INTERNATIONAL ASSOCIATION OF FORENSIC MENTAL HEALTH SERVICES

NEWSLETTER

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Winter Edition Features

Letter from the Editor

Dear members of the IAFMHS community,

Happy new year and welcome to 2020's first installment of the IAFMHS newsletter! 2020 also marks the 20th year of IAFMHS. At this year's conference in Kraków, Poland, we plan to celebrate this momentous occasion, and we would like to ask our members to share their favourite IAFMHS photos, texts, and anecdotes from the past 20 years.

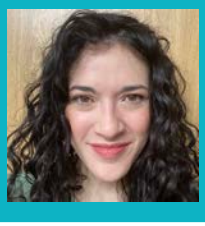
I am also pleased to announce that we are continuing to expand our newsletter team – Krystle Martin and Evan Lowder have joined as Associate Editors of two new sections, Risky Business and Spotlight on Mental Health Diversion. In these new sections, the work they and their colleagues do as part of IAFMHS's Special Interests Groups will be highlighted!

As always, we would like to encourage graduate students, early career professionals, and other members of IAFMHS to submit content to the newsletter or join our team. We welcome all comments and feedback.

Alicia Nijdam-Jones, Editor

EARLY CAREER CORNER

Applying Clinical Skills to Testimony: When in Doubt, Go with What You Know



Christine M. Collins, PsyD

Independent Practice, USA

Early experiences in testimony can be nerve-wracking. Thankfully, many experts in our field have written books and articles to assist psychologists in providing effective testimony. However, when you are on the stand for the first time, nothing is as intuitive as what is already ingrained: our clinical skills. Here are a few examples of how to apply some of these strengths:

- **Knowledge.** *You are best able to explain what you thoroughly understand.* An unfortunate, but common mistake for novice experts is basing their opinions on incorrect or outdated statutes. By knowing the appropriate and current legal statute on which you base your opinion, you can deliver a clean explanation to the Court.
- **Preparation.** *Just as you studied for clinical practice, you should also study for testimony.* Learn the basic facts of your case so that dates, diagnoses, etc., come to you easily. Bringing notes on the stand is a good way to make sure you do not confuse or conflate your data. Keep in mind, though, that (much like your progress notes in practice) anything you bring on the stand can be reviewed by the Court.
- **Humility.** *No one expects you to be perfect or omniscient.* During the voir dire, admitting you have little or no testimony experience can feel embarrassing, but everyone has a first time. Throughout testimony, it is also incredibly important to admit what you do not know as well as acknowledge what is possible. Being defensive of your opinions can be off-putting to the trier or finder of fact, and can undermine the weight of your opinions.
- **Mindfulness.** *Be present and listen to questions fully before crafting a response*. It is an attorney's job to ask difficult questions, and to sometimes lead you into traps that can subvert your testimony. Do not be afraid to ask questions, take your time, and clarify any points that may be misconstrued.
- **Breathe.** *Stay calm and allow yourself time to think.* Do not feel pressure to answer a question quickly. You can always ask for a moment to look through your notes or to compose yourself.
- **Simplicity.** *Avoid jargon and long-winded responses.* Speak to your audience using plain language because your opinion is only as good as how well you can convey it to others. Give concise answers as often as possible, and when a simple answer will not suffice, do not be afraid to speak up and ask the Court for the time to fully explain your response.
- **Confidence.** *You are the authority as much to the Court as you are to your clients.* Speak with conviction and confidence, and remember, at the end of the day, you are the expert. It is your job to use your education and experience to help the Court understand your opinion. No one knows better than you what you believe, and why you believe it.
- **Practice.** *Just as you practiced clinical skills with your cohort, practice your testimony.* Practice your voir dire and opinions aloud in the car and at home while preparing for a testimony. Better yet, if you have a willing colleague or supervisor, conducting a mock voir dire and testimony with feedback can do wonders for both your delivery and confidence.

At the end of the day, you are present in court to provide an opinion and/or discuss facts of a case. Testifying can be a daunting experience. Learning as much as you can about the legal process, practicing, and breathing through your testimony are keys to being successful. Finally, remember that a testimony is not about you, it is about the case. If you stay calm and focused, and use your clinical expertise, you will be successful.

