss the transfer by requesting the girl's attending psychiatrist complete a physician statement of disability for the probate court so that the mother can remain the teen's legal guardian after her eighteenth birthday.

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During the family session, the mother expresses her concern about her daughter's decision-making capacity. The client immediately becomes very angry with her clinician, expressing concern that her mother only wants to remain her guardian so that the mother is not left alone when the teen moves to her own apartment to begin her life as a young adult. Sensitive to the potential for alienating the mother if they document that the child does not need a conservator of person or alienating the child if they document that the child does need a conservator of person—or alienating both mother and child because they refuse to offer an opinion—the primary clinician and attending psychiatrist seek consultation from both the ethics committee and the legal-affairs group.

CLINICAL VIGNETTE OF ETHICAL DILEMMAS INVOLVING QUESTIONS OF SOCIAL JUSTICE

CASE 7

During a child and adolescent treatment team meeting, a clinician presents the psychosocial history of a four-year-old Hispanic boy referred to the clinic by a family-service worker at a school-readiness program for low-income children because of aggressive behavior directed at teachers and peers. The administrator of the program and many of the teachers believe the child's temper outbursts leave others at risk for serious injury. When reviewing the clinical history, the clinician indicates that the family-service worker reported the administrator intends to expel the child from the program permanently if there is another angry outburst. During the initial assessment, the child's biological father and primary caregiver indicated that the temper outbursts began several months ago after the child's mother returned to Latin America because her work visa expired and then called the family to inform them that she did not intend to return. According to the father, the angry outbursts only occur at school.

Following the case presentation, two other clinicians immediately comment that they had boys of ethnic-minority heritage expelled from the program under similar circumstances during the previous school year. The program director wonders aloud what the threatened expulsion of this little boy means in the context of a report recently released by a child-advocacy group indicating that African American and Hispanic boys are being disproportionately excluded from school-readiness programs throughout the state. Another clinician mentions a research report recently published in a prestigious medical journal by a faculty member at a nearby university documenting a national trend in the expulsion of boys from publicly funded preschool programs, particularly boys of African American and Hispanic heritage. The clinician working with the client asks what the clinical program is obligated to do.

FOUR TYPES OF FORENSIC-ETHICS CHALLENGES

When considering the broad range of ethical challenges involving forensic issues, there seem to be at least four types of situations that professionals working with children in the public sector may encounter: (1) situations involving the legal dimensions of clinical practice, (2) situations involving the interface between clinical and other systems of care, (3) situations involving clear conflicts between a clinical and a forensic role, and (4) situations involving questions about social justice. Situations involving the legal dimensions of clinical practice (cases 1 and 2) concern what the legal system says about the parameters of clinical practice. Situations involving the interface of clinical and other systems of care (cases 3 and 4) most often involve questions about ways a professional should collaborate with legal and quasi-legal systems while providing clinical services. Situations involving a potential conflict between a clinical and a forensic role (cases 5 and 6) frequently involve requests from other systems that may require that a professional move from a clinical into a forensic role with the same child, and questions of social justice (case 7) involve situations where there may be an ethical mandate for a professional to consider how to invoke other systems to address a social injustice affecting not only a specific child but a specific class of children.

RESOLVING ETHICAL CHALLENGES INVOLVING FORENSIC ISSUES

Although broad conceptual models of ethical decision making may prove helpful in the resolution of ethical challenges involving forensic matters, there are some specific factors for professionals to consider when resolving ethical challenges involving forensic themes. Broadly, these issues involve the need to (1) distinguish clinical from forensic roles, (2) understand the difference between clinical and forensic ethics, (3) clarify ethical obligations to children and other interested parties, (4) represent the perspective of the child in decisions being made in other systems of care, (5) understand the concept of a forensically oriented clinical provider with sensitivity to the limits of that position, and (6) address issues involving social injustice. However, this list of considerations is not meant to be exhaustive. It is simply intended to highlight the need for the professions to clarify some ethical principles to guide clinicians who work with children in settings where it is inevitable that ethical challenges involving forensic issues will emerge.

CLINICAL VERSUS FORENSIC ROLES WITH CHILDREN

Repeatedly, scholars (e.g., Greenberg and Shuman 1997, 2007; Shuman et al. 1998; Strasburger, Gutheil, and Brodsky 1997) have written about the difference between clinical and forensic roles in the delivery of psychiatric services, usually advising professionals with a clinical role to avoid being drawn into a forensic role with the same client. Generally, they argue that a clinical role usually involves providing evaluation and treatment to a client within a professional relationship, while a forensic role usually involves providing professional expertise to a legal or quasi-legal system. More than twenty years ago, Greenberg and Shuman (1997) outlined ways in which clinical work and forensic work differ highlighting four general considerations: (1) the definition of client, (2) the legal right to confidentiality, (3) the nature of the relationship with the client, and (4) the general approach to the work. Clinicians considering requests to confound clinical and forensic roles will undoubtedly find it helpful to understand clearly how the two approaches to service delivery differ.

