Managing Negative Reactions in Forensic Trainees

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The treatment of adolescent offenders often provokes strong feelings in providers on the treatment team. These feelings, or countertransference reactions, can hinder effective patient care. However, with supervision and acknowledgment, these reactions can also be used effectively in becoming aware of the patient's internal state. In this article, a resident and her supervisor discuss reactions to a particular patient on a subacute unit for adolescent offenders. We also discuss methods of teaching trainees to recognize these countertransference reactions and to work through them to provide more effective patient care.

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Clinicians working with children and adolescents often experience strong emotional responses, depending on the particular patient and clinician. In this article, we use the term countertransference to describe these emotional responses. Although many in the field would prefer a more narrow definition of a process taking place in the course of analytic work, for use in this article we define countertransference in the broadest of terms to mean, in accordance with Waska, "the psychotherapist's total reaction to the patient, which would include the therapist's personal transference, interpersonal reactions to the patient's personality, and all intrapsychic responses to the patient's projection of internal objects through the dynamic of projective identification" (Ref. 1, p 34). Furthermore, the development of transference and countertransference reactions in therapy is a multifaceted process. As Bradley *et al.* stated, ". . . the therapy relationship, as an intimate, emotionally charged, asymmetrical and typically nurturant relationship, is likely to activate many attachment-related patterns of thought and feeling and affect regulation, motivation, conflict and so forth" (Ref. 2, p 346), such that the transference phenomena:

> . . . reflect the tendency of the brain to map current on to past experience and to craft responses that represent a combination of automatic activation of procedures and mental representations from the past, integration of current with past data and experience to generate responses that reflect the coactivation of old and new neural networks [Ref. 2, p 348].

This framework explains the potential of child and adolescent work to add many more dimensions to the clinician's reactions. Therapy involving children includes not only the child or adolescent but also the parent. The clinician's childhood longings or the tendency to see aspects of their own children in the patient may trigger emotional reactions. Similar reactions may occur when working with adults, but tend to be less intense, given that those produced by work with children occur while the patient is still living with and reacting to real parents, as opposed to having memories of them. Gabel and Bemporad[3] expounded on the reasons for this. They cited Bornstein's work that found the "child's unpredictability, highly charged emotions, narcissism, and easy access to the unconscious as particularly threatening to the therapist" (Ref. 3, p 111). The child patient can revive the therapist's childhood longings so that the therapist may have a resurgence of infantile strivings, and the therapist must guard against being overly permissive or strict with the patient. In addition, the patient may try to place the therapist in the role of the parent, or, as therapists, we may have an urge to parent our patients, as we see aspects of our own children in them. They also note that the therapist may displace the anger engendered by the child patient (evoked perhaps by the child's making the therapist feel impotent by rebuffing or challenging the

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work) onto the parents and try to punish them. Gabel and Bemporad further describe the potential ways that countertransference feelings can be expressed in caring for children and adolescents. These include feelings elicited by the patient that can be acted on toward the patient, feelings elicited by the patient that can be displaced onto the parents, or feelings generated by the parents that can be acted on in the care of the patient.

Not all of the reactions provoked by working with adolescents are negative. Since many, if not most, of the youth have suffered abuse and neglect, the mental health workers who enter this field with the intention of healing often have rescue fantasies. Pearlman and Courtois considered this type of countertransference from an attachment perspective and suggested that the most typical reaction may be "to rescue or reparent them in an attempt to make up for what clients deserved but did not receive in childhood" (Ref. 4, p 455). A clinician can, however, misattribute his or her own struggles from childhood to the youth in treatment. This misattribution may result in the patient's feeling invalidated.

In addition to the problems of countertransference reactions toward youths and their parents, the provision of care for youths in the juvenile justice system has obstacles, such as role conflicts, interactions with various aspects of the legal system, and negative perceptions about people who commit crimes. The American Academy of Child and Adolescent Psychiatry[5] states that these negative perceptions and attitudes can be the result of knowing the nature of the offense, perceptions that one should be punished for the crimes he commits, and stereotypes of gang affiliation. The resulting negative countertransference may result in care that is ineffective and punitive, as opposed to therapeutic and rehabilitative. In addition, Vaillant[6] discussed the frustration of working with the criminal population due to the psychiatrist's misperception that the patient lacks anxiety, the motivation to change, and the ability to feel depression. Furthermore, he suggests that these defensive maneuvers on the part of the patient may be overcome if the patient is prevented from running, offering hope that more effective treatment will result.