IN MEMORY

Derek Eaves, Founding IAFMHS President

Quazi Haque, Chair of UK Royal College of Psychiatrists Forensic Quality Network & President-Elect IAFMHS | Christopher D. Webster, Professor Emeritus of Psychology, Simon Fraser University & Professor Emeritus of Psychiatry, University of Toronto

Derek Eaves, MD

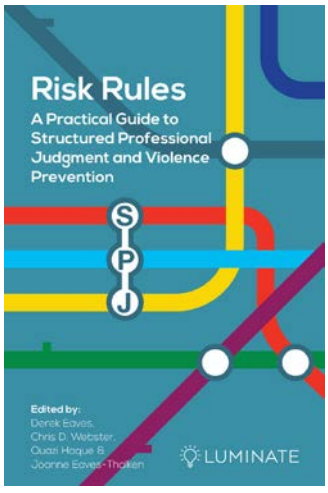
Executive Director of the Forensic Services Commission of British Columbia; Vice President of Medicine and Research at Riverview Hospital, Canada

Dr. Derek Eaves died a little over two years ago. He had a long and distinguished career as a forensic psychiatrist. After receiving his training in forensic psychiatry at the University of Liverpool, he emigrated with his family to Canada. It took him only a few years to become appointed fully in charge of the Forensic Psychiatric Hospital (FPH) in Port Coquitlam, British Columbia. Indeed, as Executive Commissioner of the British Columbia Forensic Psychiatric Commission, he was responsible for all forensic patients in the province. In that role Derek led a great number of highly innovative ventures. He oversaw, from the ground up, the planning for, and construction of, the exemplary new FPH. The hospital, located on the same extensive grounds as the original, is planned on a step-down model with several stages and with accommodations and treatments to match each stage. As well, he established specific programs in community locations. Of note was his interest in and knowledge about persons who commit sexual and domestic violent offences. He insisted there be data-informed treatment programs for the services he created. To that end he involved researchers from Criminology and Psychology at Simon Fraser University. He was behind establishing the Law, Mental Health Policy Institute at SFU. The Institute thrives to this day.

Derek's influence was not restricted to his province. From the beginning of his tenure he set out to engage researchers and clinicians from across Canada. Meetings in Vancouver were frequent. Projects on fitness-to-stand got going. Similarly, he got behind the HCR-20 venture and contributed greatly toward the development and testing of the device. With colleagues in his Service and at SFU, Derek published widely. He was prime author on a guide designed for the use of mental health professionals as they undertake assessments of risks in persons before the courts in respect to Dangerous Offender applications.

The large-scale scientific meetings held in Vancouver were very successful in bringing together Canadian researchers and practitioners of all stripes. But as the HCR-20 and other researchable topics expanded, so, too, it became evident that more could be achieved through international cooperation. The projects started to involve Sweden, Norway, Finland, Germany, and Britain. It then occurred to Derek that what was needed was an International organization to pull all these endeavours together, to get students involved, to get a good journal off the ground. Members of the International Association of Forensic Mental Health Services (IAFMHS) need to know that the Association and the Journal were his creations.

Toward the end of his life, in the last couple of years, Derek was evidently physically ill. The good thing, though, was that there was nothing whatever wrong with him intellectually. Chris Webster was lucky enough to be able to visit Derek at his home. Chris had with him a newly-published small guide for forensic mental health nurses. His pitch to Derek was that something of this sort was needed on a cross-disciplinary basis for members of the IAFMHS and like organizations. Derek picked up the idea with alacrity. Soon invitations were sent out to leading practitioners and researchers across the world. Derek's daughter Joanne Thalken-Eaves, a practicing social worker, added herself to the editorial team, as did Dr. Quazi Haque in London, England. As well as contributing to the book in her own right, Joanne played a vital "go-between" role in getting the new contributions to Derek in order to gain his approval and comments. With a lot of help from diligent colleagues at Pavilion, we, together got the book published in May 2019. It is Derek's last contribution to the field, and, like everything else he touched, a sound one.



Proceeds from the sale of Risk Rules go to supporting the annual lecture given in Dr. Eaves' honour at the IAFMHS.

Purchase your copy online: https://www.pavpub.com/mental-health/risk-rules

This publication is also available on Amazon

£27.95 | 241pp | Paperback | 9781912755240 | May 2019

RESEARCH UPDATE

The EU-VIORMED International Collaboration: Violence Risk Assessment and Treatment for Forensic Patients with Schizophrenia Spectrum Disorders

Giovanni de Girolamo, St John of God Clinical Research Centre, Italy | Giuseppe Carrà, University of Milan Bicocca, Italy | Heiner Fangerau, Heinrich-Heine-University Duesseldorf, Germany | Pawel Gosek, Institute of Psychiatry and Neurology, Poland | Marco Picchioni, King's College, UK | Hans Salize, Central Institute of Mental Health, Germany | Johannes Wancata, Medical University of Vienna, Austria | Margaret Walker, EUFAMI, Belgium