Despite consistent warnings about potential conflicts, most scholars (e.g., Strasburger, Gutheil, and Brodsky 1997) acknowledge there are times when the boundary between the two positions becomes blurred, and some of them (e.g., Greenberg and Gould 2001, Greenberg et al. 2004) have begun to outline the principles of forensically oriented clinical practice for professionals who provide clinical services to children with concurrent involvement with a legal or quasi-legal system of care, like the family-court system and the child-welfare system. This group of scholars (e.g., Greenberg and Gould 2001, Greenberg et al. 2004) has taken the position that it is useful to distinguish clinical care from clinical care *provided in the context of a legal or quasi-legal process*, and they (e.g., Greenberg and Gould 2001) have argued that professionals working with children involved with these other systems of care must be prepared to practice strategically with a clear understanding of the legal context, clear definition of their professional role to everyone involved, and proactive consideration of any limits to be imposed on information provided to the other systems. Greenberg and Shuman (2007) note that support for forensically oriented clinical practice evolves not just from practical need but also from the distinction drawn in federal guidelines for civil proceedings between a forensic expert, who has no clinical relationship with the child, and a clinical expert, who does have a clinical relationship with the child. They argue that, although subtle, the distinction is important for clinicians working with children in a legal or quasi-legal context to understand.

Building upon conceptual distinctions in the definition of clinical versus forensic roles, professional guilds have begun to outline standards of practice for circumstances where ethical dilemmas may occur. Increasingly, these guidelines for ethical practice distinguish between forensic practice with children (APA 2010, 2013; Association of Family and Conciliation Courts 2006; Bernet 1997; Herman 1997; Kraus and Thomas 2011), clinical practice with children within the legal system (APA 2012; Association of Family and Conciliation Courts 2002, 2005, 2012; Greenberg et al. 2004; Penn and Thomas 2005), and clinical practice outside the legal system with children involved with a legal or quasi-legal system (Association of Family and Conciliation Courts 2010; Lee, Fouras, and Brown 2015). When considering the situation outlined in case 3, the professional involved should, according to practice guidelines outlined by the Association of Family and Conciliation Courts (2010), have only pursued clinical assessment and treatment of a child involved in a contentious child-welfare proceeding with a full understanding of the legal context, an a priori definition of professional role, an awareness of the ways the legal proceeding might influence the clinical process, and an agreement about limits on the information to be provided to the court. Under circumstances like this, the professional may have no choice but to provide testimony if called by subpoena to serve as a clinical expert in the child-welfare proceeding, particularly if the professional is practicing in a jurisdiction where the courts have ruled that, when in conflict, the interest of the state in protecting the well-being of children supersedes the right of the child and parent to confidentiality. However, even if court testimony under similar circumstances may not be avoidable, clinicians providing clinical services to children involved in a legal proceeding can, as Greenberg and Gould (2001) suggested, minimize risk to undermine the delivery of a child's clinical services if they understand that they may be called to court as a clinical expert and adequately prepare themselves and everyone involved for that possibility.

CLINICAL VERSUS FORENSIC ETHICS

Over the years, scholars from several professions (e.g., Ratner 2002) have acknowledged that the ethical foundations for clinical versus forensic work differ in important ways, but many clinicians may not understand that the ethics that guide clinical practice differ significantly from the ethics that guide forensic practice. Generally, the ethics of clinical practice are defined by values involving responsibility to do good, responsibility to do no harm, obligation to

the individual, fairness between individuals, and respect for the individual. In the clinical context, the professional's relationship with the client and the professional's obligations to the client are the cornerstones of ethical decision making (Ratner 2002). Conversely, the ethics of forensic practice are guided by values involving the pursuit of truth, respect for the individual, honesty, objectivity, cultural sensitivity, and promotion of justice (AAPL 2005, APA 2013, Appelbaum 1997, Griffith 1998). In the forensic context, the professional's obligations to the legal process, rather than to the client, are the cornerstones of ethical decision making. Although scholars have noted that the conceptual basis may be similar, they (e.g., Koocher and Kinscherff 2016) have also noted that the ethics of forensic practice with children can differ in important ways from the ethics of forensic practice with adults.

WHO IS THE CLIENT?

As noted above, clinical, but not forensic, ethics are grounded in the context of a professional relationship with a client. Historically, scholars (e.g., Nagy 2005) have argued that the client must be clearly delineated in delivery of clinical services. However, conceptualization of the professional-client relationship can vary depending on the nature of the service and the context within which it is being delivered (Fisher 2009). As might be expected, several authors (e.g., Fisher 2009, Koocher and Daniel 2012) have noted that questions about the definition of client become even more complicated when professionals provide clinical services to children because services are almost always delivered to children at the request of a third party, most often a primary caregiver, who also participates and maintains a stake in the outcome of the process. Often, more than one third party, for example, an attorney, may participate and maintain an interest in the outcome of the process. Consequently, it is important to note that although many professionals agree that the child is the client in many systems of care, there is not agreement that the child is the *only* client (Fisher 2009). Several scholars writing about professional ethics (e.g., Koocher and Daniel 2012) have argued that it is useful to think of the child as the client in a context involving other people to whom the clinician may have some ethical obligations.

