

# Occupational Hazards versus Professional Duty in Reviewing Potentially Traumatizing Evidence

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Electronic evidence, including real-time recordings of crimes by police cameras and smart phones, is becoming increasingly relevant to the practice of forensic psychiatry. A developing literature in fields parallel to our own has described vicarious trauma experienced by mental health and legal professionals exposed to traumatic material in the line of duty. The impact of potentially traumatizing media on the forensic psychiatric evaluation and on the individual forensic psychiatrist is unknown. Calling upon the research and practices of adjacent fields, as well as the personal experience of the authors, this article outlines the benefits and hazards of examining graphic media, addresses potential strategies to mitigate its traumatogenic potential (including among trainees), and suggests how future scholarship may improve understanding of these hazards and inform strategies to prevent them.

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In the era of police cameras, smart phones, and social media, behavior of interest to the courts is increasingly recorded or otherwise electronically documented. For forensic psychiatrists, the permanent fingerprint of electronic evidence increases the likelihood of encountering potentially traumatizing materials in the course of an assessment (pornographic materials, text messages, photographs, videos regarding the commission of a crime, and others). There are currently no professional guidelines on how, or whether, to consider traumatizing materials as part of a forensic psychiatric evaluation. In addition, there is no literature regarding the impact of these materials on forensic psychiatric

opinions or on court outcomes (e.g., successful insanity defenses). Importantly for the sustainability and well-being of forensic psychiatrists, there is limited literature regarding the potential occupational hazards of viewing forensic evidence as part of a forensic psychiatry evaluation. This article outlines gaps in our understanding of the now common practice of viewing these materials and propose a framework for future scholarship in the area.

## Literature Review

### *Digital Evidence in the Forensic Assessment*

The inclusion of digital evidence in forensic psychiatric evaluations appears to have markedly increased in recent years,<sup>1-4</sup> although there is relatively little literature specific to the forensic evaluation of recorded criminal behavior. Vitacco *et al.*<sup>2</sup> discuss the increasing use of body cameras and dashboard cameras by police departments and highlight a Virginia capital murder case where the defendant's erratic behavior while pointing a firearm at a police officer, captured on body camera, was instrumental in determining that she was not guilty by reason of insanity. Vitacco and colleagues emphasize that

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## Hazards Versus Duty in Reviewing Traumatizing Evidence

**Table 1** Definitions of Concepts Related to Psychological Sequelae of Trauma Exposure

Concept	Definition	Specificity to Trauma	Specificity to Professionals
Burnout <sup>8</sup>	Emotional exhaustion in a professional resulting from differences between expectations/aspirations for interpersonal work and the depleting conditions of workplace reality	No	Yes
Vicarious trauma <sup>16</sup>	Natural response to highly demanding professional work with trauma material; can lead to long term changes in examiner attitudes and beliefs	Yes	Yes
Compassion fatigue <sup>14</sup>	Overwhelming feelings of suffering, sorrow, or sympathy arising from desire to reduce suffering of others	No	Yes
Secondary traumatic stress <sup>10</sup>	Natural behaviors and emotions resulting from knowledge of a traumatizing event, associated with wanting to help a victim	Yes	Yes
Posttraumatic stress disorder <sup>17</sup>	Clinical syndrome of discrete symptoms (intrusive phenomena; avoidance; mood, cognitive, and arousal abnormalities) following exposure to a serious traumatic event	Yes	No

video is especially relevant to the second prong of the American Law Institute (ALI) insanity defense, the ability to conform one's conduct to the requirements of the law.<sup>2</sup> More generally, they conclude that video footage proximal to a behavior in question is useful as a sample of the defendant's mental status at the time, which may bear directly on a professional opinion about criminal responsibility.

AAPL's Practice Guideline for the Forensic Assessment<sup>5</sup> acknowledges that recordings of a defendant can be provided as collateral information but does not comment on the use of recordings in its Assessment Content (e.g., recordings of the crime in question) or Assessment Process (e.g., mental status exam from video) discussions. There is no AAPL guideline pertaining to the review of real-time recordings of crimes, whether created by law enforcement, the defendant, or a third party.