The three-year EU-VIORMED study (2017-2020, www.eu-viormed.eu) was designed to improve our understanding of the nature of the association between violence and schizophrenia spectrum disorders (SSDs), including the assessment of risk factors which predispose patients with SSDs to be violent and the ability of assessment tools to predict these behaviours. Furthermore, it will review and describe the treatment programmes and care pathways across all EU countries in order to identify good practice and so to improve the quality of forensic psychiatric care. The EU-VIORMED study protocol is in press in BMC Psychiatry. The clinical project includes two studies: a case-control study and a prospective cohort study. The case-control study will compare subjects who suffer from SSDs recruited in forensic care services (both large forensic institutions and small-scale high-security facilities) with gender- and age-matched non-violent ones recruited from ordinary psychiatric services. This study has the objective to identify relevant violence risk factors, deficits in social cognition, areas of met and unmet needs, and decision-making capacity for treatment (MacArthur Competence Assessment Tool). The prospective cohort study aims to test the predictive validity of risk assessment tools, the Forensic Psychiatry and Violence tool -FoVOx-, the Mental Illness and Suicide Tool -OxMIS-, and the Historical Clinical Risk Management-20 tool Version 3 -HCR-20^{V3}- in cases over 1 year. In addition to the clinical studies, the project will complete two systematic reviews of the evidence base to support pharmacological and non-pharmacological management of violence in patients with schizophrenia. Finally, the project will map the laws, structures and processes that govern the interface between psychiatry and the criminal justice system for justice-involved people with mental disorder across the 28 EU Member States.

Preliminary Findings

Data collection started in September 2018. By November 2019, 205 cases and 131 controls had been enrolled. Recruitment for controls will last till the end of March 2020. So far preliminary analyses suggest that cases were more likely to have a comorbid personality disorder (antisocial personality disorder) compared to non-forensic patients. Statistically significant differences between cases and controls on a range of socio-demographical

and clinical factors were detected. On average, cases showed a lower education level, received less support from friends, had less frequent personal contacts with relatives and/or friends, and spent more time doing nothing. The two groups did not differ in terms of history of witnessing or being victims of physical or sexual violence, as well as in terms of lifetime suicide attempts or self/harm. Considering forensic patients only, most of them had committed reactive/impulsive violence (72%), mainly towards strangers (33%) or parents (25%). With regards to clinical assessment, preliminary findings suggest a lower likelihood of positive symptoms, lower disability and greater accuracy in recognizing facial emotions in forensic patients compared to non-forensic patients. However, forensic subjects were more likely to experience cognitive deficits in digit sequencing, verbal fluency, and symbol coding than controls. Forensic patients considered posing a moderate risk of future violence, serious physical harm, and imminent violence. On average, as assessed by FoVOx, risk of violence was 5.4% and 9.3% in one and two years, respectively. In addition, as assessed by OxMIS, risk of suicide in 12 months was low (2.0%). There were few violent incidents in the sample over the first 3 month follow-up period.

The two systematic reviews retrieved only a few high-quality studies investigating the effect of distinct interventions on violent behavior in patients with schizophrenia, with the majority carrying out a simple pre-post comparison. To date, after carefully reviewing a total number of 6,003 potentially suitable scientific abstracts from a systematic search across large databases (MEDLINE, EMBASE, SCOPUS, Web Of Science, CINAHL, PSYNDEX, PsycINFO), 10 original papers about

RESEARCH UPDATE

EU-VIORMED PROJECT

pharmacological and non-pharmacological interventions, respectively, met inclusion criteria. Psychotropic research focused on atypical antipsychotics such as risperidone, clozapine, and olanzapine. With regards to psychosocial and other non-pharmacological interventions, it seems that they may reduce the risk of violence in patients with SSDs, both within the forensic system and after release and re-integration into society. However, a considerable heterogeneity in strategies, violence operationalization and risk assessment was detected. It is worth mentioning that an extensive treatment for violence prevention, with more time per patient for treatment planning, evaluation and risk assessment, seems a crucial step in the therapeutic process.

With regards to the mapping of European forensic services, experts from 22 countries have actively collaborated and provided detailed national information. Data will be conflated to a standardized overview of European models of forensic psychiatric care. Final results are expected by summer 2020. However, preliminary analyses of questionnaires received so far on basic legal concepts, services, capacities, routine practices, and epidemiological data (admission, mean length of stay, etc.) suggest a wide variety of approaches across EU countries as well as rather differing capacities and standards of service provision. Findings are likely to support efforts to implement a reliable database or health reporting system on forensic psychiatric care in Europe.

Ongoing activities are steering the EU-VIORMED project towards forensic care quality promotion through the understanding of the association between violence and severe mental disorders and a specific focus on different treatment programmes. This appears crucial to translate research outputs about violence risk in people suffering from SSDs into clinical practice with the harmonization of different forensic psychiatric care pathways.

RISKY BUSINESS

Reflections about Risk Assessment and Management

Krystle Martin, PhD, C.Psych

Research Scientist, Ontario Shores Centre for Mental Health Sciences, CAN

Welcome to the first article of *Risky Business*, the new RISC-Team Special Interest Group section. As a new section in the newsletter, we are hoping to highlight the research, practices, and future directions of our members in the area of clinical risk assessment and management.

But first, a bit about us: led by a primary coordinator, Dr. Stephanie Penney, and many other regional coordinators around the globe, the RISC-Team offers an international forum to provide colleagues an opportunity to exchange opinion on legal, methodological, and clinical matters; create opportunities for collaboration across institutions and jurisdictions in the conduct of research and training; discuss standards for clinical and research practice; ensure that knowledge is kept up-to-date, organized, and available to members; and to offer advice or support.