As noted previously (McMahon 1993), questions concerning definition of client may only become problematic when the interests of a child receiving clinical services conflict with the interests of another person. Although everyone involved may assume that they are working collaboratively on behalf of

the child, conceptualization of the professional-client relationship may become of the utmost importance when the interests of the child are at odds with the interests of someone else. Although scholars (e.g., Fisher 2009, Koocher and Daniel 2012) have suggested it is useful for professionals to clarify their obligations to everyone involved in the life of a child proactively, there will inevitably be situations where clinicians working with vulnerable children will be forced to identify, for everyone involved, the client whose interests they are, first and foremost, obligated to advance. When confronted with ethical challenges involving forensic issues, it may, as most ethical codes require, also be helpful for clinicians to clarify the rights and responsibilities of everyone involved. As McMahon (1993) suggested, it may be important when doing so to note that rights usually come with complimentary responsibilities. Even when considering the rights of children, they also have complimentary responsibilities consistent with their level of developmental maturity.

When resolving ethical challenges, clinicians should clarify, as best they can, the rights and responsibilities of all interested parties, acknowledging that they are not necessarily obligated to balance the interests of everyone involved. Doing so may simply mean considering some conceptualization of the child's rights and responsibilities in the context of the rights and responsibilities of everyone else when outlining the ethical obligation that the clinician has to represent the interests of a child in a complicated situation. For example, the mother in case 6 undoubtedly has the right, and perhaps even a responsibility as the parent of a child with emotional and learning problems, to seek an extension of her guardianship through the probate court. Similarly, the administrator of the school-readiness program mentioned in case 7 undoubtedly has the right, and perhaps even a responsibility to the teachers and other students, to pursue expulsion of a child when there is significant risk of physical or psychological harm to others.

ON BEHALF OF CHILDREN: WHO SPEAKS FOR THE CHILD?

In clinical work with vulnerable children of all ages there is an important distinction in the approach of the professional, derived from the difference between the legal concepts of action *in* behalf of a client versus action *on* behalf of a client (McMahon, 1993). Legally, those who act *in* behalf of another act independently in the best interests of the individual, without any defined obligation to consult with the person they represent. Conversely, those who act *on* behalf of another act collaboratively to represent the best interests of the

individual with a defined obligation to consult with the person they represent. To act on, rather than in, behalf of children, professionals must acknowledge that, consistent with values outlined in the UN Convention on the Rights of Children, children have the right to participate in decision-making processes that will affect their lives, even if they do not have the competence and authority to make the final decision (Melton 1987a, 1987b). Building upon values outlined by some policy analysts (e.g., Melton 1987a, 1987b, 1999, 2005), McMahon (1993) argued that acknowledgment of the child's right to participate means that the clinician may have an ethical obligation to represent the voice of the child in institutional proceedings that do not always fully acknowledge the perspective of the child because there is an assumption that the adults involved know best. To do so, professionals must actively elicit the opinion of children in a manner sensitive to their level of developmental maturity and listen seriously to their ideas about what they believe is best for themselves.

Serious consideration of children's right to have a voice also means that, at times, it may be appropriate, if not necessary, for a clinician to represent the perspective of the child across systems of care, particularly when other adults are not able, willing, or available to do so. Some ethical challenges involving forensic issues may require that the clinician judiciously represent the perspective of the child in a legal or quasi-legal proceeding. For example, it may be appropriate in the context of ongoing conflict among the adults involved for the clinician mentioned in case 4 to give voice to the child's interest in seeing his father by providing the child-welfare system with documentation of his consistent interest in doing so in a way that might help him further clarify his family narrative, perhaps with a recommendation that the dependency court seek an independent forensic evaluation if the matter cannot be resolved in a manner acceptable to everyone involved.

COMPETENCE

As professionals have begun writing about the reconciliation of clinical and forensic roles under some circumstances, they (e.g., Greenberg and Gould 2001) have also begun to argue that clinicians need to develop the competence to think both clinically and forensically when delivering psychiatric services to children involved with legal or quasi-legal proceedings. Consistent with this, practice parameters that are being developed for clinicians working with children involved in a legal process specify that clinicians have an ethical

obligation to develop the competence to do so. For example, guidelines for the delivery of clinical services to children recently established by the Association of Family and Conciliation Courts (2010) specify that professionals must develop and maintain sufficient competence to function effectively in the clinical roles they assume with children involved in family-court and child-welfare proceedings. Moreover, the guidelines specify that competence to work with this population of children does not just evolve out of clinical experience. It must involve formal training in standards of clinical versus forensic practice, relevant research, applicable law and regulation, and the structure and operation of the legal system. Clinicians working with vulnerable children in the public sector should also proactively clarify their access to legal, ethical, administrative, and clinical consultation from professionals familiar with the systems they interface with on a regular basis because, as competent as they may be, it is inevitable they will encounter situations where they will need assistance sorting through some exceedingly complicated situation.