To our knowledge, there is no literature addressing the impact of digital evidence on opinions rendered by forensic psychiatrists. There is likewise no data on how this type of evidence may ultimately affect decisions by triers of fact. As discussed earlier, Vitacco *et al.* hypothesized that recordings of defendants have the promise to improve the reliability and validity of forensic evaluation. Accordingly, they argued that digital evidence, including recordings of criminal behavior, "should become standard collateral information reviewed when conducting insanity evaluations" (Ref. 2, p 76).

### **Harms of Occupational Exposure to Violence**

There is a growing literature concerning the potential for psychological harm to forensic practitioners related to vicariously experiencing traumatizing material.

Distinctions have been made between vicarious trauma, burnout, compassion fatigue, secondary traumatic stress, and PTSD, which are illustrated in Table 1. Most of the literature reviewed here centers on vicarious trauma (VT), in keeping with the recent attention this concept has earned in the forensic psychiatry literature.<sup>6,7</sup> We will first briefly address research on the other three concepts, given significant overlap and shared relevance.

Burnout was a term coined by Freudenberger in 1974.<sup>8</sup> It includes a sense of overwhelming exhaustion and feeling cynical, detached, and ineffective in one's role. Burnout is related to a person's appraisal of stressful situations and is mitigated by self-efficacy, the belief in one's own ability to carry out actions with goals.<sup>9</sup>

Secondary traumatic stress includes psychological symptoms which mimic posttraumatic stress disorder. Secondary traumatic stress is acquired by exposure to others suffering the effects of a trauma.<sup>10-12</sup> Baird and Kracen<sup>11</sup> noted that the amount of exposure to traumatic material and one's personal trauma history are important in the development of secondary traumatic stress. Secondary trauma is an acute response whereas burnout is a chronic response. Meadors and Lamson<sup>13</sup> noted that secondary traumatic stress may also be considered "an overidentification with the patient's experience or the patient's coping response" (Ref. 13, p 25). Secondary traumatic stress can lead to decreased empathy, increased staff turnover, and use of sick days with decreased productivity.

Compassion fatigue is a related term regarding PTSD-like symptoms of exhaustion, hyper-vigilance, avoidance, and numbing.<sup>11,14</sup> It may appear as PTSD by proxy, where the professional re-experiences or

avoids aspects of a client's traumatic events and shares in the client's detachment, anhedonia, irritability, or other symptoms.<sup>15</sup>

VT has been defined as "harmful changes that occur in professionals' views of themselves, others, and the world, as a result of exposure to the graphic and/or traumatic material of their clients" (Ref. 11, p 181). Vicarious traumatization has been described as a response to ongoing challenges to one's beliefs and values resulting in a cumulative transformation, and potentially leading to decreased motivation, efficacy, and empathy.<sup>11,12,16</sup> Vicarious traumatization may challenge one's belief in the vulnerability of the self as well as beliefs about order and justice in the world. Predictors of vicarious traumatization include one's coping style and one's personal history of trauma. Vicarious traumatization disrupts views of safety, esteem, trust, intimacy, and control.

VT in sex offender clinicians has been researched.<sup>6</sup> In summary, the data are mixed, with qualitative studies reporting high levels of VT among treaters, while quantitative studies found more modest levels. There appears to be a notable minority who are more susceptible to a traumatic reaction and endorse significant shifts in their perceived personal safety.<sup>18</sup> Barros and colleagues' mixed method study of 56 forensic psychiatrists and psychologists in Brazil identified symptoms of VT existing on a continuum in the study participants. They found that countertransference reactions of disinterest and emotional distance were stronger risk factors for developing VT than negative countertransference reactions such as hostility, fear, and irritation.<sup>6</sup>

