THE AMERICAN JOURNAL OF
PSYCHIATRY
RESIDENTS' JOURNAL

December 2014 Volume 9 Issue 12

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In This Issue

This month's issue of the *Residents' Journal* focuses on the topic of violence and mental health. In an editorial, Ijeoma Chukwu, M.D., M.P.H., provides an overview of mental illness and mass violence. In a review article, Katherine S. Pier, M.D., examines the public perception of mental illness and recent mass shootings, emphasizing the role of psychiatrists in shaping the public dialogue. Morgyn E. Beckman, M.D., explores the relationship between the insanity defense and violent crimes. Neeral Kamlesh Sheth, D.O., further assesses the not guilty by reason of insanity defense in a research article that includes historical development and forensic evaluation. In a case report, Oliver C. Joseph, M.D., discusses self-injurious behavior in a teenager with a history of comorbid mental illnesses, who acted out violently during his hospital stay. Marco A. Ramos, B.A., and Michael D. Alpert, M.D., comment on the historical role of mental health professionals with regard to the controversial subject of state violence, highlighting the need for training based in the social sciences, such as education in military medical ethics and human rights. Lastly, Matthew J. Baker, D.O., presents his review of the book *The Nazi and the Psychiatrist: Hermann Göring, Dr. Douglas M. Kelley, and a Fatal Meeting of Minds at the End of WWII.*

Editorial

Mental Illness and Mass Violence

Ijeoma Chukwu, M.D., M.P.H.
Associate Editor

Recent media coverage in the aftermath of mass shootings has focused on the relationship between mental health and violence. Perpetrators of mass violence are often portrayed as mentally ill and tormented individuals with disturbed childhoods. These views are reflected in the public perception of mass shooters, according to the results of a national survey conducted by Barry et al. (1), which demonstrated that of 1,530 respondents, 50% supported the belief that individuals with severe mental illnesses pose a greater risk for violence than those without mental illness. However, acts of mass violence are statistically rare events, and, contrary to public perception, studies have found that the vast majority of these acts are perpetrated by individuals with no history of mental illness (2). According to Fazel and Grann (3), violent acts committed by individuals with mental illness account for as little as 4% of all violent crimes in the United States. Furthermore, there is evidence to suggest that the mentally ill are more likely to be the victims of violent crime rather than the perpetrators (4).

While the mentally ill are responsible for only a small percentage of violent crimes in the United States, findings from several studies demonstrate that individuals with specific types of mental illness have a greater propensity for violence compared with the general population. Results from the National Institute of Mental Health Epidemiologic Catchment Area Study found that the lifetime prevalence of violence was 16% among individuals with bipolar disorder and schizophrenia, compared with 7% in the general population (4). The lifetime prevalence of violence among those with anxiety disorders was found to be comparable to the rates in the general population. Study participants with substance use disorders in the absence of mental illness had a lifetime prevalence of violence that was seven times that of individuals with serious mental illnesses such as bipolar disorder and schizophrenia (4). More recent findings from the National Epidemiological Survey on Alcohol and Other Related Conditions demonstrated that severe mental illness alone predicts only a modest increase in the risk of violence when compared with the risk in the general population. When participants with comorbid mental illness and substance use disorders were examined, results revealed that these individuals had a much greater propensity for violence than the general public, suggesting that substance abuse is a far greater predictor of violence than mental illness alone (5).

Perpetrators of mass violence are often portrayed as mentally ill and tormented individuals with disturbed childhoods.

The findings from these studies underscore the need to focus violence prevention efforts on substance abuse treatment. Several studies have associated a significant reduction in violence risk with substance abuse treatment. Although there are high rates of substance use among the mentally ill, efforts to address substance abuse in this segment of the population are unlikely to significantly impact the incidence of violent crimes, as those with mental illness only account for a small percentage of the perpetrators of such crimes. Drawing from this conclusion, the relationship between mental illness and violence in the media is perhaps grossly exaggerated, and violence reduction efforts may be more impactful in the general population.

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Mental Illness and Mass Shootings: Where Public Misperception Ends and Psychiatry Begins

Katherine S. Pier, M.D.

In the last 15 years, the frequency of mass homicides has accelerated, with mental illness becoming a focus of recent discussion. Just as the terror and wounds of one shooting begin to heal, the havoc repeats itself. The Columbine shootings of 1999 and the massacre at Virginia Tech in 2007 were among the early events that contributed to a kind of communal hypervigilance, which has since swept through American society. Panic ensued after Adam Lanza, a seemingly benign young man, shot his mother at home before decimating 26 others at Sandy Hook Elementary School and committing suicide. Elliott Rodgers' shootings in California and Ivan Lopez's murders in Fort Hood, Texas, punctuate 2014. These mass homicides are entrenched in the American story and part of a collective memory that will never be erased.

In not-so-quiet desperation, the public attempts to fill the unknowns with plausible narratives. Since many violent perpetrators have been treated for mental illness, our field is under scrutiny. What, if anything, could we have done to prevent the violence? How will we intervene to ensure the cycle ends? The present review on the association between mental illness and violence, as well as potential interventions, raises as many questions as answers.