Returning to the clinical vignettes, clinicians working in the setting from which they were drawn would clearly need to be familiar with the child-welfare, special-education, juvenile-justice, and probate-court systems to resolve successfully the ethical dilemmas outlined in cases 3 through 7. As the guidelines established by the Association of Family and Conciliation Courts (2010) and the American Academy of Child and Adolescent Psychiatry (Lee, Fouras, and Brown 2015) suggest, clinicians who provide psychiatric services in settings where children are likely to be referred with ongoing involvement in legal and quasi-legal systems have an ethical obligation to understand how those systems are organized and how they operate. They also have an obligation to understand the values, principles, and regulations that govern the operation of those systems. Practice guidelines (e.g., Association of Family and Conciliation Courts 2010; Lee, Fouras, and Brown 2015) also suggest that clinicians working with a specific child in a legal or quasi-legal context must have the ability to understand clearly the child's status with the system, they must be familiar with the common characteristics of children being served within that system, and they must be sensitive to ways the legal context may influence the child's presentation in a clinical context. They also must be able to deliver empirically based assessments and treatments that address clinical problems common among children being seen within the system, and they must have the personal and professional skills to consult effectively with the other system.

SOCIAL JUSTICE

Because children with emotional-behavioral difficulty living in poverty may be systematically marginalized within systems designed to serve them, it is important to acknowledge that some ethical dilemmas involving forensic issues may, as noted in case 7, involve thorny questions about social justice. Situations involving a specific child that represent important questions about social justice for a specific class of children may prove to be some of the most vexing situations to confront clinicians working in the public sector. Elsewhere, McMahon (1993) has outlined some critical questions for clinicians to consider carefully when deciding what to do. Who is the clinician obligated to act on behalf of? What advantages and disadvantages come with being inside versus outside the system in question? What are the limits of the clinician's expertise? What are the risks associated with taking action? What are the costs associated with not taking action? What is the sanction to act? What is the most responsible course of action? Given it is the professional-client relationship that will always provide justification for a clinician to address a social injustice involving a specific child, clinicians must be aware that the more they move away from the situation of an individual child being treated unjustly within a system of care they clearly understand, the more they may be moving away from clinical practice into the worlds of law and politics.

Consequently, although it may be appropriate for the clinician to work with everyone involved at the local level to avoid the expulsion of the Hispanic boy mentioned in case 7, it may not be appropriate for the same clinician to do so by pursuing a broad systemic intervention to limit the expulsion of all Hispanic and African American boys attending the program. It may be appropriate to utilize professional relationships the clinician has within the local system of care to highlight the problem, but it is important to note that action pursued on behalf of a class of children may not necessarily lead to change for a specific client. When confronted with a moral imperative to take action on behalf of a class of children, it is important for clinicians to acknowledge that, as outraged as they may be at the injustices children with emotional-behavioral difficulty living in poverty incur as a class, clinical work is always grounded in the situation of an individual client. The intent here is not to discourage professional activity that might improve things for a class of children. The intent is only to highlight the fact that there is a very different set of issues to be considered whenever a clinician pursues systemic change for a specific class of children. Under circumstances like those outlined in the case,

it may be most appropriate, after the situation is resolved for the client, for the clinician also to bring the broader concern to the attention of professionals with the knowledge and skills to address the problem for a class of children in the most effective way possible.

CONCLUSION

Children referred for psychiatric services in the public sector typically come with minimal family support and ongoing involvement with other systems of care. Although scholars have argued for a clear distinction between clinical and forensic roles, professionals working with children in the publicly funded system of care will undoubtedly encounter ethical challenges involving forensic issues at the interface of clinical and legal or quasi-legal systems. When this occurs, clinicians must be adequately prepared to function as a forensically oriented clinical provider with both a clear understanding of the difference between clinical and forensic roles and a good understanding of policy and procedures that govern the operation of the other systems that serve children. As a forensically oriented clinical provider, the clinician must also be clear that, when working with vulnerable children living in what can be exceedingly complicated social situations, they have an ethical obligation to define the child as the individual whose interests they are, first and foremost, obligated to pursue. As they cautiously pursue the interests of the child, clinicians working with this population of children must have a conceptual framework to guide decision making so that, while working collaboratively with professionals in other systems, they remain in the best possible position to provide clinical services to the child.

