LETTERS

Dear Editor:

I much appreciated the article by Drs. Gutheil and Simon, "Attorney's Pressures on the Expert Witness",[1] which addresses questions often raised by psychiatrists in training and by an equally skeptical lay public.

Having practiced trial law for 11 years before going to medical school, I brought with me to the practice of forensic psychiatry a slightly different perspective than most of my colleagues. The certain knowledge that there are few services more valuable that clinical consulting experts can perform for lawyers than to let them know they have a losing case should go a long way toward alleviating any anxieties young or inexperienced forensicists may have regarding the consequences of rendering an "unfavorable" expert opinion. Obviously, the expert who is never able to provide a favorable opinion to retaining attorneys will have a limited future. Thanks to the law of averages, however, we can all be reasonably assured that sooner or later some meritorious cases will come our way.

More importantly, even in those cases in which we cannot offer the opinion the retaining lawyer had hoped for, we can usually make ourselves useful in a number of other ways. Educating the lawyer regarding psychiatric issues, helping him or her prepare for cross-examination of an opposing expert at deposition or trial, and providing testimony on limited issues such as mitigation or damages, rather than the more central issues of criminal responsibility or standard of care, are common examples.

Objectivity is more than an ethical desideratum. It is, I suggest, one of the four cornerstones upon which the legal construct of the expert witness rests, the other three being skill, knowledge, and experience.[2]

No one can take away our diplomas or certifications. Usually only senility or sloth can diminish our knowledge or skills. And our clinical experience stands on its own. But objectivity requires our ongoing efforts. It is undoubtedly for that reason that the AAPL ethics guidelines refer to the need to "*strive* for objectivity" [emphasis added],[3] the accomplishment of which requires us to acknowledge "the limitations on our knowledge, including those due to the limits of scientific or professional knowledge, as well as those specific to a particular case."[4]

Applebaum and Gutheil state: "The court expects the expert to reach an opinion by an impartial exercise of the relevant skills and to present the opinion with as diligent a regard as possible for the uncertainties inherent in the evaluation process."[5] To do less imperils the legitimacy of our profession.

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References

1. Gutheil TG, Simon RI: Attorney's pressures on the expert witness: early warning signs of endangered honesty, objectivity, and fair compensation. J Am Acad Psychiatry Law 27:546–53, 1999
2. McCormick CT: Handbook of the Law of Evidence. St. Paul, MN: West Publishing Co., 1954, p 28
3. American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry, reprinted in AAPL Membership Directory, 1999, pp x–xiii
4. Appelbaum PS: Theory of ethics for forensic psychiatry. J Am Acad Psychiatry Law 25:240, 1997
5. Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law (ed 2). Baltimore: Williams & Wilkins, 1991, p 350

Dear Editor:

I read with great interest the article by Bukhanovsky *et al.* entitled "Assaultive Eye Injury and Enucleation" (J Am Acad Psychiatry Law 27:590–602, 1999). During my forensic psychiatry training experience at the University of South Carolina in 1999, I had the opportunity to evaluate a person charged with aggravated assault and battery due to the alleged enucleation of a fellow detainee. This case is of interest because with the exception of outpatient treatment for severe obsessive compulsive disorder the evaluee had no other psychiatric history and no evidence of psychosis, mental retardation, or psychopathology. The following is a brief synopsis of his case.

Mr. K., a 39-year-old married Caucasian male employed as an accountant, was held in a detention center pending investigation of two accounts of credit card fraud. He had posted bail but was picked up because he left the state temporarily to attend to a close family member's illness. He had no prior criminal record.

Mr. K.'s psychiatric history was significant for severe obsessive compulsive disorder. Manifestations of this illness had been present since adolescence and

had never been under good control. He suffered obsessions of contamination, was distressed by his own urinary and bowel functions, feared he would blurt out numbers, and was obsessed with the need for symmetry. He also had excessive concerns regarding the size and symmetry of faces and their proportional appearance. Compulsions included excessive hand washing, excessive cleaning of the anal area (to the point of rectal bleeding), and ritualistic behaviors. He had been treated with several antianxiety medications and had received behavioral therapy, both with poor to moderate success. His disorder was not treated at the time of evaluation.

Two days after entry into the detention center, Mr. K. reported that he had been reading an article about tree frogs. He states he was disturbed and distressed by the size and asymmetry of a frog's eyes in a photo. Over a period of several hours he studied and manipulated the page with the photo, which led to worsening anxiety. He felt unable to discard the article and twice returned to the trash bin to compulsively "reorder" the tree frog's eyes. Later the same day, he ripped the frog's eyes from the photo and disposed of them, saving the remainder of the article. In the early evening he encountered a detainee, whom he had never met or seen before, and became disturbed because the other detainee's eyes reminded him of the tree frog's eyes. He described the detainee's eyes as "enlarged, like he had a thyroid disease or something."