Although studies vary in their estimations, it is clear that mental illness alone is not synonymous with violence (1–2). Fazel and Grann (3) used Sweden's hospital registry to explore the rate of violence attributable to severe mental illness, defined as schizophrenia and other psychotic conditions. Within a 13-year follow-up period, the authors studied population-attributable risk fractions. A total of 5.2% of violent offense convictions were attributable to a cohort of 98,082 patients discharged from inpatient psychiatric facilities with diagnoses of psychotic disorders. Among the violent crimes for which they were convicted, these patients' contribution to attempted or completed homicide was 18%. The limitations of the study are acknowledged. Patients with comorbid substance use, for example, were included in the studied cohort. The literature emphasizes that substance use is the most reliable risk factor for violence, independent of and comorbid with other psychiatric diagnoses (1, 4–7). Since patients with psychiatric illness have a greater propensity for substance use (8–10), it is difficult to say whether these offenses would have taken place in the absence of intoxication. Furthermore, all of the patients studied had been under inpatient psychiatric care and carried clear psychiatric diagnoses, which was not necessarily the case for all those who have committed acts of mass violence in the United States. Finally, the generalizability of these data to the United States is limited due to the higher homicide rates and liberal gun ownership laws in the United States (11).

Gun ownership is constitutionally protected in our culture, rendering legislative initiatives that impinge on this civil liberty slow to develop. Out of the Brady Handgun Violence Prevention Act of 1993, which mandated background checks for Americans to legally purchase handguns, evolved the National Instant Criminal Background Check System, a computerized system launched by the Federal Bureau of Investigations (12). Those prohibited from purchasing guns based on the National Instant Criminal Background Check System include persons "adjudicated as a mental defective or committed to a mental institution (13)." The language here is by all measures vague. It is unclear who, by these criteria, is "mentally defective"; furthermore, many people who may have serious mental illness do not pass through the doors of our mental institutions.

Legislation since 2012 has attempted to further restrict access to firearms among persons with mental illness. In 2013, Governor Andrew Cuomo passed the New York Secure Ammunition and Firearms Enforcement Act, requiring mental health professionals to report the names and personal information of patients deemed likely to seriously harm themselves or others to local mental health authorities. The information is then checked against a database of state gun licenses, and if a match is found, the gun license may be suspended, and police may be authorized to find the individual and remove the person's firearm (14). The Secure Ammunition and Firearms Enforcement Act poses tremendous pressure on mental health providers, who may over- or under-report their patients because of clinical thresholds that vary based on experience and personal bias.

A randomized controlled trial by Swanson et al. (15), published in 2000, investigated the role of involuntary outpatient commitment in reducing violence among severely mentally ill patients. The study used a baseline sample of 331 involuntarily hospitalized patients who met criteria for involuntary outpatient commitment in North Carolina. The criteria are serious mental illness and "mental status limiting a person's ability to seek or comply voluntarily with treatment, and the likelihood that without treatment the person would predictably decompensate to a point of dangerousness or grave disability" (15). The cohort members were randomly assigned to outpatient commitment with a caseworker or to release with a caseworker. Among patients with a history of violence, the 12-month recidivism rate was 48% in the control group and 24% in the extended (more than 6 months) outpatient commitment group. During the follow-up year, the investigators found that 50% of patients who

continued to misuse substances were violent, compared with 26.5% of patients who abstained. A total of 41.6% of patients who were not adherent with prescribed medications were violent, compared with 25.5% who did adhere. This was measured using Fisher's exact test, as well as using two-tailed p values <0.001 and <0.05 for substance misuse and medication nonadherence, respectively. Involuntary outpatient commitment increased adherence and decreased substance use. The authors noted the limitations of the study. The study was not blinded; the population may not be generalizable; and the follow-up period was short. However, the study was well designed to examine the effect of involuntary outpatient commitment on reducing violence. It also proposed that increased medication adherence and decreased substance use are mechanisms by which such programs may mitigate violence among the mentally ill.

As mental health providers, we are left with the question of whether these data can be extrapolated to perpetrators of high-profile mass shootings, many of whom had no previous history of substance use or violence. Involuntary outpatient commitment might help a subsection of severely mentally ill patients with a history of violence but would not have prevented the Columbine and Virginia Tech shootings or the shooting at Sandy Hook Elementary School.

Tarasoff's Law (16), first passed by the California Supreme Court in 1974 and modified in 1976, was among the first laws to encroach on physician-patient confidentiality. This law states: "When a therapist determines … that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger" (16). At present, over 20 states "have statutes in which the duty to protect is clearly defined" (17), although statutes vary between states. In Ohio, for example, clinicians are allowed to breach confidentiality consistent with their duty to protect but are not mandated to do so (17).

Predictably, Tarasoff's Law and subsequent legislation, such as the Secure Ammunition and Firearms Enforcement Act, have stirred controversy and fear. What has happened to patient confidentiality or clinical judgment? It takes courage to seek help from a mental health provider. If the mentally ill fear that their names will be entered into a nebulous database, might this further dissuade them from seeking treatment? Will patients who know about the Secure Ammunition and Firearms Enforcement Act report suicidal or homicidal fantasies? Furthermore, a patient can easily cross state lines or go to a private gun salesperson if he or she is determined to find a weapon. In 1987, the APA Council on Psychiatry and the Law (18) issued a statement asserting that physicians will not be liable if they breach confidentiality when a patient has made an explicit threat and there is a reasonably identifiable victim. The APA further stipulates that the physician is protected so long as he or she acts similarly to another "reasonably prudent physician under the same circumstances." This implores providers to air on the side of over-reporting, which may threaten the therapeutic alliance.

Despite the flaws of the Tarasoff Law and the Secure Ammunition and Firearms Enforcement Act, they have the potential of reminding mental health providers to ask about violence and suicide, to educate family members about safeguarding firearms, and to collaborate with other professionals in the face of ambiguity. Addressing these modifiable risk factors while a person is under psychiatric care may be the most important intervention of all.