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FORENSIC ETHICS AND CLINICAL COLLABORATIONS ACROSS MEDICAL SPECIALTIES

Christy Olezeski and Thomas J. McMahon

OVER THE PAST SEVERAL DECADES, there has been an increase in the development of "interdisciplinary" or "multidisciplinary" teams to provide healthcare to children and adolescents. The Institute of Medicine (IOM) first encouraged the medical community to establish interdisciplinary teams in the 1970s (Institute of Medicine 1972), but there have been examples of interdisciplinary collaboration among medical centers traced to the early twentieth century (Baldwin 2007). While there may have been informal discussions and plans to incorporate multiple fields/professions for the provision of care, formalized documents to define interdisciplinary care and the competencies needed among different professions to provide such care were not created until the early twenty-first century (Interprofessional Education Collaborative Expert Panel 2011).

Models of interdisciplinary care suggest that team structure and processes are major themes that emerge when assessing and planning for an interdisciplinary collaboration (Xyrichis and Lowton 2008). Whereas team structure focuses on shared goals, support structures in place, and the appropriate team size and composition, team process focuses on more logistical components, such as the timing and structure of team meetings, the goals and objectives of the group, and how the team will monitor progress. Based on their meta-analysis, Xyrichis and Lowton (2008) found that when team members were split across various sites, communication among team members suffered, which led to a decrease in effective interdisciplinary care. Similarly, teams large in membership also seemed to suffer (because of difficulties in communication and decreased camaraderie), as did those lacking regularly scheduled meetings. However, if a team was large because a diversity of specialties was represented but a clear leader open to innovation and change was appointed, this led to

positive morale among team members and increased the perceived effectiveness of the team. These team qualities, along with clear roles and responsibilities for team members, regular team audits to assess for strengths and weaknesses, and a shared vision, appeared to contribute to positive affiliation among members and the perceived effectiveness of the team.

While education in interdisciplinary collaboration is not the focus of the current chapter, there are multiple review articles suggesting that interprofessional education leads to positive training opportunities as well as benefits to patient care (Broyles et al. 2013, Reeves et al. 2010, Hammick et al. 2007, Cooper et al. 2001). In addition, there are several models that can be utilized when promoting interdisciplinary collaboration (Bainbridge et al. 2001, Nancarrow et al. 2013). However, one criticism of the research on interdisciplinary models of care is that the models often lack methodological rigor and long-term follow-up (Remington, Foulk, and Williams 2006; Thistlewaite 2012).

While research on interprofessional education is still in its development, there is evidence that interdisciplinary care leads to more positive outcomes in patient care, especially in the medical or health-related fields. Specifically, when interdisciplinary care includes regular communication and shared decision making, there have been recorded increases in patient satisfaction, access to care, an easier transition of care (Rummery 2009), adherence to standards of care (Chang et al. 2001), an increase in pain management (San Martinez-Rodriguez, D'Amour, and Leduc 2008), an increase in activities of daily living among patients, a decrease in readmissions to the hospital, a decrease in mortality (Schmitt 2001), an increase in medication compliance, and a decrease in the use of multiple medications (Zwarenstein, Goldman, and Reeves 2009), although some reviews suggest that these outcomes are also mixed (Nazir et al. 2013). There is also a suggestion that interdisciplinary team collaboration in forensic settings could lead to a decrease in the incidence of violence (Morrison et al. 2002), a decrease in the number of absconders from care (Simpson et al. 2015), an increase in information gathering regarding medical-legal issues (Derhammer et al. 2000), and an increase in risk management and comprehensive care for individuals (Kapoor et al. 2016).

As noted by several authors (Myors et al. 2013, Schmitt 2009), having an interdisciplinary team is not a dichotomous variable: teams vary in their level of communication, frequency of meeting, method of interacting (in person, teleconferencing, video conferencing), professional makeup, and level of influence. It is also noted that teams often refer to their collaborations in different ways. One could even argue that there is a qualitative difference between what

is considered an interdisciplinary team versus a multidisciplinary team. As Jessup (2007) pointed out, "multidisciplinary team" suggests that there will be a "one-stop shop" for clients to obtain care from multiple providers at one location, whereas "interdisciplinary team" infers that multiple providers will work together to provide consultation and help the patient reach his or her goals as a team, with equal input from all members. This difference is analogous to the creation of two different textiles: one could either construct a quilt, where pieces are set next to one another to create a larger form (as in a multidisciplinary team), or a tapestry, where individual fibers are woven together to create a product that is fully intertwined (as in an interdisciplinary team). The implication of having a fully intertwined team implies that members are given equal weight and need to collaborate and work together in the decision-making process to have the most effective influence. How each team refers to itself and how each individual views his or her role within the team can have a profound effect on the team's effectiveness. All team members should have an equal voice and ensure that all members feel comfortable in expressing their opinions. To monitor the effectiveness of a multi- or interdisciplinary team, team leaders should incorporate quality-improvement measures to assess performance and areas of improvement at regular intervals (Buljac-Samardzic et al. 2010, Temkin-Greener et al. 2004, Poulton and West 1999) and make changes as necessary.