Studies suggest that an individual's vulnerability to VT or resilience may result from the interaction between the individual's work environment (having a heavy caseload of traumatized clients or a lack of formal training in trauma) and the individual's personality characteristics.<sup>19,20</sup> With regard to the latter, high degrees of neuroticism have been associated with negative trauma reactions and PTSD.<sup>21</sup> There may also be a relationship between VT and individuals with low emotional stability.<sup>21</sup> Conscientiousness may be a beneficial trait for trauma workers as it allows them to focus more on positive aspects of their work.<sup>22</sup> Agreeableness and openness to experience may also be beneficial traits.<sup>23</sup>

Research on therapists who work with sex offenders suggests that those with few years of experience in the field and those working with sex offenders for 10 years or more were at highest risk for developing symptoms

of VT.<sup>24</sup> A review of available research concluded that individual coping strategies, whether positive or negative, were clearly implicated in the development of VT among these therapists.<sup>24</sup> Other findings from Moulden and Firestone's review indicated that a history of personal trauma was not related to the development of VT in sexual offender therapists, though real or threatened attacks by clients were noted to exacerbate the experience of VT. Higher security settings were related to more distress among therapists. Moulden and Firestone considered, but could not determine, whether this was because therapists in higher security settings were working with sexual offenders considered higher risk, or whether it was due to a direct effect of the environments. There was some evidence that positive coping, particularly peer or collegial support, may lower the risk of developing VT symptoms among these therapists.

There is an emerging literature about the development of VT in professionals and participants in the criminal justice system as a result of their exposure to high intensity or large volumes of traumatizing material. Lawyers, judges, and jurors in particular may be at higher risk for developing VT.<sup>23</sup> Variables such as a lack of support in the work environment, absence of debriefing or supervision,<sup>25,26</sup> and inadequate formal trauma training<sup>23,27,28</sup> have been hypothesized as factors that could increase the risk for attorneys developing VT.

Finally, we must consider posttraumatic stress disorder. The DSM-5 makes a special provision allowing graphic media exposure to count as a criterion A trauma for PTSD if it is encountered in an occupational setting.<sup>17</sup> To meet criteria for PTSD, the DSM-5 requires that an individual "experience first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related)" (Ref. 28, p 271). This raises the possibility that a forensic psychiatrist could develop PTSD from witnessing graphic media during a forensic evaluation.

A study comparing a variety of clinical staff, predominantly nurses, in a psychiatric hospital with forensic and non-forensic services, found that forensic staff reported significantly higher exposure to traumatic experiences and were twice as likely as their non-forensic colleagues to meet criteria for PTSD, although digital media were not discussed.<sup>29</sup> One prominent forensic psychiatrist, John Bradford, has written about his own experience developing PTSD

resulting from exposure to videotaped sexual homicides. Bradford highlighted the absence of research in this field and the lack of validated methods of mitigating the risk of developing trauma related symptoms.<sup>7</sup> In a talk at the 2020 AAPL Annual Meeting, Bradford also highlighted that examiners with high trait empathy levels and eidetic or visual memories are at higher risk for developing PTSD.<sup>30–32</sup> He noted that in his own experience, the most traumatogenic material included high resolution images of sexual torture and murder. He also identified that videos with accompanying audio were more difficult for him to examine than videos without sound.

Research indicates that exposure to television coverage of traumatic events is associated with physical illness and posttraumatic stress symptoms.<sup>33</sup> A study after the Boston Marathon Bombing identified a dose-response effect, where more exposure to bombing-related media was associated with increased acute stress symptoms.<sup>34</sup> There is no research comparing the traumatogenic potential of video versus audio, although one study found that subjects had a greater physiologic arousal to a narrative presented in auditory form compared with the same narrative presented as a video.<sup>35</sup> Amnesty International recommends that its digital verification volunteers mute the volume if not essential to interpreting the content of a video, noting that audio can be particularly distressing.<sup>36</sup>

Any of the trauma-related concepts discussed in this section may result in physical symptoms, emotional symptoms, relationship problems, difficulties at work, or decreased quality of care.<sup>12</sup> Further, they are highly convergent constructs. Devilly *et al.*<sup>12</sup> studied 252 mental health professionals in Australia and found that burnout in the workplace best predicted therapist distress. Distress was also predicted by being a junior in the field, having worries about one's safety, and a high degree of other-intimacy (the belief that it is important to be able to spend time with others). Trippany *et al.*<sup>37</sup> noted intrusion on basic human needs of safety, trust, esteem, intimacy, and control related to distress. Specifically, they noted the following: fearfulness, vulnerability and being overly cautious with one's children may coincide with a change in one's sense of safety; decreased trust in others can lead to global suspiciousness; self-esteem impairments can cause sufferers to question their abilities; intimacy problems might manifest as intrusive thoughts or feelings of guilt during

intimacy; and a sense of loss of control can be associated with helplessness and irritability.

