Countering Countertransference: A Forensic Trainee's Dilemma

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Forensic psychiatry involves an adaptation to a role that is very different from the psychiatrist's previous clinical experiences. To render an unbiased forensic opinion, psychiatrists have to rise above their countertransference feelings. This takes years of practice and experience. The following is an account of a forensic trainee who faced several countertransference problems as he evaluated a patient charged with attempted murder. The case report is interspersed with a review of the relevant literature.

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Training in forensic psychiatry involves adaptation to a role that is very different from the psychiatrist's previous experiences during residency training or other clinical care. Such specialized training involves identifying and being comfortable with the idea that the primary responsibility of the forensic psychiatrist is not to the patient but to the person or agency requesting the evaluation.[1] According to the ethics guidelines of the American Academy of Psychiatry and the Law, a forensic psychiatrist's role is to give an honest, objective, impartial, and unbiased opinion to the retaining agency. This approach is recommended in both civil and criminal cases.[2] However, rendering a completely unbiased opinion is full of challenges for the forensic psychiatrist, because of conscious and unconscious responses to evaluees. Further, the forensic psychiatrist may be affected by the nature of the alleged crime and/or by the potential effects of the evaluation on the outcome of the trial. Such responses are an unavoidable part of the forensic psychiatrist's countertransference to evaluees and can create an impediment to giving an honest and unbiased opinion.

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Since countertransference was introduced as a psychotherapeutic concept, its meaning has evolved significantly. Freud[3] originally introduced countertransference as the therapist's unconscious response to the patient, based on the therapist's unresolved conflicts. However, Winnicott[4] broadened the definition of countertransference to include all natural reactions that the therapist has to the patient's outrageous behavior. According to Gabbard,[5] this broadened definition has decreased the "pejorative connotation of countertransference" as solely the therapist's problem. However, in forensic psychiatry this "softer" definition of countertransference does not excuse the psychiatrist from the requirements of resolving the conflict. On the contrary, the evaluating psychiatrist or mental health professional is required to rise above such countertransference feelings. According to Dietz,[6] a forensic psychiatrist's job is to pursue and seek truth. However, Dietz acknowledged that doing this with honesty and integrity is a difficult task and that it takes years of practice and experience to perfect. For someone just beginning a career in this field, pursuing this goal may be especially difficult and complicated.

The Case

The following case report is an illustration of a forensic fellow's journey through the quagmire of countertransference in pursuit of objectivity, to learn and master the art and science of forensic psychiatry. Identifying data have been changed to preserve the confidentiality of the relevant parties.

To pursue his interests, Dr. S. enrolled in a forensic psychiatry fellowship program. Early in his training, he came across the opportunity to conduct a high-profile court-ordered evaluation. The case involved a 19-year-old male patient, Mr. P., who allegedly tried to strangle his 1-year-old child. Dr. S. had, until then, handled only a few civil commitments and was eager to use his burgeoning skills in a major criminal case. When his supervisor discussed his working on this case with him, Dr. S. jumped at the opportunity, despite his limited experience in forensic psychiatry.

Dr. S. began reviewing the records. He learned that Mr. P. was a single man who had been involved in a four-year relationship with his girlfriend. They had a one-year-old son. Recently, Mr. P. had been unemployed. After a brief period of homelessness he moved into his girlfriend's home. The girlfriend provided him with food and clothes, because he could not support himself. In return, she made no demands on him. Mr. P. was grateful and initially handled the move well. He would baby-sit their child while his girlfriend worked. However, he quickly realized that child care was very stressful. The baby cried frequently. When his girlfriend returned home from work, she spent increasing amounts of time with their son. Mr. P. began to notice that he got little time and attention from her. He started becoming jealous of the baby and argumentative. One morning, Mr. P. went to find his girlfriend in the nursery. The baby was crying loudly, while she tried to calm him. Mr. P. was enraged that his girlfriend had left him, once again, for the baby. He walked to the baby, picked him up, and ran to the bedroom, locking the door behind him. When his girlfriend overcame her initial shock and realized what had happened, she ran after him. She was unable, however, to prevent him from locking the door. She started banging on the door and pleaded for him to give her the baby. Mr. P. ignored the banging and her pleas. She ran to the phone and called her neighbors to help. They arrived shortly and tried to break down the door, calling loudly, but Mr. P. ignored their yelling. As they broke into the room, they saw Mr. P. with his hands around the baby's neck, trying to strangle the baby. On seeing them come into the room, Mr. P. panicked and ran out of the house, leaving the unconscious baby behind. Police found Mr. P. later, hiding in an abandoned building.