Following the Elliott Rodger shooting on the University of California, Santa Barbara campus, Watson and Jones (19) wrote on "the clear and consistent connection between mass shooting incidents and [selective serotonin reuptake inhibitor] drugs" (19). The public rhetoric has increasingly focused on the psychopathology of the perpetrators. The Fort Hood gunman Ivan Lopez had posttraumatic stress disorder. Elliot Rodger made concerning statements on Facebook that revealed his mental state at the time he carried out the mass shooting. Adam Lanza reportedly had obsessive-compulsive disorder and Asperger's syndrome. Society has asked why psychiatrists cannot treat these illnesses more effectively. How could physicians allow such individuals to commit these acts of terror? These recent shootings place an enormous burden of responsibility on psychiatrists to mitigate risk without much evidence. However, if we do not help shape this dialogue, we may implicitly place our profession at risk, while allowing public misperception to further stigmatize our patients.

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The author thanks Nancy Glickenhaus, J.D., L.M.S.W., and Tobias Wasser, M.D., for their editorial advice, curiosity, and support in assisting with this article. The author also thanks Dr. Samuel J. Langer for helping to foster interest in this topic.

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The Insanity Defense and Violent Crimes

Morgyn E. Beckman, M.D.

In 1991, Callahan et al. (1) reviewed 8,979 insanity defense cases and found that acquittees were more likely to have serious mental illness and to have committed more serious offenses compared with defendants who were convicted. Successful not guilty by reason of insanity acquittees were more likely to be older, female, and single, as well as more educated. Just over one-half of those individuals pleading not guilty by reason of insanity and 84% of those acquitted under the not guilty by reason of insanity defense had schizophrenia, other psychosis, or an affective disorder. Numerous studies have been completed in the years since regarding the relationship between the insanity defense and violent crime.

Method

The present article is a review of the literature from 1994 to 2014 on the relationship between the insanity defense and violent crimes. PUBMED, EMBASE, and PsychINFO were searched using the following terms: (violence OR crime) AND (mental illness OR mental disease) AND (insanity). Eighteen of 91 articles meeting search criteria were chosen based on their inclusion of data on mental health and violent crime or characteristics of persons pleading and/or acquitted under the not guilty by reason of insanity defense.

General Mental Illness and Violent Crime

The literature included several articles about the relationship between mental illness and violent offenses. Fazel and Grann (2) examined the psychiatric diagnoses of homicide defendants in Sweden. Ninety percent had a psychiatric diagnosis, most commonly psychotic disorder (20%), followed by substance use disorder (19.7%). Tiihonen et al. (3) found that when mental illness was involved, violent crimes were most frequently perpetrated by male offenders with alcohol-induced psychoses or schizophrenia with concurrent substance abuse. Swartz et al. (4) echoed the finding that substance use significantly increased the risk of criminality. Controlling for substance abuse and personality disorders, Brennan et al. (5) found that persons with schizophrenia were significantly more likely to be arrested for criminal violence. Using data from persons discharged with a diagnosis of schizophrenia linked to Sweden's national crime registry, Fazel and Grann (6) calculated that the expected crime rate would decrease by 5% if there were no persons with schizophrenia in Sweden, or one in 20 violent crimes would be avoided.

Lack of a national database has led to fewer U.S. studies (7). Martone et al. (8) examined the charts of 278 randomly selected homicide defendants. Defendants were mostly young African American males, and 58% had at least one axis I or axis II disorder, most commonly a substance use disorder (47%). Swanson et al. (9) assessed patients for two levels of violent behavior: minor (assault without injury or weapon use) and serious (assault with injury or lethal weapon, threat with lethal weapon in hand, or sexual assault). The 6-month prevalence for violence was 19.1%, with 3.6% classified as serious. Positive psychotic symptoms increased risk for both levels, while negative symptoms lowered the risk of serious violence. Minor violence increased with substance use, younger age, female sex, and residing with family. Serious violence increased with childhood conduct problems and victimization.

Elbogen and Johnson (10) investigated results from the National Epidemiologic Survey on Alcohol and Related Conditions data. Offenders were more likely to be young, male, less educated, and to have a history of violence and juvenile detention. Incidence of violence was higher for persons with mental illness, but when corrected for confounders, mental illness was a predictor only for those with comorbid substance use. Severe mental illness did not independently predict future violent behavior, emphasizing the importance of evaluating clinical, historical, and contextual factors.

Despite high rates of mental illness, inmates have rarely received effective treatment. Matejkowski et al. (11) reported a lack of mental health treatment noted in charts, suggesting that many of the offenders in their study were not receiving treatment or taking medications at the time of the crime. Fazel and Grann (2) reported that 53% of their study sample had psychiatric diagnoses, but less than one-half had been hospitalized, with 8% receiving treatment in the 3 months prior to the offense. In the Swartz et al. study (4), of the 331 subjects awaiting outpatient commitment for severe mental illness, 71% had not taken their prescribed medication in the 4 months prior to admission, suggesting that even with appropriate care, many patients are nonadherent. Moreover, substance abuse and medication nonadherence were significantly associated with serious violent behavior prior to hospitalization.

Persons Found Not Guilty by Reason of Insanity

Not guilty by reason of insanity acquittees make up a small population, since only 1% of felony cases use the not guilty by reason of insanity defense, and approximately 26% of these result in an acquittal (1). Nielssen et al. (12) reported that 272 offenders were found not guilty by reason of insanity of violent offenses over 17 years in New South Wales. Twelve of the 272 were determined to be manic at the time of the offense, 10 had schizoaffective disorder, and two had a bipolar disorder.