### Benefits of Viewing Forensic Evidence

Reviewing collateral sources of information is a core component of a forensic assessment. The AAPL Practice Guideline for the Forensic Assessment outlines the importance of such data in assessments in which the evaluatee's historical mental status is the focus of the evaluation.<sup>5</sup> Traditionally such collateral data includes crime scene analyses, autopsy reports, and recorded personal narratives such as the evaluatee's diary, email, and computer and phone files. Crime scene analyses that include site visitation provide several advantages to further understanding an individual's mental status at the time of a crime. Mohandie and Meloy<sup>38</sup> suggest numerous potential benefits to crime site visitation, including the following: assessing the credibility of witnesses' reports, identifying the circumstances of behavior, clarifying the evaluatee's behavior, and illuminating an evaluatee's decision-making and motivation. The literature on sexual offenders, in particular, has highlighted the important application of crime scene analysis in understanding an offender's motivations and risk of recidivism.<sup>39–41</sup> Specifically, the use of crime scene indicators differentiated between sexual and non-sexual homicides as well as enhanced the assessment and prediction of risk in some sexual offenders.<sup>42</sup> The diagnosis of sexual sadism, a difficult diagnosis to make in the absence of an individual's disclosure, may rely heavily on crime scene behaviors.<sup>43</sup> Nitschke *et al.*<sup>44</sup> conclude that the Severe Sexual Sadism Scale, which is based on crime scene actions, improves diagnostic reliability, and is a useful complement to clinical diagnostic approaches.

Technological advances have changed the landscape of both collateral data and criminal evidence. The availability of real-time audio-video recordings provides memorialized data that is not subject to memory errors or observer bias. The application of such technologies is already embedded in our culture. In the criminal arena, police body and dashboard cameras and videotaped interrogations are common. Investigations into a defendant's or witness's social media, including live streaming, Twitter, and Facebook accounts, are not uncommon in court proceedings.<sup>2</sup> The ability to capture an individual's mental status at different moments in time is especially useful in conducting a forensic evaluation where the mental status at a particular time is the

crux of the evaluation. Without such technologies, the determination of an individual's historical mental status is based on the individual's report, available witnesses, and crime scene indicators. Real time videos, text messages, and other social media posts provide material for a contemporaneous mental status examination.

The benefits of reviewing contemporaneous collateral data include the following: information about an individual's mental status at different periods of time; minimization of bias associated with an individual's account or witness accounts; and the enhancement of the defendant's memory to facilitate postoffense discussion of behaviors and thinking. Our experience has included cases where forensic evaluators for both the prosecution and defense reviewed all materials including graphic mutilation videos. In one case, the defendant pled guilty and the only question at hand was mitigation. Although the defendant had confessed to killing and mutilating the victims, the death videos were reviewed by both experts, as the question of trauma-related dissociation was raised as part of mitigation. In this case the videos served as an additional account of the defendant's mental status at the time. The death videos were also shown to the judge who presided over the case. In situations such as this, omitting the videos would put the forensic evaluator in a precarious situation, having less information than the opposing expert.

In cases of child pornography offenders, the utility of viewing the child images is often raised. Prior to computer forensic inventories, which summarize images, the only way to understand what the defendant viewed was to look at the images. Today most cases use computer experts to log the images and their content. Not all computer forensic inventories include salient clinical information, however, such as the Tanner stage of the individuals, which is important in diagnosing pedophilia. In cases of child pornography risk assessment, it is important to understand whether an individual meets the diagnostic criteria for a paraphilic disorder, including pedophilia. Reviewing child pornography images allows the forensic psychiatrist to assess Tanner staging and thus more accurately estimate a minor's age. In addition, some defendants will minimize the volume of prepubescent images and report most pornography was adult or teenager images. By looking at the images, the forensic evaluator can determine whether

the defendant is being truthful in describing the collection.