Starting with our first meeting held in May 2001 in Vancouver, we continue to meet annually in conjunction with the IAFMHS conference. During our last meeting held in Montréal, members in attendance shared their interest in risk assessment and management, as well as current projects, research, and practices in which they were engaged. Some of the topics of these included incorporating protective factors in risk assessment and how both risk and protective factors are utilized in practice; the challenge of risk assessment in the elderly and individuals with intellectual disabilities; the intention to use risk assessment as a way to move toward prevention, rather than merely prediction; and the relationship between risk and recovery. Our members also spoke about risk to the broader IAFMHS community during pre-conference workshops (*Advances in Structured Professional Judgment, Advancing Risk Assessment and Risk Management using Analytics, and Assessment of protective factors in adults, young adults and juveniles*) and throughout the conference proceedings.

And second, a bit about me: I am a clinical and forensic psychologist, and work primarily as a Research Scientist at Ontario Shores Centre for Mental Health Sciences in Whitby, Ontario, Canada – a public psychiatric hospital. The hospital provides comprehensive mental health and addictions services to individuals who present with complex serious and persistent mental illness. Within the Forensic Service, it has six units designated as general and secure (i.e., minimum and medium) – a total of 138 inpatient beds – and an outpatient department that supports approximately 110 people, which provide treatment services for individuals found NCRMD. I also consult for our regional police organization and am part of a large private practice clinic. As the new associate editor of *Risky Business*, I welcome thoughts, suggestions, etc. from readers about what you would like to see in this section or offers to contribute articles – please do not hesitate to connect with me. Also, note that membership within the RISC-Team is open to all IAFMHS members so if you are interested, please join our meeting in Kraków!

SPOTLIGHT ON MENTAL HEALTH DIVERSION

Mental Health Diversion

Evan Lowder, PhD

Assistant Professor, George Mason University, USA

As the Coordinator of the Mental Health Courts and Diversion Programs Special Interest Group, I am pleased to introduce the "Spotlight on Mental Health Diversion" section to the IAFMHS newsletter. Through my work with this SIG and as a researcher doing work in this area, I have had the opportunity to visit mental health diversion programs across the United States and internationally. A continual theme throughout these visits is how unique and customized these programs are to various jurisdictions. This theme is reflected in the research literature as well. Mental health diversion programs have been shown to vary in their structure and financing, in the eligibility criteria for participation, in the conditions of participation, and in the extent to which services are integrated as part of the program. Such wide variability in the design and practice of diversion programs is a challenge to researchers doing work in this area, but it is also an opportunity. Mental health diversion programs have been operating for well over a decade. New programs are developing all the time, often under new models. A fairly solid body of research suggests mental health diversion programs are effective (even if to a small extent) as a crime-control strategy. However, we know little regarding the strategies that could make these programs more effective in decreasing recidivism or improving access to and use of behavioral health services.

Efforts are underway internationally to improve criminal justice responses to individuals with mental illness, including through the development of new mental health diversion models and through refining existing approaches for this population. These efforts provide opportunities for researchers and practitioners alike to learn more about what makes mental health diversion programs an effective crime-control strategy for justice-involved adults with mental illnesses. Aligned with these growing efforts, my goal is to use the "Spotlight on Mental Health Diversion" section to highlight new, emerging, or novel mental health diversion initiatives or evaluations that seek to answer these important questions. Through these features, my hope is that we will continue to bridge the gap between research and practice by connecting practitioners and researchers who are doing work in this area.

If you are a practitioner or researcher engaged in new or novel mental health diversion initiatives and would like to see this work highlighted, contact Evan Lowder at elowder@gmu.edu.

FORENSIC MENTAL HEALTH NURSING

Development of the Forensic Managed Care Network for Northern Ireland

Noel McDonald, MSc

Forensic Network Manager, Northern Ireland

The Bamford review of mental health and learning disability services in Northern Ireland recommended the need to provide appropriate assessment, treatment and rehabilitation, for people with a mental illness who are subject to the criminal justice system and pose a significant risk of serious harm to others. It also recommended that forensic services consider the needs of service users, their careers, the wider public and other health service providers.

McCann (1999) described the needs of the forensic patient as being complex, involving a number of agencies, requiring a collaborative and coordinated approach across service and professional boundaries. Forensic services work collaboratively with the five Trust services in Northern Ireland, for example: generic mental health teams; Intellectual Disability teams; substance misuse teams; primary care, and social care. In addition they link with the independent sector and criminal justice agencies, such as: courts; police; prison; probation and public prosecution services. There is a need for close working relationships between these groups in order to promote positive outcomes, with the overall aim of forensic services being to reduce offending behaviour and minimise risk to others.

Recent regional investment has been directed at services targeting community Intellectual Disability and child and adolescent client groups. There is currently a review of the Intellectual Disability service in Northern Ireland to help shape the service model for the future, including the community team and inpatient forensic service.