In another study, Nielssen et al. (13) compared persons with first-episode psychosis and previously treated persons with psychosis who were found to be not guilty by reason of insanity for a violent offense. Schizophrenia was the most common diagnosis (86%), with 46% of cases being

a first episode. Across studies, psychotic disorders were the most common diagnosis. Novak et al. (14) reviewed records of 42 sex offenders found to be not guilty by reason of insanity, identifying 67% with psychotic disorders. Dirks-Linhorst and Kondrat (15) examined not guilty by reason of insanity acquittees between 1980 and 2007 in Missouri and reported similar findings: 85.8% were male; 69.6% were Caucasian; 62.4% had psychosis; and 56% had a substance use disorder. A study of Argentinian not guilty by reason of insanity acquittees (16) identified 26.6% with schizophrenia or other psychotic disorders and 23.2% with substance use disorders. Victims were known to the offender in 58.9% of cases, and women were statistically overrepresented (16). A New Zealand study conducted by Simpson et al. (17) also found proportionally more female offenders, charged with homicide, who were acquitted under the not guilty by reason of insanity defense.

Studies of women, particularly mothers, have increased recently given the increase in homicide of children. McKee and Bramante (18) studied a sample of 80 mothers in Italy who had attempted to kill or who had successfully killed one or more of their children between 1967 and 2003. Mothers who were found guilty had lower IQs, were less likely to have graduated from high school, and more likely to have divorced parents. Mothers who were found not guilty by reason of insanity were more likely to have a substance use diagnosis, previous psychiatric hospitalizations, suicide attempts, and prior attempt of child homicide.

Ferranti et al. (19) compared female homicide offenders found not guilty by reason of insanity with male offenders committed to the same hospital. Women were more likely to have a mood component, with 52% meeting criteria for schizoaffective, depressive, or bipolar disorder. Psychotic disorders remained the most common diagnosis, with 60% having schizophrenia, schizoaffective disorder, or other psychotic disorders. Childhood physical and sexual abuse, as well as intimate partner violence, were more common among women, and their victims were more likely to be family members under age 18.

Discussion

Research from the past two decades supports the findings of Callahan et al. (1) that a large percentage of violent crimes committed by individuals with mental illness were among those with psychotic disorders (1). Future studies regarding crimes committed by persons found to be not guilty by reason of insanity or pleading not guilty by reason of insanity are needed. Researching a broader population provides updated demographic and diagnostic information of those who are acquitted compared with those who are not. Ferranti et al. (19) have provided a good starting point, which could be expanded by adding not guilty by reason of insanity acquittees of all crimes and comparing their sample to women with unsuccessful not guilty by reason of insanity defenses. Inmates are a highly guarded population, causing study difficulties, and possible sites for not guilty by reason of insanity studies produce only small sample sizes that lack sufficient statistical power. International studies lack generalizability due to a higher rate of violent crime in the United States. Without a centralized U.S. database, conclusions are based on information from an evaluating psychiatrist or psychologist and criminal records. Determining the diagnosis at the time of a crime can be difficult, let alone weeks or months later when an evaluation is requested. In order to gather information more effectively, common definitions of severe mental illness and violent crimes need to be implemented.

The judicial system could benefit from more research of the mentally ill committing violent crime. Better identification of risk factors and mental illness in the correctional population could change sentencing or lead to fewer mentally ill persons subjected to punishment that may worsen their illness. Treatment within the correctional system could decrease recidivism rates. Improved mental health screenings at the time of the arrest could identify mentally ill offenders before they escalate to more violent crimes. Screenings could also guide better treatment during incarceration because illnesses would be identified earlier and possibly at a lower level of severity.

Despite high rates of mental illness among perpetrators of violent crimes, many of these offenders have not received adequate treatment (11). Increasing the number of providers and screening at-risk populations could significantly decrease the rates of violent crime. This is especially pronounced in the female not guilty by reason of insanity population, who most commonly victimize persons within their own family. Improved screening for postpartum mental illnesses and intimate partner violence could have helped these offenders to obtain the mental health care necessary to prevent violent crimes.

As the legal and psychiatric systems evolve, it is important to collect and review current information about individuals affected by both. Better understanding of the relationships between persons who plead not guilty by reason of insanity and the violent crimes they commit can improve mental health treatment and violence prevention and have a positive impact on violent crime rates.

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The author thanks Drs. Jean Clore and Ryan Finkenbine for their assistance in preparing this article.

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Not Guilty by Reason of Insanity: A Controversial Defense

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In order for a person to be found guilty of a crime, the law states that it must be proven, beyond a reasonable doubt, that the person not only committed the crime but also held the intent to commit that crime. For this reason, killing someone by accident, during declared war, or in self-defense does not meet legal criteria for murder (1). Individuals in extreme psychiatric distress may also perform illegal and immoral actions without preconceived intent. In clinical situations, this is evident with promiscuity in mania, suicide attempts in depression, and violence in psychosis. When viewed in a legal context, the presence of an active psychiatric illness during a crime could indicate that the offender did not intend to perform that particular act. The insanity defense was developed over time due to the recognition that people with mental illness may not be legally responsible for crimes produced as a result of their illness. As the determination of a defendant's intent is usually not straightforward, there can be much disagreement when the insanity defense is considered. The present article focuses on the historical development and the forensic evaluation of insanity to provide a general overview of the concept.

Historical Development

Dating as far back as Aristotle's time, society has struggled with penalizing those who perform criminal acts unknowingly. Aristotle himself argued for punishment to be reduced or dismissed for unlawful behaviors resulting from ignorance or compulsivity (2). Evidence of similar debates also occurred in early Roman and Judaic law. In the 13th century, an English jurist, Henry de Bracton, defined insanity as a condition in which "a man must have no more understanding than an infant, brute, or Wild Beast"(3).