We are not aware of information regarding the likelihood of or details related to which stimuli trigger mental health sequelae when forensic psychiatrists view evidence. The literature and anecdotal accounts indicate there is potential risk to the evaluator. Some may suggest that one mitigation approach is to review transcripts or summaries rather than pictures or videos of potentially traumatic data. For example, reviewing a transcript of a videorecorded mutilation could confer information about the defendant's mental status at the time, while omitting the graphic visuals. Such an approach has been considered for jurors, with one study finding that jurors prefer imagery that is modified to have a less graphic appearance.<sup>45</sup> A transcript is not a replacement for a video, however, as the latter provides additional information such as body language, facial expressions, tone of voice, and affect, all important components to a mental status examination. Forensic evaluators utilizing a limited version of the available data would have to explain why they omitted important information, information which is commonly shared with the jury. Another approach could be to minimize the volume of data reviewed, for example looking at some child pornography images but not the extent provided by the computer forensic inventory. The problem with this approach is that it assumes that all the images are similar, when in fact the images may have important, risk-relevant differences (such as the use of force). Finally, leaving evidence to other specialties to review and summarize is insufficient. As we have learned from crime scene analysis, psychiatrists bring a unique lens to analyzing behavior, one that is not easily adopted by other specialties.

### **Hazards of Viewing Forensic Evidence**

In the field of forensic psychiatry, it is generally accepted that it is important to see all evidence available to determine what evidence may or may not be important in reaching an expert opinion on the legal question. An expert who does not consult all available evidence runs the risk of being judged as careless or lacking rigor in formulating opinions. An expert's evidence may simply be ruled inadmissible by a judge who determines that the expert neglected to consider important factors in the case.

Confidentiality inherent in criminal justice proceedings contributes to the traumatogenic potential

of work within the legal system, as opportunities to process the case with colleagues and peers are often limited. Medical and psychiatric training may prepare forensic psychiatrists with a more robust education and professional understanding of trauma compared with other legal professionals exposed to violent material. Likewise, forensic psychiatrists are perhaps better prepared than forensic psychologists to view images of deceased or injured bodies as a result of medical training in anatomy, surgery, and emergency trauma. Interestingly, multiple trauma history was associated with higher distress related to VT among lawyers, but not among psychiatrists.<sup>46</sup> Regardless, it stands to reason that personality and other individual factors related to propensity for developing VT or PTSD still contribute to the psychiatrist's risk of developing symptoms.

Negative effects of VT and PTSD in forensic psychiatrists can include a change in an expert's world view (more pessimism and cynicism), a tendency to be more suspicious and less trusting of an evaluatee's self-report during an assessment, burnout, emotional exhaustion, and compassion fatigue.<sup>8</sup> Given the current understanding of VT, several factors are worth exploring when considering the potential impact of viewing evidence. When one is in the initial stages of negotiating involvement in a case, it could be important to know what kind of potentially traumatogenic material the expert will be asked to view, including the format (photographic, audio, or video), as well as the volume, duration, and quality of these materials. If the case involves video of an accused torturing and killing a victim over a prolonged period, the expert could ask if there may be any mitigating strategies that can be used in viewing the evidence. Some experts might refuse to look at such evidence and ask for the other parties involved in the case to produce an agreed statement of facts. Experts must weigh this with the potential for the reduction in the quality of the information and the potential impact on their opinions. Unfortunately, highly adversarial cases may make such a strategy impossible. Experts may always refuse to get involved in a case, but because this should happen before accepting a case, it is important for all parties to have a detailed understanding of the materials available for examination.

