

# AAPL EXAMINER



American Academy of Psychiatry and the Law

## Ask the Experts

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We will answer questions from members related to practical issues in the real world of forensic psychiatry. Please send questions to [nskaye@aol.com](mailto:nskaye@aol.com).

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We would like to introduce Ryan C.W. Hall, MD, as a new byline writer for this column. Dr. Hall becomes the fourth expert to help address AAPL member questions.

Dr. Hall graduated from Georgetown University School of Medicine. He completed his psychiatric residency at Johns Hopkins and a forensic psychiatry fellowship at Case Western Reserve. He has been practicing psychiatry in Central Florida since 2008 and is affiliated with University of Central Florida School of Medicine, University of South Florida School of Medicine, and Barry Law School. Dr. Hall also serves on the Florida Suicide Prevention Coordinating Council as the Florida Medical Association representative. He has served as president of the Florida Psychiatric Society, Southern Psychiatric Association, and Physicians Society of Central Florida and is a member of the Florida Medical Association Delegation at the American Medical Association's House of Delegates. He is on the editorial boards of the *Newsletter* (now *Examiner*) and *Journal* of AAPL. He is currently the chair of the AAPL Psychopharmacology Committee, a former AAPL Councilor, and an AAPL Program Co-Chair.

**Q. The material in my latest case is rather traumatizing for me to digest. Can you help?**

**A. Kaye:**



It is inevitable in the forensic sciences that exposure to traumatic material will occur. This can happen in many ways, such as review of records, interviewing involved persons, listening to recordings of police interviews, viewing crime scene photos, or watching videos of crimes being committed. Some clinicians who work with victims of violence and trauma may experience vicarious trauma (1) with similar conditions more applicable to the clinical world, including compassion fatigue, (2) controlled empathy, (3) and burnout. (4)

The DSM-5 “A” criterion for post-traumatic stress disorder (PTSD) includes repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). Full-blown PTSD in forensic experts, including psychiatric experts, is, unfortunately, common. (5, 6)

I was involved in a high-profile child abuse case with over 100 victims and hundreds of hours of videos of abuse occurring on children as young as one year old. I decided that, after just a few hours of watching the defendant’s behavior, I had seen enough to reach an opinion, and that to watch every second was unnecessary and unhealthy. I can also say that is the last time I will do such a case.

In another case, the issue was suicide, and the opposing expert’s child had committed suicide. The lawyers were aware of this, too, and I have no doubt that the cross-examination attack was designed to re-open the wounds for this still- grieving parent to show their bias. My belief was that the expert should not have taken the case, inviting exposure to what was easily predictable.

Each of us likely has certain topics that are more likely to trigger a trauma-like response. Common ones include child abuse, sexual abuse, horrific violence, war injuries,

sadism, mutilation, and refugee-related trauma. When I am referred a case that is more likely to be traumatizing or just “pushes my buttons” too far, I have learned to decline the offer.

**Glancy:**



To begin, I would like to briefly define some terms. Post-traumatic stress disorder first appeared in the DSM-III in 1980. (3) The DSM-IV took into account that the same symptoms may be generated by threatened death or injury of another person, such as a family member. In later research, this was found to include emergency

responders and other people working in the area. (1) The term *secondary traumatic stress* was used to describe this phenomenon. *Compassion fatigue* was also used, engendered by a parent or witness to the suffering of others. *Vicarious traumatization* describes the experiences of therapists dealing with traumatic material presented by patients in therapy. (2) In the original descriptions, the point was made that these may intersect with schemas already held by the therapist. The DSM-5 included "experiencing repeated or extreme exposure to aversive details of the traumatic event" in criterion A. This would seem to make the term *secondary trauma* obsolete.

Forensic psychiatrists reviewing images of child pornography, or child abuse material, as it is known in the Canadian criminal code, may experience post-traumatic stress symptoms. One of the first cases involving videotapes was the notorious “Ken and Barbie Killers.” In this case, Paul Bernardo, who began as a voyeur before progressing to rape and then sexually sadistic murders, had a passion for videotaping his crimes. Following his arrest, the tapes surfaced and were used as compelling evidence at his first-degree murder trial. A retrospective qualitative study found significant adverse effects on many of the personnel involved in this case. (4) Dr. John Bradford, who was one of the psychiatric experts, reviewed the tapes. Some years later he was involved in another high-profile murder case, which also included video material, which by this time was much more sophisticated. Tragically, the combination of these cases caused PTSD in Dr.