The last review of Forensic Mental Health and Intellectual Disability services in Northern Ireland was carried out in 2006 and highlighted that the service fell substantially below the standards set in other parts of the UK.

Prior to the opening of Shannon Clinic, Medium Secure Unit (MSU), in 2005, there was no specialist inpatient forensic service in Northern Ireland. Forensic patients were treated in psychiatric intensive care units across the region, in prison and in the high secure facility Carstairs State Hospital, Scotland. Community patients were managed by generic community mental health services. There were other forensic patients in other high and medium secure units across the UK who were then repatriated back to Northern Ireland.

There is currently no specific forensic low secure provision in Northern Ireland for mental health patients. The community forensic teams were developed across the region in parallel with the development of the Shannon Clinic.

The Six Mile low secure unit opened in 2006. This is a purpose built facility which provides care for adult males with intellectual disability who are in contact with the criminal justice system in Northern Ireland and require a level of secure care. In 2008 the responsibility for healthcare within all prisons in Northern Ireland was transferred to local health Trusts.

The Community Forensic Child and Adolescent Mental Health Service is a new development to forensic services in Northern Ireland . It is a multi-professional team of health and social care and youth justice specialists, developed in partnership with the local Trust and the Youth Justice Agency.

The Forensic Managed Care Network for Northern Ireland was established in May 2018. It was developed to sustain the coordination of multi-agency working across Health and Social Care Services, Criminal Justice Agencies, Third Sector and user and carer organisations. The FMCN will ensure continuity of regional service coordination, cooperation and planning for the benefit of a complex and often high-risk client group, who are supported by carers and family members. Forensic Mental Health Services assess and treat justice-involved people with mental illness and patients with major behavioural, mental health problems and intellectual disability, in a range of secure health facilities and the community, in police stations, courts and prisons (Ridley et al, 2014).

The Forensic Managed Care Network covers both mental health and Intellectual Development Disabilities Services. It is a partnership initiative in collaboration with the Scottish Forensic Network and the Irish National Forensic Mental Health Services, Dublin, Ireland. The Forensic Network Manager was appointed in July 2019 in conjunction with a local Trust for a period of six months.

Shannon Clinic, Medium Secure Forensic Unit

FORENSIC MENTAL HEALTH NURSING

Aims & Objectives of the Forensic Network

The overarching aim of the Forensic Managed Care Network is to bring a consistent approach to the planning of services and address fragmentation across forensic services in Northern Ireland. Additionally, it aims to determine the most effective care for justice-involved people with mental illness and consider wider issues surrounding patient pathways. Lastly, it aims to align strategic planning across Northern Ireland, and address teaching, training and research needs.

The key responsibilities are to coordinate and support the three sub-groups to deliver on Forensic Network work plans. These three groups include the Criminal Justice Interagency & Clinical Practice Group, the Research and Quality Improvement Group, and the Training & Education Group. It is important to ensure timescales and work plans are met as agreed by the Regional Forensic Managed Care network Advisory Board.

Key priorities for the Forensic Managed Care Network

- Meet key stakeholders across the region on an interagency basis to generate networking opportunities and raise awareness of the Forensic Managed Care Network and its intended work plan
- Build relationships with the key staff to promote collaborative working on specific projects
- Complete the Regional Forensic Care Pathway and Service Model for the Forensic Services in Northern Ireland
- Expand multidisciplinary recruitment in community Intellectual Disability teams
- Develop a Forensic Managed Care Network communication strategy and partner with Scottish Forensic Network to use their website for publication of Forensic Managed Care Network

To conclude, the introduction of the Forensic Managed Care Network will help address current issues and steer forensic services in a positive direction. We hope to secure core funding to sustain the Forensic Managed Care Network with the substantive posts of the Forensic Network Manager, Clinical Director, Administrative support, Quality Improvement and Research Assistant which will be critical to the development of forensic services in Northern Ireland.

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20th Annual IAFMHS Conference

Join us for our 20th anniversary in Kraków Poland!

To celebrate this momentous occasion, we would like to ask our members to email us photos, texts, and anecdotes from the past 20 years!

Special Edition #IAFMHS2020 merchandise coming soon!!

All benefits go directly to IAFMHS student grants, awards, and activities.

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STUDENT SECTION

SPOTLIGHT: INTERVIEW WITH JOHN F. MORRISON

Student Section Editors: Maria Aparcero, Student President, Fordham University, USA | Sarah Schaaf, Student President-Elect, Fairleigh Dickinson University, USA | Silvia Fraga, Student Secretary, Royal Holloway University of London, UK

Dr. John F. Morrison is a Senior Lecturer in Criminology at Royal Holloway University, where he also leads the BPS accredited BSc programme in Criminology and Psychology and co-leads the MSc programme in Terrorism and Counter-Terrorism Studies. John is the co-director for the newly established *Conflict, Violence and Terrorism Research Centre*. He is the associate editor of two leading academic journals in terrorism studies, *Perspectives on Terrorism* and Behavioral Sciences of Terrorism and Political Aggression. Outside academia, John produces and hosts the Talking Terror podcast, where he interviews experts in terrorism and counter-terrorism studies.