Examiners must also be diligent in distinguishing mental status observations obtained by video footage

from those made during a clinical examination. There is currently no training or research on conducting a standardized mental status exam from non-interactive video footage such as recorded evidence. Such an evaluation may be limited by the inability of the examiner to interact with the evaluatee, solicit information, and ask clarifying questions about observed behavior.<sup>1,4</sup> When viewing real-time video of a crime, examiners must also address the possibility of bias clouding decision-making (e.g., based on the emotionality of the content). The analogous practice of carefully considering the admissibility of overly prejudicial evidence may be relevant. Further research on the potential benefits and limitations of assessing mental status in recorded evidence would be a welcome addition to the literature.

### Mitigation of Vicarious Trauma

Trippany and colleagues<sup>37</sup> recommended that therapists consider work-life balance, psychotherapy regarding personal traumas and countertransference tendencies, supervision and peer supervision, education, reducing the number of traumatic cases, and spirituality in mitigating the development of VT. Specifically, peer supervision allows for social support, normalization of one's feelings, connecting with others, sharing coping resources, allowing one to vent, examining one's own reactions and countertransference, and reaffirming one's confidence in one's own skill. For example, in other countries, such as New Zealand, peer supervision and peer review are compulsory.<sup>47</sup>

Pearlman and Saakvitne have written about the treatment of vicarious trauma.<sup>20,48</sup> They suggest that mitigation strategies can be divided into personal, professional, and organizational categories.<sup>48</sup> Organizational strategies suggested include ensuring a private space for therapists to control (e.g., arrange, decorate, schedule) as they wish; providing trauma-informed peer supervision and consultation for therapists as part of the organizational infrastructure; and cultivating a professional atmosphere that compensates therapists appropriately and does not overburden therapists with administrative work.<sup>48</sup>

Personal coping mechanisms of importance include a balance of home play and rest, socializing, creativity, physical activity, a sense of personal identity, journaling, meditating, and maintaining personal psychotherapy.<sup>37</sup> In fact, Meadors and Lamson noted "having a culture that encourages providers to take some time off, ensures

that providers eat during their shift, and promotes self achievements is essential for minimizing the likelihood of compassion fatigue” (Ref. 13, p 33). Spirituality allows for understanding of the importance of a larger sense of meaning in one’s work and may incorporate meditation or opportunities to volunteer.<sup>37</sup>

The impact of these protective interventions is not clear. Bober and Regher<sup>49</sup> studied 259 therapists and found that they largely believed that leisure, self-care, and supervision were useful. They did not, however, find a dose-response relationship between time spent on protective activities and reduced scores on trauma symptom measures; on the other hand, they identified a dose-response relationship between time spent vicariously experiencing trauma and trauma symptoms. It may be reasonable to extrapolate that the risk to a forensic psychiatrist increases with increased duration of exposure to potentially traumatizing material, and that the protective benefit of coping strategies is unknown.

With this caveat in mind, some best practice approaches are worth consideration. It might be prudent to avoid viewing highly traumatogenic material when one is tired or experiencing a high degree of personal stress. A high degree of vigilance in managing one’s work-life balance during times when one is involved in such a case is likely a worthwhile practice for trainees and early career psychiatrists, as well as those who are very experienced, if the data related to sexual offender therapists is considered. Viewing traumatic material at home is likely ill-advised; whether to use judicial offices or one’s personal office may depend on the characteristics of the available spaces and the preferences of the examiner. Knowing one’s own risk factors for an adverse trauma reaction could be useful. Seeking personal psychotherapy may be a useful strategy, as some studies show lesser VT scores in assessors who have undergone such treatment specifically to address their own countertransference reactions to evaluatees (particularly those who evaluate sex offenders).<sup>6</sup> This may help mitigate the risk that indifference and immature defense mechanisms play in development of VT. Increasing experts’ awareness of their feelings, such as when assessing sex offenders, can assist in how they properly manage their emotions. For example, disinterest, distance, and immobility appear to be associated with VT in treaters of sexual offenders, whereas hostility, fear, and irritation appear not to be.<sup>6</sup>

