AAPL: Ask the Experts-2017

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Neil S. Kaye, MD, DFAPA and Graham Glancy, MB, ChB, FRC Psych, FRCP (C), will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send questions to nskaye@aol.com.

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Q.: Recently I started doing C & P evaluations for Veterans. I'm finding the material grueling. How do I manage this?

A. Kaye: There is no doubt that forensic work can frequently entail emotionally disturbing and draining material. In many ways, this is not unlike clinical work. One difference is that in the clinical setting, dealing with transference and countertransference is often part of the therapeutic process and so it is often acknowledged and addressed. This is perhaps less commonly confronted in the forensic world.

I think it is important for every forensic psychiatrist to be aware of her/his own sensitive areas, blind spots, biases, and Achilles' heels. As an example, if you are against the death penalty, don't do capital cases. If you are emotionally vulnerable to child issues, you shouldn't do sexual abuse cases. I highly recommend screening cases before you sign on to make sure you can stomach the material that may be presented. It is always better to turn down a case with which you are not comfortable than to try to get through it while being avoidant.

That being said, I also hope that each and every one of us is affected by the stories we hear from evaluees regarding their trauma. To fail in this endeavor would be inhuman and impede our goal of truly hearing what is being expressed during the evaluation. Empathic listening does have a role in forensic psychiatry, so long as it is not used inappropriately to disarm an evaluee in the effort of obtaining information that would not otherwise be shared.

The role of consultation with a colleague to help manage the emotions stirred up by a specific case can be invaluable. Supervision has been part of our educational foundation and is integral to our learning and growth as psychiatrists and as forensic scientists. Discussion with a colleague about your feelings can help you emotionally; it can also help you to see the case in a more objective and impartial light.

A. Glancy:

If a forensic psychiatrist as eminent and experienced as former President of AAPL, Dr John Bradford, acknowledges experiencing secondary trauma, rest assured you are not alone. Dr Bradford has gone public and lectured on this topic to forensic psychiatrists and other professionals. What you mention is the forme fruste of secondary trauma, the first sign of this syndrome. Professor Cheryl Regehr has researched this topic in emergency services personnel and has found that 20-50% of these workers suffer from secondary trauma. It arises when repeatedly working with clients who discuss traumatic events, when the worker is responsible for serious outcomes, and often when the worker is under stress and working alone. Repeated exposure to traumatic material, the dosage model, or expressing forensic empathy, contributes to symptoms. Often old scars are opened by new material. This is especially the case when other things in one's life contribute to stress and anxiety. One particular aspect that may be particularly important for forensic psychiatrists is the viewing of pornography in photographic or particularly in video form. In the case of John Bradford, he was involved in a particularly gruesome serial murder case, where the victims were video recorded, and 15 years later he was involved in two cases that involved video evidence in quick succession.

The consequences can range from the full range of posttraumatic symptoms to burnout. Forensic psychiatrists tend to work in isolation and assess case after case. They may well be particularly at risk of developing these syndromes. As well as the well-known symptoms above, this can lead to a change in one's worldview, and also to cynicism and lack of caring, which are likely protective mechanisms.

One particularly interesting aspect arises in child pornography cases. We discussed this issue amongst our colleagues in Toronto, in our Journal Club. One psychiatrist, Dr Jeffrey McMaster, was asked to view a video of the kidnapping and sexual assault of a young girl. He raised his reluctance to view the video with his colleagues, and we all agreed that viewing the video would not further his understanding of the client or his risk assessment. He, therefore, wrote a letter to the retaining counsel who presented this to the Judge. The Judge was indignant, making the point that he had to view the video, why shouldn't forensic psychiatrist. Dr McMaster replied that it was repeated exposure to this material, which is common for forensic psychiatrists who do these types of cases all the time, that could make one vulnerable to secondary trauma.

Regarding self-care, it is important to try and be aware of the stresses on ourselves. It is also important to have a support network, or supervision, or a team approach, where one can voice and share these concerns and symptoms. It is also important to attempt to diversify by one's practice to decrease the dosage of exposure. Additionally, the usual modes of self-care, involving

avoidance or reliance on alcohol or drugs, healthy eating and sleeping, and living a balanced lifestyle are a sine qua non for maintaining one's equilibrium. It is also important to use resources, possibly in the form of mindfulness and meditation, or possibly psychotherapy, and even pharmacotherapy if necessary. In the particular case above I realize that the questioner only raised the fact that he found the material grueling. I have used this as a springboard to discuss more serious manifestations of workplace stress, with vicarious PTSD the extreme version of the spectrum.

Take Home Points:

Early intervention is vital so we must give credit to the insightful colleague who raised this issue, prompting this article. We would encourage all of our colleagues to be so honest and open, so that early recognition, acknowledgement, and help seeking will avoid more serious mental health issues.