Bradford. He sought treatment, and bravely publicized his illness to help prevent others from experiencing this disorder. (6)

Our group in Toronto made the decision to decline to view or even be in possession of child abuse material, but to ask lawyers to give a brief description. For instance, when completing a C-PORT, a standardized instrument for predicting recidivism or a hands-on sexual offense, the only criterion related to the actual material is whether there is more male than female material. I have found this procedure to be satisfactory in several cases. I have had to deal with cross-examination in which the prosecutor has insisted on showing me images, attempting to make me say that the recidivism rate must be higher because the images are shocking. I have been able to resist this, pointing out that however shocking the images are, it is only the above-noted criterion that is proven to affect recidivism rates and, therefore, relevant to my testimony. As Dr. Hall points out, some commentary on police suggests that viewing as a group may ameliorate traumatic effects. In the Bernardo case, I reviewed the materials with a group of lawyers and assistants in the lawyer's office, whereas Dr. Bradford viewed the materials alone. In his second case, he viewed the gruesome material alone in a rural police headquarters. This may support the group theory.

As Dr. Kaye notes, if you want to avoid this risk, it is likely best not to take cases involving this type of evidence.

**Hall:**



It may be worthwhile to look at how other forensic fields are impacted by potentially traumatizing material. There is significant literature regarding first responders and vicarious trauma in individuals who work in specialized units that are isolated, such as cybercrime or specialized search-and-rescue. We know that groups that experience trauma together are less likely to develop PTSD, due to a “normalization” effect that destigmatizes the individual’s symptoms; however, being more specialized, there is less of a sense of camaraderie or being understood by the larger force, feeling like a failure or loss of identity if unable to keep up or meet expectations of the specialized work, and a perceived higher likelihood of having work scrutinized in court or by

the public. Those affected by trauma who start or have premorbid substance use disorder and have lower education achievement are often more prone to developing occupational problems (e.g., burnout, “stress,” PTSD) (7, 8). Not all these factors directly translate to forensic psychiatry; but other factors, such as engaging in court work, where we frequently find ourselves on the opposite side of another expert or an aggressive cross-examiner may. One article looking at investigators of Internet crimes against children noted that having young children increases the risk of PTSD and stress. (10)

Replace the words “digital examiner” with “forensic psychiatrist” and it is not hard to see how home life factors and what we see at work could become intertwined. If you are having difficulty with objectionable material, try to maintain a safe refuge, if possible. Make an effort to either keep it entirely out of the home or discuss just enough so your partner and family can help support you.

This is consistent with anecdotal observations I have made from fitness-for-duty evaluations for police and fire departments. Several evaluations I have done seemed to indicate a window of vulnerability for burnout or vicarious trauma in first responders who have usually worked for about ten years or longer and are parents to elementary- to middle-school-age children. The first responders note that there was usually some exposure that reminded them of their own kids or that their children and family were potentially vulnerable.

This over-identification with the case(s), both initially and over a period of years, started to wear them down. Many noted that over time it became harder and harder to deal with new cases and let past ones go. As a result, when talking with colleagues about burnout, I often encourage them to examine their circumstances for a period of years prior to when they think the problems started, because the roots may go back further than they think.

Additional general advice I would give is to remember your training regarding transference and countertransference. (6, 8, 9) Note your emotional reactions, to whom they are occurring, and what the meaning may be. Try to step back and identify how your emotions are impacting all areas of your life and how long this has been occurring (as

noted above, it may not be recent). Reach out to trusted colleagues and friends for a more removed perspective, especially if you cannot discuss your concerns with your partner or family. Avoid isolation and engage in self-care (sleep, exercise, healthy eating habits, creative outlets or hobbies, time for meditation or spiritual reflection). Look for solutions within your own field (e.g., professional journals, professional society resources, the local medical community, or your hospital's medical staff resources). Also, as noted by one of our own seasoned and esteemed colleagues, Dr. Bradford, if what you are experiencing is more than simple burnout, you should seek professional help for your own mental health.

### **Take-Home Points:**

You are not alone, nor are you weak or inferior because of the impact the material has inflicted. This is a time to seek consultation with a senior colleague for mentoring and perhaps a therapist if the symptoms are substantially impairing. Managing your own mental health is critical to performing your work and maintaining balance. Maintain self-care, eat well, rest, and exercise. Modulate your workload. Consider a sabbatical. Utilize available evidence-based treatments for vicarious trauma. Knowing your limitations, declining to work on certain cases, and seeking consultation when you are feeling triggered are always good ideas.

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