Recent initiatives in Canada illustrate a growing attention to the risks of VT in the trial process for violent crimes, particularly for jurors. In Ontario, free, confidential, and professional counseling has been provided to jurors through the Juror Support Program since January 2017.<sup>50</sup> In the province of Manitoba, jury members can access four hours of posttrial counseling with a social worker, if a judge deems it necessary.<sup>51</sup> Similarly, jurors in Quebec can access five one-hour sessions with a psychologist if they present a prescription to a judge.<sup>52</sup> It is currently against the law in Canada for jurors to discuss their knowledge of cases even after a trial has been completed. It has generally been at the discretion of judges to allow jurors to access counseling. At the federal level, Senate Bill S-207<sup>53</sup> was introduced in the Canadian Parliament in December 2019 with the goal of allowing jurors to access mental health care related to trauma experienced while performing their civic duty. If passed, it would create an exception in the existing federal law that prohibits jurors from disclosing knowledge of cases where the disclosure occurs in context of their seeking assistance related to their mental health. Such services in the United States vary widely by jurisdiction.<sup>54</sup> Federal judges have the discretion to extend jury duty service on an administrative basis so jurors may qualify for counseling through the federal government’s Employee Assistance Program, as was done following the case of the Boston Marathon bomber.<sup>55</sup>

More generally, research on stress management in health care workers has identified a number of interventions that are effective at improving employee mental health.<sup>56,57</sup> They include physical exercise,<sup>58</sup> cognitive behavioral therapy,<sup>58</sup> team effectiveness training,<sup>59</sup> psychoeducation,<sup>60</sup> changing structural factors such as referral patterns,<sup>61</sup> and communication skills training.<sup>62</sup> Michie<sup>56</sup> offers an excellent review of this literature, addressing mitigation of both environmental and individual factors that contribute to workplace stress.

### Addressing VT in Training

If a fellow in a forensic psychiatry training program is going to be exposed to material potentially containing Criterion A traumas, the supervisor should carefully consider whether viewing each individual material is helpful to the case, and helpful to the trainee’s learning. The supervisor may view the material together with the trainee and discuss the

material and the trainee's experience. Material should be introduced gradually, with consideration of the trainee's unique experiences. The supervisor should discuss in advance with the trainee that material can be difficult to view, not minimizing potential adverse consequences or expecting a trainee to be unfazed by potentially traumatizing material. Fellowships should offer lectures and training on self-care and prevention. Supervisors should also be modeling self-care. Trainees should be encouraged to self-monitor and discuss their responses with supervisors. Programs with multiple fellows may similarly find peer supervision to be helpful.

### Conclusion

Electronic evidence is becoming ubiquitous in criminal law and, when pertinent to the prosecution of violent or sexual crimes, will increasingly expose forensic psychiatrists to potentially traumatizing material, including recordings of crimes as they are being committed in real time. Given the benefits of reviewing such data, the question, in our opinion, is not if forensic evaluators should review such information as part of an evaluation, but how to simultaneously minimize negative outcomes such as vicarious trauma when they do.

Our analysis raises several critical questions that remain unanswered in the literature. First, although we have argued that the interpretation of digital evidence may often affect our conclusions regarding the mental status of a defendant, there are neither data to demonstrate that this is necessarily the case, nor consensus. Second, there are no data on psychological harms to forensic psychiatrists. Likewise, data are limited on psychological harms of recorded or otherwise digital evidence encountered in a professional setting, even though the DSM-5 makes a special provision for this type of traumatic exposure. As the standard of care evolves regarding assessment of these types of materials, these questions are critical to our ability to perform our work safely, and to train the next generation. Until we fully understand the potential risks in viewing graphic and violent collateral data, we might return to our fundamental training in psychiatry about the importance of self-awareness. Becoming familiar with our countertransference and liabilities makes us better psychiatrists. Understanding when reviewing forensic evidence becomes problematic will make us better forensic

psychiatrists. Perhaps the answer to how to best minimize potential job hazards associated with such material is to recognize our individual vulnerabilities and to take the necessary steps to ensure our well-being. Inherent in this recognition is understanding when to avoid cases that have the potential to make us unwell.

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