Editor:

We appreciate Dr. Wettstein's thoughtful reading and commentary[1] on our paper "POWs Versus Torturers: Forensic Evaluation of Military Personnel,"[2] and would like to share some of our responses to his critiques, particularly regarding our methods in evaluating the group of 17 plaintiffs suing the Republic of Iraq. Dr. Wettstein rightfully highlights the potential flaw in the evaluations performed largely by telephone contact with the POWs and their families. An ideal scheme would have involved recruiting separate experts nationwide to perform individual evaluations of the plaintiffs. We would be interested in learning if this approach has ever been undertaken in a tort involving multiple plaintiffs.

As we point out in our paper (Ref. 2, p 318), such a scheme was neither feasible nor realistic, given the logistic realities and time limitations in this matter. Although Dr. Wettstein suggests that we should have declined to conduct these evaluations given the limitations, we argue that our findings and opinions are valid.

Dr. Wettstein specifically questions the accuracy of our assessments, given the use of telephonic interviews that averaged approximately 1.5 hours with the POWs and 1.2 hours with their family members (mostly spouses). We should have noted in the paper that the length of these interviews was dictated by the material covered and that no artificial time limits were imposed. Further, plaintiffs' responses, coupled with the extensive documentation, touched on all the areas noted by Dr. Wettstein as relevant to the forensic evaluation of trauma (Ref. 2, p 330). Each of these areas was, in fact, covered in our reports for each individual.

We continue to maintain that, in light of the extensive documentation of our interviews, we were able to perform valid evaluations and formulate reliable opinions, which we then couched in more conservative language in deference to possible objections regarding our telephone interviews. Further, as we noted, our findings were consistent with the literature in course and frequency of symptoms. This congruence served as a check on possible bias and what Dr. Wettstein refers to as the "risk of being overfocused" (Ref. 2, p 330). In our own forensic experience we have observed that experts rarely compare their findings with the literature. This deficit was highlighted in a presentation at the most recent American Academy of Psychiatry and the Law (AAPL) meeting regarding prognostication in cases involving PTSD.[3] A more systematic study of how the literature is utilized in forensic reports would be a useful contribution.

Dr. Wettstein also suggests that experts familiar with military trauma may have had more specific expertise in evaluating the plaintiffs in this case. However, we felt that our collective experience in the evaluation of trauma in forensic settings was specific enough for us to provide reliable opinions. At the time of the evaluations, each of the examiners had more than a decade of experience evaluating the effects of a wide variety of traumas in both clinical and forensic settings. Dr. Levin also had evaluated asylum seekers who had been tortured, and both Drs. Levin and Gold had experience in treating military personnel. It is unclear what advantage would have been conferred, except perhaps if the experts were specifically experienced in the area of military captivity and torture, not simply combat-related trauma. Setting a standard demanding that an expert's experience exactly match the case at hand seems unduly restrictive and would effectively exclude many of the forensic examinations performed by our colleagues. It should also be noted that plaintiffs' counsel thought that because the action involved a tort against a sovereign state, U.S. government employees, including military psychiatrists, should not serve as experts because of possible perceived bias and/or conflict of interest.

We did, in fact, have the benefit of information gathered by a team of military experts familiar with POWs immediately upon the POWs' repatriation and for a period of several years following their captivity (Ref. 2, p 319). Although Dr. Wettstein observes that prior records may be unreliable regarding the presence of trauma, the paper he cites involved a study of charts at a general psychiatric clinic[4] and not records generated by trauma experts.

Finally, Dr. Wettstein expresses concern that information gathered by e-mail would be inherently flawed. We agree and noted in our paper that no opinions were expressed in these cases (Ref. 2, p 319).

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Editor:

There are a modest number of published studies of homicide followed by the suicide of the offender (homicide-suicide), perhaps because of the intrinsic difficulty in studying the motives of an offender who has died. Hence, the recent review by Eliason[1] of 16 studies is a useful addition to the literature. However, our systematic review of the epidemiology of homicide-suicide[2] reached a different conclusion from those of Eliason and two earlier reviews.[3,4] Instead of finding a relatively fixed rate of homicide-suicide, we found a 100-fold variation between the lowest rate and the highest rate in the 65 samples of homicide-suicide located by using exhaustive search strategies. The earlier reviews also concluded that the rate of homicide-suicide is unrelated to that of other homicides. However, we found a strong association between rates of homicide and homicide-suicide in the United States, which has high rates of both. In addition, we analyzed a subset of 18 studies reporting firearm use in homicide-suicide with a finding that supports Eliason's conclusions about the significance of guns in these events.

Similarly, the belief that the rate of homicide by the mentally ill does not vary significantly between regions, or over time, is not supported by the evidence. We re-examined with updated samples the data used by Coid[3] and Taylor and Gunn[5] and found a strong association between rates of homicide by people with schizophrenia and total homicides[6] and a significant rise and fall in the rates of homicide by the mentally ill in the United Kingdom.[7] The presence of wide variations in both the rates of homicides and homicide-suicide committed by the mentally ill demonstrates the need to examine not only illness variables but also the importance of societal factors associated with these tragic events.

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Reply

Editor:

Drs. Large, Nielssen, and Smith[1] have brought forth several important concerns on the subject of homicide-suicide. They assert that the rate of homicide-suicide is not fixed and that the rate can be related to the rate of homicide alone. In their recently published paper, they report a variation of rate from 0.137 events per 100,000 in countries outside the United States to 0.313 per 100,000 within the United States. These statistics show a 2.5 times higher rate of homicide-suicide in the United States than in other countries. Although this is a greater incidence, homicide-suicide is still a relatively rare event that occurs at a rate lower than 1 per 100,000. They presented compelling evidence that the homicide-suicide rate may be related to the rate of