John F. Morrison, PhD

Senior Lecturer in Criminology, Royal Holloway University, UK

Q: Could you tell us about your educational background and how you became interested in the fields of terrorism and extremism?

A: I have a BA in Psychology from University College Dublin, an MA in Forensic Psychology from University College Cork and a PhD in International Relations from the University of St. Andrews. When I started my undergraduate degree, I was adamant that I wanted to be a sports psychologist. However, as the degree progressed, I realized that this was not for me after all. Knowing about my interest in politics, my supervisor Prof. Ciaran Benson, recommended that I look at anti-American or anti-Israeli prejudice as my dissertation topic. With the Iraq war in its early stages at the time, growing anti-American sentiment was being debated internationally, so I decided to research Anti-Americanism. That led me to the psychology of terrorism literature, which fascinated me. Then, I completed the Forensic Psychology master's program in Cork, which had a module on psychology of terrorism. There, I met Dr. John Horgan, the instructor of the module, who later became my PhD supervisor, then my boss at Penn State, and ultimately a very close friend. Without Ciaran Benson's advice on changing my research focus and meeting John Horgan in Cork, I doubt I would be studying terrorism today.

Q: What are your current projects and how does a typical workday look like for you?

A: I am currently finishing a project with colleagues on the social ecology of radicalization, funded by the Minerva Research Initiative. I am looking at the role that place plays in people's involvement in modern-day armed republicanism in Belfast. This has involved interviewing people who were previously involved in armed republicanism, and key stakeholders working in communities where armed republicanism is still prevalent. Of course, I am also engaged in non-research related tasks, such as teaching and administrative work. I often look at academia as working for an employer (i.e., for the university), while at the same time being self-employed (i.e., research). For the latter, you have to be self-motivated, and self-organised. You have to come up with research ideas, chase funding, and carry out the research. For external observers, this is the work you will be known for; however, it is equally important to pass on the knowledge to your students. Being able to share knowledge with the next generation of experts in this ever-growing area is really satisfying to me.

Q: Have you experienced any challenges that are particular/unique to terrorism research?

A: One of the key challenges I experienced in this area is to resist the urge to be always 'relevant' in the eyes of the general public. There are many terrorism researchers who strive to follow the current trend. However, we also need to be able to research areas, groups, and aspects of terrorism and extremism that are not deemed newsworthy. When I was doing my PhD, I was analyzing the splits in the Irish Republican Movement and the origins of the violent dissident Irish Republican groups. While historically the paramilitary republican groups were the most researched throughout the history of terrorism studies, everyone was paying attention to Al Qaeda and other jihadist groups. All that research was vitally important, but there were still areas and topics that needed to be studied elsewhere.

TALKING TERROR

STUDENT SECTION

SPOTLIGHT: INTERVIEW WITH JOHN F. MORRISON

We have to think of non-traditional ways of research dissemination without losing the substance of what we are trying to say

Q: In your opinion, what role does psychological research play in political decision making on how to combat terrorism? How could we better disseminate our research findings?

A: I feel that it should play a key role and is beginning to play a bigger role. The history of the psychology of terrorism research demonstrates the relative psychological normality of people who commit terrorist offenses. This has to guide our research. So, for me, a central part of my research has been the analysis of the role that trust plays in terrorist decision-making. But this is not a message that really resonates with political decision makers, or at least it is not politically expedient as a central aspect in the decision-making on how to combat terrorism and extremism. I am writing this in the aftermath of the November 2019 London Bridge attack. We only need to look to the political reaction to see how much work there needs to be done to elevate evidence-based initiatives above political rhetoric and fearmongering in this area. We need to look beyond the traditional academic journal articles and conference presentations, as policy makers and practitioners don't have time to access them. So, we have to think of non-traditional ways of research dissemination without losing the substance of what we are trying to say. This is not always easy. But I think that my approach to the *Talking Terror* podcast has hopefully achieved this to some extent.

Q: How did you come up with the idea of the *Talking Terror* podcast? What is its mission?

A: The honest answer is, I was becoming frustrated with myself because I was only reading books and articles relevant to my own research. I was going to conferences and seeing great research done by others, and thinking "this is all great, but I will never get a chance to read all of this." So, I set up the podcast to force myself to do so. The first series had guests identifying three pieces of research that influenced their career and three pieces of their own which they wanted to discuss. This format forced me to read much wider in order to prepare for the interviews.

Its mission is to introduce people to the nuanced understanding we have of terrorism through excellent research. Too often terrorism experts are interviewed in the media in the immediate aftermath of an attack, where little to nothing is known about the perpetrator, motive, etc. There is no real chance to go in depth on key issues relating to terrorism. This podcast will hopefully help students, researchers, practitioners and policy makers to easily access some of the best research out there.