As Dr. S. read the details of the police and witnesses accounts, he could not help feeling enraged. Being the father of a one-year-old infant himself, he could identify with the mother of the one-year-old victim. "How could Mr. P. do this?" he thought, "No man should get away with this."

In several publications, articles have described the feelings of repulsion and anger that are awakened in forensic evaluators and treating clinicians in response to discovering the harrowing details of a defendant's crime.[7–9] In most cases, this just represents a personal opinion. Dr. S.'s response to this defendant's crime is a similar expression of personal opinion.[10] However, the intensity of this opinion signals a countertransference reaction. When Dr. S. started thinking that Mr. P. "should not get away with it" he became overtly judgmental—that is, "moralistic, and condemnatory."[11] This potentially impaired his ability to evaluate and diagnose Mr. P.'s psychiatric disorder effectively. Protter and Travin[11] called this reaction the "Moralistic and Punitive Response Set" and said that this stance can significantly impair the psychiatrist's ability to diagnose the patient's illness.

Dr. S. was uncomfortable with the way he was feeling. He realized that his judgmental thoughts might compromise his objectivity and impartiality in conducting a criminal responsibility evaluation of Mr. P. He recognized that his thoughts were based, not on information gained from his evaluation of Mr. P., but on his preconceived notions of right and wrong. Moreover, he was aware that his reaction was related to countertransference feelings. Dr. S. realized that if he allowed these preconceived notions to affect him, his opinion would be biased. He made a conscious effort to put aside his bias so that he could evaluate the defendant with an open mind.

Dr. S. met with Mr. P. the next day. Mr. P. presented as a young man, with long, dirty hair and a muscular physique. He had not shaved, and his clothes were dirty and stained. As Dr. S. entered the room, Mr. P. gave him a suspicious look and turned away, as he did throughout most of the interview. Dr. S.'s sense was that Mr. P. was arrogant. He started the evaluation by giving Mr. P. the relevant warnings about the limitations of confidentiality. Mr. P. appeared to understand what was said but did not answer. He was not in acute distress and did not appear to be experiencing any auditory or visual hallucinations. When Dr. S. pressed for some kind of acknowledgment, Mr. P. still refused to speak. When

asked again, Mr. P. said that he did not want to talk. When asked why, Mr. P. replied, "Because I said so." Taken aback by his response, Dr. S. got up and left the room, thinking that Mr. P. must have a significant antisocial character disorder.

Dr. S. was experiencing blatant defiance by the defendant and was feeling helpless and castrated because of his inability to respond effectively to Mr. P. Dr. S.'s defense was a type of acting out, in which he labeled Mr. P. as having a significant character disorder. This is not an unusual response. Protter and Travin[11] called this the "Mad or Bad Response Set." This phenomenon describes clinicians who feel so controlled, helpless, and undercut by the behavior of the evaluee that they become extremely angry and completely withdraw from the evaluee. This reaction may cause the clinician to end an evaluation too soon and prevent the clinician, inadvertently, from uncovering further useful information, which can lead the clinician either to misdiagnose an underlying mental illness or to miss the symptoms of mental illness altogether. The evaluee may even be given a formal diagnosis of antisocial personality disorder.[11] This phenomenon was apparent in this case, when Dr. S. had spent little time with Mr. P. and prematurely dismissed the possibility of a more serious Axis I condition. Further, Mr. P.'s behavior and Dr. S.'s response to it also appear to be a sort of projective identification that led to Dr. S.'s acting out and terminating the evaluation.[12] After this incident, Dr. S. probably became the aggressor in Mr. P.'s psychic reality and Mr. P. would now, arguably, identify with the aggressor and refuse to answer any further questions,[13] making a bad situation worse.