From "madmen" to "natural fools," vague descriptions of insanity continued up until the 19th century, when English courts established a standardized legal classification. When Daniel M'Naghten, a Scottish woodworker, developed persecutory delusions and assassinated the personal secretary to the British Prime Minister, he was found "not guilty by reason of insanity," which led to significant public outrage and controversy (4). In response, Queen Victoria instructed the courts to explicitly define the insanity defense. Ultimately, the standard was implemented as follows: "To establish a defense on the grounds of insanity, it must be clearly proved that at the time of the committing of the act, the party accused was labouring under such defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong" (1–3). This evaluation of a defendant's cognitive ability to determine between right and wrong, entitled the "M'Naghten rules," remains the foundation of the insanity ruling today.

The M'Naghten rules were criticized by some as too stringent, since individuals with psychosis who appeared rational while acting on the influence of their delusions would not be protected. In response, some courts added an "irresistible impulse" test that took into consideration whether an act was volitional (2). Under this test, if a mentally ill defendant was unable to exert control over his or her actions, then that individual could be termed legally insane, regardless of his or her ability to distinguish between right and wrong. A standard devised by the American Law Institute also revised the M'Naghten rules to broaden the definition of insanity. First, it required that defendants "appreciate," instead of "know," the wrongfulness of their act. To incorporate the "irresistible impulse" test, it indicated that a mentally ill defendant was not responsible for a crime if he or she lacked the capacity to "conform his conduct to the requirements of the law" (5). The American Law Institute standard also explicitly rejected antisocial personality disorder as a "mental disease or defect," thereby preventing persons with this diagnosis from qualifying for the insanity defense.

In the early 1980s, the insanity defense once again came under extreme criticism after a notorious assassination attempt by John Hinckley, Jr. on President Ronald Reagan (2). Hinckley had initially become obsessed with the film *Taxi Driver* starring actress Jodie Foster. After developing an erotomanic fixation on Foster, he began a series of failed attempts to stalk her. Eventually, he decided to impress her by assassinating the president, which was similar to a plot point in *Taxi Driver*. On March 30th, 1981, Hinckley shot at Reagan and was immediately taken into custody. His defense successfully argued for insanity, and he was acquitted, inciting public outcry. In response, the federal courts enacted the Insanity Defense Reform Act of 1984, which attempted to reduce the number of not guilty by reason of insanity verdicts by changing the definition of insanity once again. The act removed the volitional aspect of the American Law Institute standard, banned ultimate opinion testimony by forensic experts, and shifted the burden of proof to the defense (6). Shifting the burden of proof meant that the defense now held the total responsibility to prove insanity, whereas previously it was the prosecution's role to disprove insanity when claimed by the defense. Some states such as Idaho, Montana, Utah, and Kansas went even further by abolishing the insanity defense altogether (7).

Forensic Evaluation

A forensic assessment to evaluate for insanity has many complexities that separate it from a clinical psychiatric evaluation. Firstly, forensic assessments are done retrospectively. Confidentiality is limited, and defendants are made aware that the examination could be damaging for their defense. As one can imagine, this can greatly hinder a defendant's willingness to cooperate. A high suspicion for malingering must also be kept in forensic settings, since the potential secondary

gain is tremendous when one may be facing harsh punishment for a violent crime. Dramatic presentations, inconsistent reports of psychiatric symptoms, and extreme deliberateness during the interview can be clues of deceitfulness; however, a finding of malingering should not rely solely on the forensic interview (8, 9). Evidence of past instances of malingering and collateral information can be very helpful in validating an examiner's suspicion of malingering (10). Neuropsychological testing is an essential feature of forensic evaluations and can also be helpful in detecting malingering, especially with tests such as the Minnesota Multiphasic Personality Inventory–Revised and the Miller-Forensic Assessment of Symptoms Test (10, 11).

Once it is determined that a genuine mental illness was present at the time of the crime, it still does not imply insanity until the association between the psychiatric illness and the crime is investigated. It must be established that the mental illness directly inhibited the defendant's capacity to keep his or her behavior within the boundaries of the law. This might not be the case, for instance, if a defendant with paranoia could have simply run away instead of resorting to murder when feeling that he or she was being followed. There are also situations in which an active mental disease does not directly contribute to the criminal offense. An example would be if a defendant charged with sexual assault has unrelated command auditory hallucinations to kill others. In certain cases, it might even be determined that the crime itself caused the onset of a psychiatric disorder. Some examples of this include dissociation occurring after committing a murder, posttraumatic stress disorder emerging after witnessing one's own criminal act, or a disorder developing due to increased stress during legal proceedings (8).

There are several other elements of a forensic case that must also be considered to determine culpability. Efforts to keep from getting caught after committing an offense might imply that the defendant was aware of the wrongfulness of the crime, making insanity less likely. Intoxication from mind-altering substances can certainly lead to defendants performing offenses without intent; however, several states have laws that specifically prohibit the use of the insanity defense in cases of intentional intoxication (12). In cases in which defendants may have unknowingly ingested substances leading to a temporary psychiatric condition, the insanity defense can still be admissible. Amnesia does not usually qualify for acquittal under the insanity defense because it can be easily feigned, and there is no clear method to determine its validity (13). When considering sexual offenses, judges and juries rarely decide on a not guilty by reason of insanity verdict. However, those who are acquitted usually have a clear diagnosis of schizophrenia or schizoaffective disorder (14).

Conclusions

The insanity defense has been a heated subject of debate for centuries and will likely continue to be one of the most disputed legal doctrines related to mental health. Although the insanity defense is seldom employed, misperceptions about the frequency and success of its use are commonplace because of the high degree of sensationalism that these cases receive (15). Since there is generally a lack of public awareness regarding mental health issues and many of the crimes involved can be of a violent nature, laypeople understandably may feel confused and upset when a not guilty by reason of insanity verdict is called. Although many psychiatrists outside of the forensic setting may never perform insanity assessments, it is important for all psychiatrists to understand the key features of the insanity defense because it falls under the realm of our profession.