With the provision of inter- or multidisciplinary care, one could imagine that having a "one-stop shop" would be beneficial for patients and professionals alike. There is one structure to navigate for multiple services, service delivery has fewer delays, billing is generated by one entity, and medical records are kept within the same system. In addition, patients appear to have higher utilization of services when engaged in multidisciplinary care (Makary 2011), which may be attributable to benefits such as less time to wait for appointments, ease of scheduling, and lower overall cost to the patient (Ratliff and Rodeheaver 1995). However, challenges also arise when professional goals and standards are at odds.

ETHICAL DECISION-MAKING MODELS

One challenge to interdisciplinary models of care is aligning different theoretical models of care, should they be discrepant. Cottone (2012) clearly lays out several distinct models of ethical decision making: principle ethics (based

on the idea of choice in decision making, doing no harm, and treating people fairly), virtue ethics (focused on the character of the decision maker and on virtuous decision making), and relational ethics (taking contextual factors into consideration when making ethical decisions), all of which fall under the theme of multicultural sensitivity (cultures and traditions of the patient, provider, and other stakeholders, which influence decision making). Based on each member's training, professional-ethics codes, and practice guidelines, these frameworks could be discrepant.

Related to ethical frameworks, decision making in an ethical manner often follows a stepwise model. Regardless of the particular ethical decision-making model that one subscribes to, the common elements involved include the following: developing ethical sensitivity; identifying parameters of care; identifying the problem; identifying potential issues related to the problem; identifying stakeholders to engage; consulting with legal and ethical guidelines as well as standards of care; applying specific codes of ethics; identifying who will be affected by the decision; evaluating the rights, responsibilities, and welfare of those involved; identifying various courses of action and the costs/benefits of each; obtaining consultation with peers, supervisors, and colleagues; deciding on the best course of action; evaluating the plan; choosing an alternative based on unforeseen problems or negative effects; and having a final reflection on the decision and process. While this stepwise approach has been a helpful framework for professionals, it does not offer guidance in situations where there is a difference of opinion among professionals.

CHALLENGES IN ETHICAL DECISION MAKING

While there are many benefits in having more interdisciplinary systems of care for patients, there are also several challenges inherent in this work. Each system of care tends to have its own values about patient care, and ethical standards across professions may differ slightly. Further, while there are organization-wide practice guidelines for some professions (e.g., American Academy of Pediatrics 2016, American Psychological Association 2013), there are practice guidelines for specific subspecialties or for the treatment of specific ailments in others (e.g., National Comprehensive Cancer Network 2003, Ramnath et al. 2013, Weber et al. 2014). While providers in inter- or multidisciplinary teams tend to conceptualize cases based on their training, expertise, and professional guidelines, they are not often versed in the guidelines or ethical

frameworks of their colleagues. In addition, if there are forensic issues involved in the case presentation, not all providers may understand the intricacies involved in the ethical decision-making process. This can potentially lead to differences in treatment approach and goals for the patient.

To address potential conflict when working within an inter- or multidisciplinary team, Cottone (2001) offered one model for dealing with differences of opinion while addressing ethical dilemmas, based on the social-constructivist model. Based on his model, negotiation, consensus building, and arbitration are all potential components within the ethical decision-making process, as ethical decision making is done within a social context and varies across time, decision makers, background (both of the ethical dilemma and the group involved in the decision-making process), and presenting problem. Based on Cottone's model, one could utilize the ethical decision-making tenets from any philosophical ethical decision-making model (principle ethics, virtue ethics, or relational ethics) and utilize the stepwise elements laid out in the decision-making process, while also noting the relationships inherent in the interdisciplinary team and deciding when negotiation and arbitration might be necessary to move forward with a decision. As the individuals composing interdisciplinary teams abide by different professional guidelines and practice standards, it is possible that without specific, concrete, and circumscribed conversations about professional guidelines and standards, individuals may easily misinterpret a team member's viewpoint or decision in a manner other than what was intended. This model may be useful in the immediate situation to address conflict and move forward in the best interest of the patient. It is noted that this model is intended to be utilized "in the moment," and, should a case be discussed in the future, the model should be reviewed again to ensure that all proposed interventions that have occurred thus far, and all information that has been gathered since the previous team meeting, is taken into consideration prior to making a decision on how to proceed with treatment.

It is noted that, as there can be a difference in opinion among professionals regarding their theoretical orientations to care, it may be important to integrate medical or forensic ethicists into the decision-making process, in order to offer another perspective and help integrate what could be discrepant perspectives on patient care. These specialists can bring the focus back to patient care and ethical decision making, while also helping members examine not only their own ethical considerations but also how the patient will be affected by the decision making. An added benefit of adding forensic or medical ethicists into the decision-making process is to learn more about the legal

implications that may be lying ahead for both the team and the patient. Based on Cottone's model, these experts could be utilized in each level of the social-constructivist model, depending on the team's needs.

