Commentary: "Countertransference" on Trial—Witness or Defendant?

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Sattar, *et al.*[1] have made a contribution to our profession generally in the manner of our use of terminology by noting that some phenomena observed in psychotherapy are similar to those in the work of the forensic psychiatrist, such as in the psychiatric evaluation, preparation of testimony, and provision of testimony. In doing so, the authors clarify the definition of the work of the forensic psychiatrist, as well as that of the psychotherapist. They clearly demonstrate the usefulness of these ideas (especially "countertransference") but raise questions about whether the term "countertransference" is appropriate to describe the work of the forensic psychiatrist. They are right to do so, and in doing so, raise a challenge to the field of psychotherapy as well as forensic psychiatry about how we use words. The concept of countertransference bears witness to some of the complexity of the forensic psychiatrists' work and at the same time may misrepresent the tasks of the forensic psychiatrists.

Review

I think it useful at this point to review briefly the term countertransference, at least in how it is used in the field of psychodynamic psychotherapy and psychoanalysis. Countertransference, broadly speaking, is any emotional reaction of the therapist toward the patient. There are two definitional traditions, classic and totalistic. The classic definition defines countertransference as the emotional "transference" reactions that the therapist has toward the patient. This is what Freud meant when he coined the term *gegenübertargung.*[2] Freud did not develop this idea, but simply called the therapist's reaction "counter" to the patient's transference. He rarely used it. But clearly, he thought it was something that had to be avoided and needed to be monitored. The totalistic definition of countertransference includes the classic tradition, refers to all the therapist's emotional reactions toward a patient, and divides it into three general areas: (1) the therapist's specific irrational transference feelings toward a patient; (2) the "realistic" emotional reactions of a therapist (what any therapist might be expected to feel) toward a patient; and (3) the emotional psychological reactions of the therapist toward the patient that are specifically in response to the patient's transference reactions toward the therapist. Over the years, incorporating the work of Melanie Klein[3] and others and the ideas of object relations theorists (especially the idea of countertransference as a reaction to the patient's transference), countertransference has come to be thought of as a useful source of information in the psychological, particularly psychodynamic or psychoanalytic, work with patients as opposed to some pathological reaction that must be controlled.

But our field of psychiatry is not always precise in its use of terms, and by far the more prevalent usage of countertransference is all the therapist's emotional reactions toward the patient, without clear differentiation among these definitional nuances.[4]

As Honest Witness

The authors give rich clinical accounts of a specific case with many broad emotional reactions of the forensic psychiatrist. Countertransference, as a broad emotional response, is abundantly present in the material presented in this article. But some examples are not specifically related to the patient. For instance, the trainee forensic psychiatrist who makes the mistake of misunderstanding the patient's "demeaning

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look" and consequently feels "intimidated" seems to be committing the kind of mistakes that beginners make when not fully cognizant of the manner in which psychopathology can present and therefore simply misunderstand the signs of major mental illness. In other words, the trainee misperceives the patient's look of terror and fear borne of psychosis for the derogatory criticism of the narcissistic/sociopathic character. The error is one of inexperience and misunderstanding of psychopathology.

The authors note that these kinds of reactions are typical threats to the goals of neutrality and objectivity in forensic evaluations. And, of course, it is part of the professionalism and a function of training and experience that these impairments of objectivity and neutrality are removed or diminished.

Other examples in the paper seem to be matters related to the trainee's feeling criticized or his fear of being confronted for his testimony. In the example, the episode of seeing the family members of the defendant, the presence of the journalist, and finally, the emotional outburst of a relative of the presumed victim all involve problems of critical evaluation and confrontation. Of course, one would have to be robotic not to have feelings or fears about one's performance in coming from a medical context to a forensic one of an adversarial proceeding. In court, there is a systematic attempt to discredit testimony, to challenge and confront. Of course, one is going to be confronted and challenged, and naturally there are going to be strong emotional reactions to this process. But again, this appears to be a function of professionalism, training, and experience, rather than a specific emotional reaction to this specific defendant and this defendant's family and circumstance. The authors are correct to note that forensic psychiatrists are no different from other mental health professionals in that they also react personally to the actions, words, and behavior of others. What is different for forensic psychiatrists, however, is that they are not involved in a healing relationship, they are not involved in a process that systematically calls for them to identify with their client (although they might). Rather, they are there to advocate for neutrality and, as far as possible, for the objective elaboration of social reality or truth as it can be known.

As Defendant

To the extent that the work of the forensic psychiatrist, then, is involved in understanding unwitting or unconscious emotional reactions in the courtroom and associated venues of all of its actors, there is an analogous notion between the emotions experienced by the forensic psychiatrist noted in this article and the idea of countertransference. However, the authors are correct to suggest that the term countertransference is probably not appropriate. But why is it not appropriate? The authors note that the forensic psychiatrist is not in a healing relationship with the person being evaluated, and while the forensic psychiatrist may have spent many hours with the defendant, the purpose of that is to be able to answer fairly narrow questions about whether or not, as best as can be determined, the defendant's mental state meets criteria for criminal (or civil) responsibility as defined by statute. In other words, the goal is quite specific, quite narrow, and not based on an effort to bring about psychological healing through insight. Using the term countertransference implies something more therapeutic. Furthermore, as the authors note in their article, the emotional reactions of the forensic psychiatrist may have nothing to do specifically with the individual client. I completely agree with the authors that forensic psychiatry needs a concept of the forensic psychiatrist's emotional response that is not generated by a specific dyadic relationship. This distinction is important because the correction of the distorting impairment to truth is different depending on how one defines the problem. If the problem is due to inexperience and level of training, one gets more of both. But if the problem is due to the unwitting reaction specific to the forensic psychiatrist and the specific client, then the correction is psychotherapy and supervision of the forensic psychiatrist. The term then becomes a source of problems, a defendant.

Perhaps a fruitful approach would be, rather than conceptualizing or producing a cartography of the emotional responses that the forensic psychiatrist may experience, to develop more thoroughly, conceptually as well as technically, the goals of objectivity and neutrality.

But what are objectivity and neutrality? A definition of neutrality and objectivity would include a portion of what it means psychologically to be "neutral" (not a human default position) as well as technically how one achieves neutrality and how one demonstrates it. And neutrality and objectivity would not mean without emotion. For there is no way that a human being can be a forensic psychiatrist

or, for that matter, any kind of examiner of the human condition or mental health professional without having emotional reactions. To do so would not be human. However, what "the professional" in these circumstances can do is learn how to recognize his or her own patterns of response and be able to understand how these particular responses enhance or impair objectivity and neutrality and the elucidation of the truth. In some ways, the requirements are great, but they must be met for forensic psychiatry to continue to enjoy the enormous prestige and respect that it has earned.

What Does This Say About Psychotherapy?

No one can control how a term gets used by speakers of the language. Once an idea and a word become a part of our language use, then the speakers will determine how it gets used. No one group can control this, nor should it try. However, for psychotherapists, this article should be a warning of the need to keep our own house in order *vis à vis* a disciplined approach about how we employ our concepts and how we speak about them to others. In our craft, the term countertransference is drifting toward definition as a specific reaction to the patient's transference, and in the rest of the field it is drifting toward use as a broad emotional reaction toward a patient. It is probably not a good idea for psychotherapists to use the term in this broad way to describe all the emotional reactions of the therapist to the patient, but rather to reserve this very specific term for the transference reactions of the therapist and the emotional reactions specifically in response to the patient's transference. In this way, countertransference will continue to be a witness and will not become a defendant and a source of problems in our work.

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