

Dear Editor:

I enjoyed the latest issue of the AAPL Journal with the new "face-lift."

The article about the future of forensic psychiatry by Faulkner (28: 14–19, 2000) and the commentary by Bradford and Glancy (28: 20–22, 2000) were of particular interest to me. The first article, which sounded much like a marketing pitch, was put into better perspective by the commentary. Psychiatry has been the stepchild of medicine, and any subspecialty carries the burden of that legacy. Still, we need to let our colleagues and the public know what we do. I wholeheartedly agree with Bradford and Glancy that we need to focus on better treatment for the population we serve.

Forensic psychiatry is unique in many ways. If patients with mental illness are stigmatized, patients whom we deal with are stigmatized even more; they are the criminally insane, rapists, murderers, drug users and dealers, and burglars. These miscreants of our society play roles that are glamorized on the silver screen. In real life, the society would prefer they did not exist. We are faced with the arduous task of diagnosing and treating patients who do not come to us voluntarily and often do not pay us directly. The task of establishing a therapeutic alliance with them is made more difficult because of lack of trust in them, questions about their malingering, and a frequent context of limited confidentiality. Direct care staff regularly see them as inmates rather than patients, and a number of patients are convinced that the secure hospital is more aptly called a prison.

Forensic patients often come from dysfunctional families and have a view of the world that is not flattering to human beings. They already feel that they cannot trust anyone, that the only way they can get anything is by force or stealth. A higher percentage of these patients compared to the general population have an underlying personality disorder, which makes it a formidable task to engage them in real therapy. Lack of continuity of care in the community or in the correctional system further complicates the situation. Psychopharmacological treatment for these patients is not simple either. It is hard to obtain proper past psychiatric and medical histories and/or reliable sources of information. Many of

the forensic psychiatrists treating them, especially in inpatient settings, don't feel any urgency about discharge or aggressive state-of-the-art treatments. These patients present us with diagnostic dilemmas, which an average psychiatrist is not equipped to handle. Violence and aggressive behavior are often a compounding problem that is handled more with confinement and containment. Limited understanding of various ethnic cultures and the culture of secure/correctional systems obfuscates the picture further. Given the direction in which the political wind is blowing and the intolerant mood of the society, our jails/prisons are being filled with people who are mentally ill.

For forensic psychiatry to flourish and not just survive, we need to focus on innovative treatments and train our psychiatrists better in dealing with these complicated issues. We have few textbooks in forensic psychiatry, and no new book seems to be on the horizon.

Marketing is essential, but let us put together a comprehensive package with the patient in the center.

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Dear Editor:

I read with interest the special article by Faulkner (28: 14–19, 2000) as well as the commentary by Bradford and Glancy (28: 20–22, 2000) in the recent edition of the AAPL Journal. My interest was particularly stimulated coming, as I do, from the point of view of a Nigerian forensic psychiatrist, living and practicing forensic psychiatry in the United Kingdom, as well as being a member of AAPL.

It seems to me that Bradford and Glancy have put their finger, in a very articulate way, on a very strong impression that I have gained since I started attending AAPL meetings some five years ago. That impression is that forensic psychiatry, as viewed by American forensic psychiatrists, is much more legal than clinical in its orientation, and it seems to me that there might be a number of reasons for this. The absence in the United States of a social health care system such as the United Kingdom's National Health Service means that forensic psychiatrists in the United States are, essentially, independent con-

sultants who offer opinions to courts, but rarely have to take responsibility for treating the patients about whom they proffer opinions. This is very different from the position in the United Kingdom, where the vast majority of forensic psychiatrists work within the National Health Service and have responsibility for assessing, treating, and rehabilitating not just mentally disordered offenders on whom they give opinions to the courts, but also non-offender patients, the severity of whose illness leads to challenging behaviour.

One suspects that if American forensic psychiatrists were more often obliged to "put their money where their mouth is," it might produce a lessening of the legal, and a strengthening of the clinical orientation of their practice. There is a case to be made for suggesting that the absence of legislation that bars the continued detention in prison of mentally disordered people, and impels their transfer to hospital for treatment, contributes to this diminution of a clinical focus to forensic psychiatric practice.

The best way to ensure that forensic psychiatry thrives as a medical specialty in the 21st century is to be in a position where forensic psychiatrists are viewed as a body of credible professionals and not as a confederation of small businesses. There is, perhaps, more than a grain of truth in the statement made to me by an American forensic psychiatrist along the lines of "the trouble with American forensic psychiatrists is that some of us are frustrated lawyers who spend too much time trying to decipher what Justice X meant when he said such and such in the case of so and so, and not enough time figuring out what is wrong with the patient." This particular

forensic psychiatrist was of the opinion, forcefully expressed, that this American approach to forensic psychiatry was unfortunate.

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Dear Editor:

In their commentaries on the *Wendell Williamson v. Dr. Myron Liptzin* case, both Dr. Alan Stone (27: 451–61, 1999) and Dr. Emanuel Tanay (28:113–15, 2000) place too much emphasis on the role of the testimony by forensic psychiatrists during the trial. The jury decision in favor of the plaintiff is, in my view, more likely the result of Dr. Liptzin's performance on the witness stand than his alleged inadequate treatment.

According to a report in *Psychiatric News* (Nov. 6, 1998, p. 22), Dr. Liptzin stated that if he had to testify again, he would be "more humble" than he was during the trial. I reacted to this by recommending strongly that colleagues, before testifying in court for the first time, consult with a psychiatrist certified in the subspecialty of forensic psychiatry (*Psychiatric News*, Dec. 18, 1998, p. 9).

I still think that is good advice. To paraphrase the immortal words of Georges Clemenceau, "Psychiatric testimony is much too serious a matter to be entrusted to the legal profession."

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