Q: From your perspective, what are some of the obstacles our field faces (i.e., intersection of psychology and law)?

A: I think that our core strength of interdisciplinarity can also be our Achilles heel. By being spread across a range of disciplines we need to be sure that we are still able to engage in the core debates that are going on within our disciplines, as well as the key areas relating to our own specific intersection of disciplines. To advance these intersections, we need to be able to bring the key findings from our home disciplines and test them within our specific area. That is why within terrorism studies the most interesting advances are being made by criminologists, psychologists and others who are drawing on their core disciplines to shape their research. This may seem like an obvious thing to do, but for too long we have not been doing enough of it.

Don't always think about the next step. If you are making the most of your time in the present, then future opportunities will look after themselves.

Q: Looking back at your graduate school days, is there anything you would have done differently? Any advice you have for others interested in following your path?

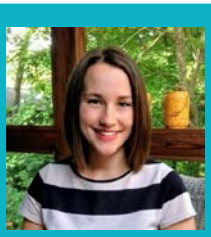
A: I sometimes regret rushing into getting a lecturing position. This is not to say that I did not enjoy or gain a lot from my time as a lecturer, but the PhD and Post-Doc experiences are some of the best you will have. For most of us, there is not a chance to really immerse yourself in research again. I would therefore advise everyone to make the most of every stage of their career. Don't always think about the next step. If you are making the most of your time in the present, then future opportunities will look after themselves. We are in a privileged position as researchers. We can really shape the focus of our career. Be sure to pick something that interests and fascinates you, but also embrace the opportunities to move into other areas of research.

Visit our Spotlight page on the IAFMHS website to read the full interview with Dr. Morrison, including tips on balancing work and personal life, on finding a good mentor, and last but not least, on how to create your own podcast!

STUDENT SECTION

Deciding on a PhD: Should I Stay, or Should I Go? (Part III)

This is the third and final feature on salient differences between PhD trajectories across major regions in the world. In this feature, we focus on the last stretches within a PhD program, which can look quite different depending on where you are. If you missed the first and second feature, visit the previous newsletters.



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Tamara De Beuf

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7. Work those Courses

In many European and Commonwealth PhD programs, students have little to no coursework, as they immediately start working on the research project that will result in their dissertation. Students might be required to attend a few seminars each year. In sharp contrast, North American programs come with heavy coursework, especially in the USA where the first two or three years primarily consist of courses and seminars. In addition to courses, some doctoral programs in North America require internships and practicums.

8. Intermediate Assessment during a PhD

The comprehensive exam (also called preliminary examinations', "prelims"; general examinations, "generals"; or qualifying examinations, "quals") is a major component of PhD programs in North America. In fact, in some programs, a student is not considered a PhD candidate and cannot submit a dissertation proposal until they have passed this comprehensive exam. The exam often includes both a written and an oral component though the exact structure and content are decided by each program. Students may pass unconditionally, with conditions (edits required), or they may fail. Depending on the field of study, a student who fails the comprehensive exam may be expelled from the program or given the opportunity to take the exam again within a year. Many Commonwealth and European programs do not require a comprehensive exam, with a few exceptions. For example, Sweden and Hungary require written and oral exams at the halfway point of a PhD program. In the UK, universities require an informal oral exam of the progress a student has made toward their dissertation after one year of full-time study.

The first two years of coursework in an USA doctoral program are equivalent to obtaining a master's degree in Europe.

9. It was Fun While it Lasted…

For students who prefer a short track to their doctor's title, a PhD program outside of North America would be recommended, especially if they already have a master's degree. Completing a full-time PhD program in North America takes three to eight years of a student's life, with an average of about 6 years.

In the USA, compared to Canada, there might be less pressure to finish as students can keep funding until they complete the program. This is different from Commonwealth and European countries in which a full-time PhD takes three to four years to complete. However, that is when the absolute numbers are considered. A PhD program in the USA can be entered with a bachelor's degree; therefore the first two years of coursework in an USA doctoral program are equivalent to obtaining a master's degree in Europe. When accounting for a one or two-year master's program, graduate school in Europe also lasts four to six years. Finally, program duration might differ per university, per department, and program type (e.g., research vs. clinical).

10. The Cherry on the Cake

Much of the dissertation and defense process is similar in countries around the world. However, some specific details of the process vary between countries (e.g., committee members, timing). In North American programs, PhD students begin to work on their dissertation after comprehensive exams are completed, usually in year 3 of their program. Once a student passes these exams, they propose their dissertation (i.e., topic, literature review, analytic plan, expected results) to a committee and then begin the process of data collection and writing. In most European and Commonwealth PhD programs, students propose their dissertation as a part of the application process and begin working on it upon program entry. The length and structure of the dissertation varies by field and program requirements. Typically an APA paper structure is followed, however, some programs allow a publication-based dissertation (i.e., 3 to 5 journal articles tied together with an introduction and conclusion).