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Case Report

Urethral Self-Injury: A Case Report

Oliver C. Joseph, M.D.

Self-injurious behavior is common in the psychiatric patient. The present report is of an adolescent with repeated self-mutilation by self-insertion of foreign bodies, and the unusual act of urethral self-insertion is discussed.

Case

"Jason" is a 17-year-old single Caucasian male with a past psychiatric history of comorbid disorders, including bipolar disorder, attention deficit hyperactivity disorder (ADHD), posttraumatic stress disorder, major depressive disorder, anxiety, and impulse control disorder, who presented twice to the hospital over a 6-week period. He had a long history of self-injury by inserting objects into his nose, penis, and rectum. The patient recounted one prior suicide attempt approximately 3 years ago when he cut his rectum. He reported having four to five surgeries for self-inflicted abdominal wounds. He had been admitted to inpatient psychiatric units, including a state hospital, at least five times for durations of 3–4 weeks. He recently had been admitted to a long-term residential program for adolescents with impulse control disorders.

The patient appeared disheveled and was dressed in scrubs. He was missing his entire right eyebrow. He initially refused to interact with the team but eventually became more engaged. His eye contact was limited. He demonstrated no abnormal movements. His speech was spontaneous, fluent, and loud at times, with some pressuring. He also frequently swore. The patient's mood was angry, and his affect was irritable and dysphoric. His thought process was circumstantial and tangential, while the content was dominated by vague ideas of persecution and reference. He presented what appeared to be confabulatory stories about various girlfriends and childhood trips he had taken at a young age by himself to various parts of the country. He also mentioned a girlfriend's death that he later retracted. He was noncompliant with cognitive questioning, but his cognition appeared intact. His insight and judgment were significantly impaired. His participation in the milieu was quite limited. He spent most of his time in his room and came out only for meals, often angry and verbally abusive. He acted out violently several times, including destroying his hospital bed, tearing out his arm wound sutures, and throwing furniture. He required both physical restraints and emergent injectable medications.

The patient was started on medication for a self-inflicted laceration to his right forearm. He filled the wound with fingernail clippings and sunflower seeds to prolong hospitalization. On the medical floor, he inserted a foreign body into his rectum, causing lacerations. The team believed that the self-insertion was also to prolong hospitalization. When questioned about the insertion in his rectum, he deflected and instead explained that he was raped by an acquaintance several years ago, a detail he had not previously mentioned. He was transferred to the inpatient psychiatric unit following medical treatment of these conditions.

Eight days following discharge from the inpatient psychiatric unit, the patient was readmitted for recurrent depression with fragmented sleep, hopelessness, guilt, reduced energy, and command auditory hallucinations telling him to kill himself. He identified the voice as the person who sexually abused him. He inserted a popsicle stick into his forearm wound and voiced dislike for his group home.

During his inpatient stay, the patient had two explosive episodes in which he reported inserting a straw into his urethra and eliminating it during urination. He also reported, in a fit of anger, having inserted a fork and later an open paperclip into a healed abdominal wound. Imaging failed to display a fork; however, an open paper clip was revealed, for which the patient underwent surgery.

Discussion

Self-injurious behavior can involve cutting, scratching, and rubbing, particularly to the wrist, and there are other radical examples, including ocular (e.g., eyelid inversion and enucleation) and genital (e.g., self-castration) self-mutilation (1–3). Polyembolokoilamania refers to the insertion of foreign bodies into one's own orifices. It is an atypical and likely underreported form of self-injury (4).

Patients who insert objects into their bodies span different demographics. In the adult patient population, these individuals likely have psychiatric comorbidities (5). Sexual gratification is by far the most common motivation; however, various other reasons have also been reported, including nonsuicidal self-injury to regulate emotional release, suicide attempt, psychosis, depression, factitious disorder/malingering, and cognitive disorders (4–7). The prevalence of patients who self-insert is unknown (5). Of note, a small proportion of these patients have a history of serious medical complications associated with repeated self-insertion, suggesting that hospitalization is insufficient to prevent future episodes (5), a pattern seen in the patient in the above case.

Insertion usually occurs through bodily orifices (3) Urethral self-insertion is particularly uncommon (6, 7), although cases are increasingly being reported in the psychiatric literature (4). Urethral self-insertion among males is well described in the urologic literature, typically as autoeroticism (7, 8). Early psychoanalytic theory attempted to explain the phenomenon through regressed libidinal drives, sadomasochistic tendencies, and fetishism (2, 6). Patients commonly delay presentation and are anxious and shameful (7), in contrast to our patient.

The disorder is more common in males, who use objects such as cables, tubes, and straws (4, 5), which our patient claimed to have used. There are also reports of patients having inserted fish hooks, light bulbs, batteries, and even a 16-inch decapitated snake (6, 7).

Our patient carried a diagnosis of ADHD. Aggression is frequently encountered in patients with ADHD (9). Antisocial behavior is seen in 10%–50% of ADHD patients, and 23% develop sociopathy as adults, compared with 2% of patients without ADHD (9). Children with ADHD are more likely to self-insert nasal and aural foreign bodies, perhaps because of their propensity for aggression, risk-taking behavior, and impulsivity (10). A link between ADHD and urethral self-insertion has not been reported.