To provide effective patient care, a clinician working in this population should be taught to recognize and process his or her own countertransference, as well as to recognize the common reactions of professionals working in this field. Educating trainees on signs of countertransference is beneficial. Such signs include feelings of depression (when not suffering from a true depression) or any other uncharacteristic mood changes, encouraging acting out behavior or acting out with the patient, dismissal of the reaction as realistic, feeling a need for the child's approval, or repeated arguing with the patient.[7] The presence of shifting feelings and confusion in the therapist should suggest that the patient is experiencing dissociation.[4] Valliant[6] further asserts that the therapist's wish to control an offender's anxiety with drugs or confinements results from a countertransference reaction: the unconscious desire to collude with the patient to avoid discomfort.

In this article, we present a case of a countertransference reaction to a juvenile offender. Following the case description, we discuss the role supervision played in the resident's recognition of the countertransference and how it facilitated the resident's overcoming it. Identifying data have been changed to ensure the patient's confidentiality.

Case Example

James (not his real name) entered the interview room. The resident introduced herself and invited the patient to take a seat. Her smile was met with crossed arms and an angry glare. James crossed the room, slumped onto the couch and continued to glare at the resident with crossed arms. The interview proceeded with little change. His answers were slow with deliberately long pauses, as if he were carefully deciding exactly how much information to share. By the conclusion of the interview, he had endorsed only vague symptoms, such as anger, irritability, and bad feelings about his incarceration. While he would provide little information about the gang he belonged to, he was clear about his affiliation and plans to continue this association on discharge. After the first encounter, the resident felt the case was hopeless. James had endorsed only vague symptoms to target pharmacologically and otherwise seemed to lack the desire to change.

On the unit, James was abusive toward staff and peers. He verbally threatened others while clenching his fists, and he defied established unit rules. During morning rounds, he took a long time to respond after he was requested to enter and then stomped into the room. He continued to glare at the interviewer with crossed arms and was deliberately slow in answering

questions. As his behavior on the unit and interviews continued, the resident's frustrations with the case grew and her feelings that it was hopeless increased. One morning, during a discussion of James, she commented with frustration, "But I don't really see the point; he has no desire to change. He just wants to get out and go back to his gang."

Analysis

When encountering negative reactions, it is important to consider potential etiologies, such as differences in demographics, prejudices, and countertransference reactions. In general, the resident involved in the case was nonjudgmental and sympathetic toward the patients on the unit. She enjoyed working with children and adolescents and had requested the rotation because of her desire to pursue a career in child and adolescent psychiatry. During her training, she had treated patients from many different cultures and backgrounds, including some with gang affiliations. In addition, in this case the resident and patient were from the same socioeconomic class and had similar religious views. They were of different race and gender, but these differences had not been an obstacle when treating other patients. The resident had attended the poorer high school in a small city with a relatively large amount of gang and criminal activity. Coming from this background made her generally tolerant of gang members. Her negative reaction to the patient and her statement were uncharacteristic; the resident had not experienced such an intense reaction when working with other youth in the facility, including patients with similar presentations. As Sattar *et al.*[8] noted in similar cases with forensic trainees, the "intensity of this opinion (the trainees' uncharacteristically strong response) signals a countertransference reaction." Since the reaction to the patient was intense, uncharacteristic of the usual reactions of the resident involved, and was not elicited by other patients with similar presentations, it seems most likely that the resident was experiencing a countertransference reaction toward the patient.

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The supervisor, having heard the resident's negative reaction, had a choice of several techniques that could be used to help the resident to recognize her reactions and deal with the patient therapeutically. Direct acknowledgment of the patient's affect or behavioral reaction can be effective. However, at this point the resident was still experiencing negative feelings toward the patient. She was unaware of her countertransference and regarded her statement as a realistic interpretation of the situation. For example, if the supervisor had responded with a statement such as, "You seem pretty negative toward this patient" or "I think you're reacting very strongly," the resident may have suppressed her negative opinions to appease the supervisor, but without any real change in her feelings or understanding that the suppression was still unconscious. It can take time, experience (especially on the part of the supervisor), and training within an effective supervisory alliance to overcome negative feelings. A similar, potentially effective technique may be for the supervisor to ask questions regarding the resident's feelings, such as, "So, how do you feel about James?" After the resident identifies and verbalizes her feelings, the supervisor can more effectively discuss the problems in the patient, his family, and the resident that are contributing to the resident's feelings, without the supervisor's adding her own assumptions about the relationship. Both parties must recognize that this is supervision rather than therapy for the resident, and it can be helpful, when necessary, to redirect the discussion back to the case at hand.