There are several areas where the authors have seen collaboration among multidisciplinary and interdisciplinary groups run into difficulty, which we will use as examples for discussion. How does one reconcile the different goals of medical treatment and mental-health treatment? Who chooses what is the right decision? Is there a hierarchy of care, in terms of whose professional opinion matters more, which therefore dictates treatment? How do you proceed with medical care for a patient when there is a question about the patient's ability to consent to such treatment? What if the parent of the patient has limited capacity to consent for treatment? Finally, what can we do when there are no guidelines for a medical treatment that could be helpful to the mental health of the youth? While these questions do not encompass all the issues that may arise when working within interdisciplinary settings for children and adolescents, it is our hope that the general discussion with the vignettes and commentary will allow us, as practitioners, to see how other difficulties can be addressed in a similar manner.

The following vignettes are composite summaries based on clinical experience. They are not actual cases.

CASE VIGNETTE 1

A young male with type 1 diabetes and borderline personality disorder has been seeking care at the emergency department on a daily basis. He presents with extremely high sugar levels and tells hospital staff that no one has helped him get food this week, so he is unable to control his insulin. When you contact the attending psychiatrist, who also is a member of his treatment team at the local outpatient clinic, he states that the client has a case manager to help with groceries but that the client refuses to use public transportation. You also learn that the client has recently engaged in physical altercations with case-management staff when staff has not gotten groceries or completed other chores for the client. The client currently has assault charges pending in court but has not attended his court appearances, which has put his benefits in jeopardy. The psychiatrist goes on to mention that the team believes that, given the personality difficulties of the client, he should be discharged with the expectation that he will need to get groceries via public transportation. When you approach your team at the hospital, they decide that they cannot send the client home without a plan for food, so they get a sack of food for him to take home. When you present the client with the sack full of food, he reports

"CONTINUED"

that he is feeling suicidal and does not feel comfortable leaving the hospital. He insists on being admitted and begins to engage in superficial self-injurious and aggressive behaviors in your presence. You consult with his psychiatrist a second time. The psychiatrist says that the patient should be discharged, as admitting him would reinforce his self-injurious behaviors. He also suggests that the hospital encourage the client to go with his case manager to buy groceries, learn healthful eating habits to better control his diabetes, and to attend to his legal charges in order to get his benefits reinstated. You are concerned that this patient might still pose a threat to himself, even though he is currently medically stable, and also worry that he will not follow through with the courts, thereby increasing the risk that he will be readmitted to the hospital.

CASE VIGNETTE 2

An adolescent female (birth assigned male) presents to your interdisciplinary gender clinic. As you proceed with the initial consultation and readiness evaluation, it is clear that she has a very limited cognitive capacity. School records confirm this. It also appears that her mother (the sole legal guardian) has limited cognitive capacity and a very negative impression of medical professionals. It is Mom's belief that medical professionals do not have the patient's best interests in mind and that they only proceed with treatment based on what "perks" they get from pharmaceutical companies, not on what medical research suggests. The patient and her mother inform you that they have been seeing a therapist for several years (together) and would like the patient to begin cross-hormone treatment as soon as possible. The patient is eager to start cross-hormone treatment and believes that she will "grow" a vagina when treatment commences. As you continue the conversation about cross-hormone treatment, you hear that she would also like to have her own biological children one day and is under the impression that if she starts cross-hormone treatment, she will be able to get pregnant. Her father is not supportive of her medical treatment, although he is not the legal guardian. He has not been involved in any medical appointments and has seen the patient only once in the previous two years. While he is not involved in her care, he does contribute a small amount of money each month for child support. You are aware that current clinical guidelines suggest that cross-hormone treatment is started when a person is age sixteen but also understand that the patient is having a great deal of difficulty with her facial hair, which is becoming thicker and darker. You are concerned about proceeding with treatment when there is a question of capacity to consent, a lack of understanding surrounding the effects of treatment, and the mother's lukewarm support of her daughter's transition.

CASE VIGNETTE 3

A young birth-assigned female presents to your interdisciplinary gender clinic. She asks you to use the pronouns "they/them," as they identify as gender nonbinary

"CONTINUED"

and sometimes feel more male and sometimes more female. They have been identifying as such for several years and have been fully supported by their parents and school regarding preferred name and pronoun use. The patient does confide in you that they have been having increasing difficulty in using the female bathrooms and locker rooms, especially when they are presenting in a more masculine manner. The patient reports that they would like to start on a low dose of testosterone treatment in order to have a physical look (a deeper voice, increased facial hair) that more closely aligns with their identity. The parents are divorced, but both are supportive of medical treatment. There are currently no medical guidelines on how to work with gender-nonconforming individuals in providing cross-hormone treatment, and the patient and their family are concerned about what will happen in school when the patient begins to use the bathroom (either male or female) at school once they start to transition.