Dr. S. was able to identify the role of countertransference in this encounter. He promised himself to try again with an open mind. He repeatedly met with Mr. P. over the next few days and was finally able to talk with him (Mr. P.'s compliance with his antipsychotic medications may have been helpful in facilitating his cooperation with the evaluation). Despite Dr. S.'s initial impression that Mr. P. had not been experiencing psychotic symptoms, Dr. S. learned that Mr. P. had a long history of psychotic illness. According to the available records, two hospitalizations had occurred in the recent past that were precipitated by psychotic symptoms. Just before the alleged incident, however, Mr. P. had missed at least two appointments with his outpatient psychiatrist and had run out of his antipsychotic medications. Soon after running out of these medications, he started experiencing auditory hallucinations. He described these hallucinations as God's telling him that "The baby was the devil's reincarnation and should die." There were other reports that suggested that Mr. P.'s behavior was odd, and he appeared very withdrawn just before the alleged incident. With this information, Dr. S. thought that Mr. P. might have been experiencing symptoms of a mental illness at the time of the alleged offense. Dr. S. thought that it was also possible that this may have affected Mr. P.'s abilities relevant to criminal responsibility.

Dr. S. finished up his assessment and went to discuss his findings with his supervisor. Despite his most recent opinion about Mr. P., Dr. S. could not help wondering whether he was making the correct decision in opining that Mr. P. was not criminally responsible for the alleged offense. He knew that ultimately Mr. P.'s responsibility for his actions would be determined through the court process, but he also realized that his evaluation might affect the decision. Further, he wondered whether his evaluation should reflect or consider the public's concern and opinions about Mr. P.'s alleged offense. Dr. S. also wondered if his being a parent affected his opinion. What if he was making a big mistake in his first major case? What impact could this have on his reputation and his budding career as a forensic psychiatrist? Dr. S. approached his supervisor for help in grappling with the many questions that were weighing on his mind.

Discussion

Problems of countertransference, such as those faced by Dr. S., confront forensic psychiatrists at all stages of practice and levels of expertise. However, these situations are especially difficult for trainees and others with limited expertise in the field to manage. According to Dietz,[6] the novice expert can face "influences, distractions, and temptations" that more experienced experts may contend with more easily. He also wrote that several factors such as self-doubt, supervisory influence, and public pressure can have significant negative impact on the objectivity of the early-career forensic psychiatrist. Furthermore, the inexperienced forensic psychiatrist may not recognize the broad range of countertransference responses that could affect an evaluation.[6]

Countertransference may be broadly considered an unconscious reaction that any person experiences in interaction with anyone.[14] Being a forensic psy-

chiatrist confers no special immunity to these reactions. However, because of their unique role in applying psychiatric knowledge to answer important medicolegal questions, forensic psychiatrists may exercise considerable influence on the administration of justice.[15] Therefore, it is essential for forensic psychiatrists to be aware of this influential role and the potential for this influence to be misused, either consciously or unconsciously. Forensic psychiatrists should recognize that it is very common to have their thoughts and feelings affected by people around them. Once these feelings and emotions have been affected, they may change the thinking and opinions of the clinician in a forensic setting.[14] Therefore, it is incumbent on forensic psychiatrists to be mindful of these possibilities and make conscious efforts to deal with all situations in which countertransference arises. These may occur as a positive countertransference response, such as that in the case reported herein in which the defendant was called a "patient," and/or a negative countertransference when the same defendant may have been labeled as having a character disorder without supporting evidence. Both of these types of countertransferences can affect the objectivity of the final forensic evaluation.