The largest report of urethral foreign-body insertion described six inmates in a maximum-security prison for the criminally insane with 29 instances of urethral self-mutilation over a 1-year period (2). The patients were young men, aged 21–29 years. Three of these patients had borderline personality disorder, two had antisocial personality disorder, and one had mild intellectual disability and borderline personality disorder (2). Our patient in the above case did not carry a formal diagnosis of borderline or antisocial personality disorder, given his age, but urethral self-mutilators reportedly have higher incidences of these disorders (2). It appears that patients may engage in urethral self-mutilation for either attention-seeking behavior or to prolong hospitalization (2).

Urethral self-mutilators experience turmoil in their home lives, show difficulty adjusting to social situations, have numerous psychiatric hospitalizations, have varying degrees of criminal activity, and have poor sexual development (2). These patients have an extensive history of self-injurious behavior prior to urethral self-mutilation, suggesting that the self-injurious behavior is escalated (2). This finding is consistent with the patient described in our case, who experienced numerous stressors preceding hospitalization. He entered a residential program for adolescent males with impulse control disorders. Since then, he had increased irritability, anxiety, agitation, depression, hopelessness, and worsening sleep, as well as decreased appetite. He also endured numerous recent losses, including that of a close family member and a close friend's suicide. He blamed himself for his relative's death, stating that he "did not check on him frequently enough." He had another close relative who was in deteriorating health. Additionally, he had been investigated for "touching a younger girl"; however, the charges were dropped after investigators found that the victim may have misidentified him. It was unclear how forthcoming the patient was in providing details of these pending legal charges.

Conclusions

The rarity of urethral self-insertion makes evidence-based treatment difficult to identify. The varying topography of self-insertion may indicate different treatment approaches. Motivation, insertion site, type/number of objects inserted, and psychiatric comorbidities may require different approaches spanning the dynamic, behavioral, and cognitive-behavioral therapies (2, 4, 5). Self-insertion, particularly in more atypical sites, presents a unique and difficult management challenge.

Dr. Joseph is a first-year resident in the Department of Psychiatry, University of Massachusetts Memorial Hospital, Worcester, Mass.

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Commentary

On the Right Side of History: Mental Health and State Violence

Marco A. Ramos, B.A.
Michael D. Alpert, M.D.

State violence and the mental health profession share a troubling history. From CIA interrogation techniques during the Cold War to the involvement of psychologists at Guantanamo Bay, mental health experts have all too often become "pawns" in unethical systems of state violence. Some researchers have suggested that this may be due to a lack of training.

Psychology graduate students receive almost no education in military medical ethics or human rights. The situation in psychiatry is hardly better, and involvement of mental health professionals in the military has only escalated with the global war on terror (1, 2). Experts are calling for the inclusion of human rights in mental health curricula to ensure that the profession stays on the "right side of history." However, though a crucial start, training in ethics and human rights is not enough. Undoubtedly, human rights and ethical frameworks can help practitioners make informed decisions in ethically fraught encounters. Knowing, for example, when the Geneva Convention requires an individual to disobey orders from a superior goes a long way toward empowering a physician to say "no" to involvement in torture. But collaboration in state violence is not just due to lack of knowledge in ethics or human rights. It is also the product of a larger military, professional, and academic system that has employed psychological and psychiatric expertise for security purposes, including violent interrogation, since the early 20th century (3). To know when and how to resist such a system, we need to first understand it.

Collaboration in state violence is not just due to lack of knowledge in ethics or human rights.

Practitioners would benefit from learning about the Health Care Personnel Delivery System, for instance, which is a federal law that allows drafting of health workers for military service. Psychologists may benefit from studying the American Psychological Association's complicated history with military interrogation to better understand how and why institutions may seek to use (and abuse) the expertise of individuals.

Teaching practitioners about the systems that co-opt our profession in the name of security requires moving beyond the traditional clinical curriculum. Medical training programs are incorporating perspectives from anthropology, sociology, and history to teach students to think more broadly about their role in the political, economic, and social systems in which they are inserted (4). Regarding mental health and state violence, the social sciences offer a rich body of research ready to be tapped. To give one example, historians have explored not only the close ties between mental health and security from World War II through the Cold War and beyond, but also—and perhaps more importantly—the work of practitioners who have used psychiatry as an activist platform to critique state violence and speak truth to power (5).

To end our role as the military's unwitting pawns, we must learn to see the whole board. Training based in the social sciences can help us to better understand the larger game we are playing and to suggest systems-level interventions that target the structures that push us toward complicity with human rights violations. Standing on the right side of history will first require learning some history.

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Book Forum

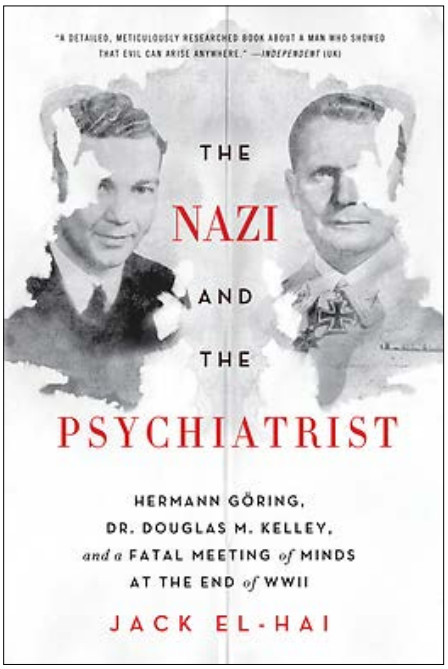
The Nazi and the Psychiatrist: Hermann Göring, Dr. Douglas M. Kelley, and a Fatal Meeting of Minds at the End of WWII

by Jack El-Hai. New York, PublicAffairs, 2014, 304 pp., $15.99 (paper).

Review by Matthew J. Baker, D.O.