K. tried to ignore the eyes of the other detainee but found that he kept staring and pursued the detainee throughout the open area of the facility. About one hour after first encountering the other detainee, K. told a guard that he felt he was losing control with regard to his thoughts about "removing his (the detainee's) tree frog eyes." The guard dismissed Mr. K.'s concern and suggested he return to his open unit bed. Mr. K. did as instructed but continued to obsess about the asymmetry of the frog's and detainee's eyes. A short time later, he used a pencil to gouge and enucleate the other detainee's left eye. Information obtained from guards and other inmates were confirmatory of his reports.

Based on my review of the article by Bukhanovsky *et al.*, this case may represent the only known case of enucleation based solely on obsessive compulsive disorder and may be added to the growing list of fascinating but gruesome enucleation cases.

Ryan Finkenbine, MD
Assistant Professor
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Reply

Dear Editor:

We appreciated reading Dr. Finkenbine's clinical case report [see preceding letter] of an individual who was thought to have an obsessive-compulsive disorder and who apparently gouged out a person's eye, which reminded him of a tree frog's eyes.

We are in the process of surveying clinicians with the hope of collecting multiple cases of subjects who have engaged in this behavior so that we might deal with the data more systematically. If any readers of the Journal are interested in contributing to this effort, they should send a statement of interest to: Alan R. Felthous, MD, Chester Mental Health Center, P.O. Box 31, Chester, IL 62233-0031. Tel.: 618-826-4571 (ext. 308); Fax: 618-826-5823; E-mail: dhsc6624@dhs.state.il.us.

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Dear Editor:

I am writing to congratulate the authors of the article entitled "Assaultive Eye Injury and Enucleation." Their case series of 10 eye gougers is an important start in coming to understand this particular dangerous phenomenon. I write to thank them for broadening the historical understanding of eye gouging. I would like to alert them to two further cases that I have been involved in, in our security hospital. The first is a case of a patient who had schizophrenia who gouged out his eye. The second is a case of a schizophrenic who gouged out both eyes of his "girlfriend."

The first case was a 35-year-old African American with a longstanding diagnosis of schizophrenia who

regularly attended Bible study on the unit. When he became aggressive, he was placed in seclusion in an agitated state; he requested the Bible. Staff felt this might help him calm down. He was given a copy of the Bible, and on the next 15-minute check, the staff observed him pulling out his right eye. In fact, as he told staff later, he had read Christ's command that "if thy right eye causes you to sin, pluck it out . . ." (Matthew 5:29, The Holy Bible, Revised Standard Version). After reading Christ's command in his agitated state, he felt compelled to act on it. He was able to lacerate the orbit of his eye with the fingernail of his right index finger, insert his finger, and pull his eye out of the socket, causing so much damage that the eye was subsequently surgically removed.

The second case involves a 46-year-old Caucasian male who was found Not Guilty by Reason of Mental Disease or Defect for the mutilation of his girlfriend. Over about a 12-hour period, acting on what appeared to be command hallucinations in an actively psychotic state, using his thumbs he gouged out first one of her eyes and then the other, which resulted in the victim's becoming totally blind. He is still guarded about the reason he committed the act except to say that he thought his girlfriend was possessed.

These cases are dramatic and provocative. I reported these cases in a presentation at the APA's Annual Meeting in Toronto and in a paper entitled "The Dangers of Religious Regression" (submitted for publication).

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Reply

Dear Editor:

We read with keen interest the two cases of enucleation reported by Gary Maier, MD. The report of the schizophrenic patient whose self-enucleation was related to his just having read the Biblical command to "pluck out [his eye]" (Matthew 5:29) is consistent with the literature on autoenucleation. The theme of autoenucleation being related to this Biblical command is regularly reported. Rajs Shiwach, MD, found no reported cases of autoenucleation in the non-European Christian culture and referred to such behavior as a "pathoplastic" effect of culture (Shiwach R: Autoenucleation—a culture-specific phenomenon: a case series and review. Compr Psychiatry 39:318–22, 1998). This is an interesting proposition, although we suspect autoenucleation occurs in other cultures without having been recorded in the professional literature. For example, Dr. Bukhanovsky reports a case in the atheistic cultural context of the former U.S.S.R. A psychotic man enucleated one of his eyes and unsuccessfully attempted to gouge out his other eye. By the Russian diagnostic classification, this man's diagnosis was paraphrenic syndrome with active delirium and a megalomaniac delusion about a fight between God and Satan. However, this "atheistic" individual was unfamiliar with the Bible, which he had never read. Nonetheless, the case of autoenucleation reported by Dr. Maier illustrates the risk of a psychotically disturbed individual interpreting a religious injunction in a powerful, divine, concrete, and very personal way.

We are especially interested in Dr. Maier's case of assaultive enucleation, the subject of our article. We would like to invite Dr. Maier, and anyone else with such cases, to participate in our survey of assaultive enucleation. Contacting information is given in our reply to Dr. Ryan Finkenbine.

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