In most EU and CW programs, students decide on their dissertation topic on application and begin working on it upon program entry.

'The Defense' is the final step before obtaining a PhD (also called a viva voce in some countries). In North America, students defend their dissertations to a committee of approximately four academics. These include their primary supervisor, two professors from within their department, and one professor external to their department. In Europe and Commonwealth of Nations, the size of the committee varies and includes at least one professor from within the student's department and at least one professor or expert who is external to their department. The length of the dissertation defense, or viva, varies but is typically one to two hours. During this time, committee members ask questions about the specific contents of the dissertation, such as the main hypothesis or methods of collecting data, as well as more general questions to test a student's knowledge of the field. In some countries, the defense is open to members of the program and the public, while in other countries (primarily in the UK), the defense is private. Overall, this final step of the PhD process is quite similar across countries so PhD students around the world can relate and commiserate over the process of writing and defending a dissertation.

*For some great advice on how to survive your viva, check out **this article** from two of our previous student board members!*

11. Life after a PhD

Traditionally, PhD-holders have ended up in academia or research. People interested in this track often take a post-doc position for a couple of years and then move into a full-time academic position. However, in recent years PhD holders have increasingly looked outside of academia for work. This trend is common in the North America, Continental Europe, and CN. To illustrate, just over half (59.6%) of PhD earners in the US and just under half (47%) in Europe work for universities in traditional academic positions. Many PhD holders are seeking positions in nonprofit organizations, hospitals, government, industry/business, and other fields. Many of the skills gained in a PhD program can be easily (and successfully!) transferred to work settings outside of academia (although there is some disagreement). With the highly competitive nature of the current academic job market, this is an important route to consider. In fact, many universities around the world are beginning to include training for non-academic jobs as a part of their PhD programs. Even though finding employment within academia can be challenging, unemployment rates for people who hold PhDs in social sciences are low worldwide (4% in Europe and under 2% in the US). Thus, although some PhD holders may end up in career tracks they did not originally envision, rates of employment are high and many PhD holders report happiness with their jobs.

There is More to It

In this article series, we have sketched the difference between PhD trajectories with broad strokes. We understand that this approach has limitations. First, to maintain overview, we decided to discuss three broad regions in the world. We acknowledge that there are more regions that offer competitive PhD programs beyond North America, Continental Europe, and Commonwealth of Nations. For example, Asian countries such as Singapore and South Korea have a well-established system of higher education, and countries such as China and Saudi Arabia are expanding their higher education. The mentioned differences may not generalize to these programs. Second, our comparison zoomed in on 11 topics. While these themes may relate to the most obvious features of PhD programs, there are more characteristics to consider, for example the work-life balance. Third, we focused on full-time and university-based PhD programs. Alternatives, such as part-time programs and external (company-funded) PhD programs were left out of the discussion.

Wrap Up

In sum, while PhD programs around the world have common themes (e.g., term structures, dissertation format, defense process), there are considerable differences in approach. Some of the most notable distinctions relate to tuition and funding, focus of the program (broad versus subject-specific), coursework and teaching, and determining the primary supervisor. Awareness of these variations between regions may assist prospective students in choosing a graduate program that aligns best with their skills, talents and future aspirations. Among PhD students, this awareness could challenge one's assumptions on overseas programs and serve as a great conversation starter at events and conferences.

resources website.

We welcome feedback and comments via students@iafmhs.org or @IAFMHS_Student.

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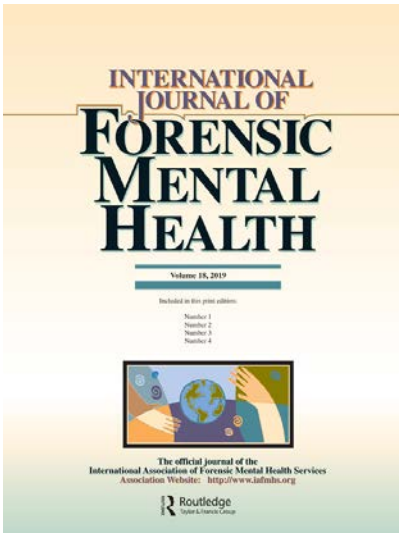
Feature Article



Psychopathic Traits and Empathic Functioning in Detained Juveniles: Withdrawal Response to Empathic Sadness

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In order to gain insight in empathic deficits in juveniles with severe antisocial problems and psychopathic traits, self-reported psychopathic traits and trait empathy were assessed in 416 detained male juveniles. State empathy was assessed by self-reported empathic and autonomic nervous system (ANS) responses to sad film clips. Psychopathic traits were significantly negatively correlated with empathy, although not with ANS responses. Individuals reporting no empathy showed significantly less heart rate withdrawal compared to individuals reporting higher empathy. This implies that physiological responses may be helpful in identifying juveniles with severely impaired empathic functioning, even in a severely antisocial sample.

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