For over 70 years, mankind has struggled to understand the violent and unimaginable atrocities committed during the Second World War. With this spirit, author Jack El-Hai sets out to examine two opposing figures: the highest ranking Nazi German military figure remaining after Hitler's death, the Reichsmarshall Hermann Göring, and Dr. Douglas M. Kelley, the young American Army Psychiatrist who delved into Göring's psyche while he was imprisoned at the end of the war. The Nazi and the Psychiatrist explores the unexpected similarities between these two men and attempts to explain the puzzling fact that, although a dozen years apart in age, they shared a similar fate: suicide by cyanide ingestion.

The story begins by introducing the scene of Dr. Kelley's home as it appeared on New Year's Day, 1958, when the psychiatrist unexpectedly and dramatically took his own life in front of his family. We then encounter Hermann Göring, the grandiose, vain, and charismatic Supreme Commander of the Luftwaffe, who surrenders to American forces at the end of the war. This narrative is juxtaposed with the life of Dr. Kelley who, having been from a family of high achievers, distinguished himself from his peers early in his life. El-Hai argues that, like Göring, Kelley had a love for attention and mastery, which led to his identification with the prisoner. Although Kelley is assigned to maintain the health of the



prisoners while they await trial for war crimes, he uses the opportunity to satisfy his own curiosities by exploring the Nazi minds, for which purpose he utilizes the Rorschach technique. He appears to take a special interest in Göring, often being challenged to maintain appropriate boundaries. Kelley eventually finds competition with an Army psychologist, Gustav Gilbert, prompting him to leave Nuremberg prior to the trial so as to be the first to complete a book on the experiences. He later learns of Göring's unexpected suicide. Subsequent chapters examine the debates surrounding Kelley's viewpoint that the war atrocities were better explained by social and cultural factors than by psychopathology in the Nazi leaders. This expertise leads to Kelley's subsequent career, where he works to combine the fields of psychiatry and criminology. Yet he remains haunted by his own quest for perfection, sending him into a descent of alcohol, anger, and family problems before taking his own life. El-Hai argues that Kelley's method of suicide suggests identification with Göring; suicide was a noble escape from an otherwise painful existence.

Although not a psychiatrist himself, El-Hai draws attention to related elements of the two men's personalities that are interwoven with history to create a superb narrative. Although the interpretation may seem forced at times, the author draws on diaries, interviews, and other reports, creating a cogent explanation. Residents will find interest in the delicate therapeutic issues of transference and identification, particularly since Dr. Kelley's experience at Nuremberg was quite early in his career. Military residents will be fascinated by the complexities of dual agency and the incredible opportunities that are possible early in one's military career.

Dr. Baker is a fifth-year child and adolescent psychiatry fellow at Wright State University, Dayton, Ohio.

Test Your Knowledge Has Moved

Our Test Your Knowledge feature, in preparation for the PRITE and ABPN Board examinations, has moved to our Twitter (www.twitter.com/AJP_ResJournal) and Facebook (www.facebook.com/AJPResidentsJournal) pages.

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1. Two to three Board review-style questions with four to five answer choices.
2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.

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Residents' Resources

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**To contribute to the Residents' Resources feature, contact Tobias Wasser, M.D., Deputy Editor (tobias.wasser@yale.edu).*

January Deadlines

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
Resident Psychiatric Research Scholars **Deadline: January 15, 2015**	American Psychiatric Foundation and Janssen Pharmaceuticals	For psychiatric residents with the potential to become leaders in clinical and health services research in all areas of psychiatric research. Emphasis will be placed on special mentoring and career enrichment programs both at the APA Annual Meeting and throughout the year.	PGY-1, 2, or 3	Rosa Bracey Phone: 703-907-8539 E-mail: scholars@psych.org	http://www.psychiatry.org/researchers/research-training-and-career-distinction-awards/Resident-Psychiatric-Research-Scholars
APA/Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship **Deadline: January 30, 2015**	APA and SAMHSA	Selection Criteria: Commitment to serve ethnic minority populations; awareness of the importance of culture in mental health; interest in the interrelationship between mental health/illness and transcultural factors; and demonstrated leadership abilities.	APA Resident-Fellow Member; PGY-2; U.S. citizen/resident	Marilyn King Phone: 703-907-8653; Fax: 703-907-7852 E-mail: mking@psych.org	http://www.psychiatry.org/practice/professional-interests/diversity/awards-and-fellowships/minority-fellowships
APA/SAMHSA Substance Abuse Fellowship **Deadline: January 30, 2015**	APA and SAMHSA	Selection Criteria: Commitment to serve underrepresented populations; demonstrated leadership abilities; and interest in the interrelationship between mental health/illness and transcultural factors.	APA Resident-Fellow Member; PGY-5; U.S. citizen/resident	Marilyn King Phone: 703-907-8653; Fax: 703-907-7852 E-mail: mking@psych.org	http://www.psychiatry.org/practice/professional-interests/diversity/awards-and-fellowships/minority-fellowships
Diversity Leadership Fellowship **Deadline: January 30, 2015**	APA and SAMHSA	2-year commitment during which fellows attend the annual APA September Council meetings and participate in various Council deliberations, the Annual Meeting, and (when funding allows) the Institute on Psychiatric Services meeting. Participate in workshop presentations at the APA meetings and get exposure to training opportunities that develop psychiatry leaders geared toward improving the quality of mental health care for diverse and underserved populations.	APA Resident-Fellow Member; PGY-2	Marilyn King Phone: 703-907-8653; Fax: 703-907-7852 E-mail: mking@psych.org	http://www.psychiatry.org/practice/professional-interests/diversity/awards-and-fellowships/minority-fellowships

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2. **Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
3. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
4. **Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
5. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
6. **Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
7. **Book Review:** Limited to 500 words and 3 references.

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