RESOLUTIONS

In the cases noted above, resolutions (imperfect as they may have been) occurred when collaborators discussed various options for treatment, weighed the costs and benefits of each before proceeding, took the patient's needs into consideration, respected one another's expertise and opinion, and engaged in negotiation and consensus building. In the first case, where a multidisciplinary team had been working together in an outpatient setting, their goals for the client clashed with the multidisciplinary team working with the patient in the hospital setting. In this particular case, each team had worked separately through the ethical decision-making model to decide on a particular course of action. However, when the teams were brought together (and learned of additional information regarding other systems of care, such as the patient's pending charges in the judicial system), they then had to engage in another process of negotiation and consensus building, with this additional information. A representative from the courts was asked to join the collaborative effort as a consultant, to weigh in on the forensic issues involved. In a review with a forensic ethicist, the team was able to think carefully about the autonomy of the client as well as the potential legal and professional liabilities linked to the matter of caring for the patient. Following several meetings between both inpatient and outpatient staff, all viewpoints were heard (including the patient's), and a consensus for treatment was agreed upon. This decision making took into consideration not only the client's history and team recommendations but information gathered while the patient was hospitalized, including information from the conservator and the courts. Unfortunately, the first course of action was not successful, so the teams needed to meet again to

discuss why the first option did not work, and they proceeded to work through the decision-making process a second time to decide on an effective, fair course of action, which was ultimately successful for the patient. The struggle was effectively centered on weighing the efforts to reinforce the patient's preferences against the efforts to care for the patient, maximizing beneficence and compassion.

In the second and third cases, additional professionals were asked to join the interdisciplinary meetings to plan for the patients' care, including a medical ethicist and a legal representative from the hospital. In the second case, the interdisciplinary team worked with the patient and her mother to explain the risks and benefits of prospective medical procedures in a very concrete manner, including diagrams and pictures, rather than written information, to account for their cognitive limitations. Some members of the team worked with the mother individually to help understand her perspective of the medical profession, and the team used this information to interact with her and her daughter in a more effective manner. The team recognized, when deciding on the course of action for treatment, that there was an uncertainty among some members about moving forward with treatment, so an independent medical ethicist was asked to join the team to discuss the potential benefits and risks of providing treatment to this family, and a legal consultant was also asked to join the discussion to weigh in on issues regarding legal custody. Again, the professionals were asked to think about the principle of justice, in whether they were withholding treatment in this case where they might not in others (addressing issues of autonomy in decision making, legal responsibility, beneficence, and nonmaleficence). In the end, the team was able to work through the decision-making model and, with the input from additional collaborators, come to a consensus for treatment. Regarding the third case, the interdisciplinary team consulted with specialized standards of care for transgender health (Coleman et al. 2012, Hembree et al. 2009) and other specialists in the field who sit on similar interdisciplinary teams in other areas of the country to clarify treatment options for the patient. They also consulted with an advocate in the community to better understand nonbinary identities and learn how to treat the patient with respect. Following the various consultations and trainings, the team was able to come together to work through the ethical decision-making process and come to a consensus on treatment. Finally, the team consulted with a legal representative to discuss what rights the student had in school regarding bathroom and locker-room use and was able to work together with the family to make a plan for their transition back to school as they started their medical transition.

CONCLUSIONS

As can be seen from the vignettes presented above, ethical decision making in multi- and interdisciplinary teams is not a static process but very dynamic in nature. While there are multiple benefits for patients and providers when engaging in these types of teams, there is a great deal of time and effort that needs to be taken to develop an effective team infrastructure. In addition, there needs to be continuous quality improvement, a safe space for all voices to be heard, and effective and fair leadership. When considering ethical decision making within such a structure, teams need to value the expertise of each team member, work together for the common good of the patient, be willing to bring additional resources into the decision-making process, and use information "in the moment" to come to a consensus or decide on how to arbitrate the situation. This dynamic decision making might need to occur multiple times with the same patient, and outcomes and decisions among patients may differ widely.

As noted by Knapp (2006), there is a desire to do more than follow the law and not bring harm to one's patients. The intent should also be to have a positive effect on the provision of appropriate services, in a climate of respect for the patient's autonomy, while also attending to mundane matters such as the patient's potential to harm self or others or to disrupt the smooth running of institutions such as schools or healthcare clinics. As we have noted above, much of this form of ethics consultation, when working in an interdisciplinary team, includes balancing ethical and legal standards of care for each profession with the needs of the patient and the expertise of the provider(s). This process, along with Cottone's (2001) social-constructivist model, can be utilized to provide the best possible care for each patient, on an individual basis.

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