Forensic trainees must be especially cognizant of the potential impact of these countertransference feelings. Their inexperience and eagerness to venture into the arena of high-profile cases (as when Dr. S. "jumped at the opportunity" to evaluate Mr. P.) may interfere with their ability to ask themselves whether they are qualified to handle a particular case. They may hide or deny their countertransference reactions in an effort to be regarded as a valid forensic psychiatrist. Additionally, trainees may have difficulty managing the feelings evoked when they learn the details related to violent crimes. As such, they may make efforts to distance themselves from the information they read. In this case, Dr. S. referred to Mr. P.'s son as "the baby," perhaps in an effort to distance the defendant's son from his own infant child.

Several authors have outlined methods to manage such countertransference responses. Dietz[2] recommends that if forensic psychiatrists notice that they are becoming "aroused, attracted, afraid, or angry" during an evaluation, they should be aware that it is most probably because of countertransference. Cases that elicit such sentiments should be discussed with a colleague or supervisor for a second opinion. Further, when such feelings surface, one should not rush the evaluation. Buying some time to reflect on what might be happening may prevent the evaluation from being misled by countertransferences. The urge to arrive at a final opinion should be resisted until the feelings are processed and dealt with in a meaningful way.[6] Protter and Travin[11] recommend that another way to deal with the countertransference in a meaningful way is to discuss the case in a clinical conference with peers. King[16] also emphasizes the importance of discussing difficult cases with colleagues and supervisors. When there is reason to suspect that the forensic psychiatrist is having an unrecognized countertransference response that could interfere with the objectivity of the evaluation, the onus of responsibility to raise the issue may rest with the supervisor. In managing these situations, the supervisor should be mindful of his or her own countertransference reactions to the case and to the trainee.

The forensic psychiatrist can also deal with the arousal of countertransference by having some experience with psychotherapy on a continuing basis.[10] Although forensic evaluators are not acting as therapists, continuing psychotherapy can help them become aware of personal traits that could elicit countertransference reactions in their forensic evaluations. This can be especially important when the countertransference conceals itself within certain "countertherapeutic scotomas" within the trainee, who may be completely oblivious to them.[17] Unless explored, these "countertherapeutic scotomas" could bias an opinion on a continuing basis. This is evident by the eagerness with which Dr. S. sought to take a high-profile case, even though he was aware of his limited experience. In such cases, therapy may help to provide better insight into the evaluator's reactions and behavior and further improve chances of objectivity.

Gorman[18] suggests that the risk of countertransference in forensic evaluations can be decreased by including professional ethics courses early in the training of forensic psychiatrists. Formal study of professional ethics can help identify the importance of recognizing the problems associated with bias in forensic evaluations. In their article, "Guidelines for Forensic Examinations," Simon and Wettstein[19] wrote that forensic psychiatrists must be aware of biases that could influence the results of their evaluations and take appropriate steps to deal with them.

Hayes *et al.*[20] report five factors that could play a central role in managing countertransference in

treatment settings: anxiety management, self integration, conceptualizing skills, empathy and self-insight. Even though they explicitly refer to management techniques in treatment settings, these principles may apply equally to countertransference that arises in forensic evaluations. The attainment of these skills is not a simple matter. Anxiety caused by encounters with difficult forensic evaluees can lead to a sense of helplessness. This can be especially problematic in the face of growing countertransference reactions. Anxiety management can therefore play a critical role in the work of a forensic psychiatrist. In addition, examiners should have the skills to conceptualize the psychic constructs of their "self" and that of their evaluees. Through this, they will better understand themselves, their evaluees, and their responses to them. This can lead to a more objective assessment of the effect of the evaluee's symptoms on the forensic question at hand.

Conclusions

In the field of forensic psychiatry, the path of a trainee is riddled with the potholes of countertransference. Negotiating a safe passage through this path is a difficult but essential task in the pursuit of excellence in the field. To succeed, the forensic psychiatry trainee must gain some self-awareness and use this self-awareness to explore the existence of countertransference. Once this is accomplished, the difficult but important goal of striving for objectivity can begin.

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