In this case, the supervisor, knowing that the patient would be on the unit for an extended (more than one-month) period, chose to allow time for the resident's feelings to soften before discussing the countertransference. She encouraged the resident to attend the patient's family sessions, to call his family when he requested or when needed by the team providing his treatment, and to be actively involved in his daily care. She participated in multidisciplinary rounds with the therapists (psychologist, counselor, and family therapist) and floor staff (nursing, technicians). She listened as all the professionals discussed their interpretations of James' case, and the patient's reaction to and influence on the milieu. She began to see how other members of the team, typically nurturing, were also feeling helpless, angry, and frustrated in their attempts to treat James. Through this process, she became conscious of the parallel atypical reaction that she was having.

Over the course of the next few weeks, the resident learned more about James. She began to see beyond his tough persona and to realize that it was a defense

against feelings of loss and vulnerability. For example, during one of his family sessions he began to cry on his mother's shoulder and suck his thumb. He stated that he wished his deceased grandfather were still alive and recalled through his tears being present as the ambulance drove away with his grandfather on the day he died. The resident began to see the regression and ambivalence about growing up that she had seen in other youths on the unit. One day, in discussing his case, she referred to him as a scared child. At this point, the supervisor realized the resident's negative feelings toward James had markedly lessened. Then, the supervisor was able to bring up the subject of the resident's initial reaction to the patient and use it as an effective means of exploring countertransference.

James felt that if he let down his macho, gang-sign-throwing persona he would again be victimized (as had happened in violence in the home and on the street). Identifying with gang members, committing violent crimes, and carrying a gun allowed him to manifest a powerful image, even though he felt very vulnerable and fragile. The resident and her supervisor were able to discuss the patient's true feelings, and also were able to present them gently to him. Afterward, he gradually began to soften in sessions and on the unit. He was willing to work on how he reacted to redirection, and he started anger management therapy. His family attended sessions with the resident and the social worker, and his mother came to understand the root of his behavior. He improved enough that the juvenile authorities felt it safe to release him to the community with intense supervision, gang task force support, and other services.

Working with juvenile criminals can be extremely rewarding but very difficult. Many hospital staff shy away and even refuse to cover juvenile units, because they do not see oppositional behavior as a mental illness or as amenable to any treatment. Negative reactions can be heightened in staff who have been victims of crime or who do not have much experience in dealing with socioeconomically disadvantaged people or children who have been abused. These youth often provoke a feeling of helplessness in the provider, but staff should be encouraged to regard this feeling as a reaction to a youth who has never had any hope for his future (projective identification). Youth in juvenile custody are typically not trusting, are angry at authority figures (who beat them or are critical), and reject any commands. Their behavior can provoke anger and fear among staff who want their hard work to be acknowledged. Without special training or experience, it is hard to see behind the youth's anger and recognize the fear that drives it. Alternatively, there are reactions that are quite the opposite but are equally unhelpful. Normally law-abiding or internalizing clinicians may have fantasies of breaking the law and may externalize their desires by inadvertently encouraging such behavior. This behavior fulfills the need of the clinician, as opposed to the needs of the patient, and can be exploitative. Appelbaum and Guthiel[9] defined such behavior as boundary violations. These boundary violations not only hinder effective patient care, but can also be unethical.

Conclusions

As a result of working on this case, the resident gained a better understanding of countertransference. With the help of her supervisor, she was able to learn the importance of recognizing and exploring her feelings toward her patients. Through understanding her own feelings, she was better equipped to understand her reactions and the therapeutic implications of the reactions. The overall goal for teaching about countertransference in this case was to point out to the resident how it "may function as an empathic tool, allowing the resident to understand otherwise [incommunicable] intrapsychic experiences of this patient" (Ref. 10, p 556).

Thoughtful supervision is critical to teaching residents and other trainees how to work effectively with all patients, but it is particularly salient in working with delinquent youth. With the future of psychotherapy training and supervision having been a concern for some time,[10] it is important to be mindful of how to provide effective supervision to assist residents and staff in recognizing and effectively using countertransference at every opportunity. In forensic settings, such supervision is particularly important because of the psychodynamic processes that arise in managing and treating forensic patients.[11] The added demand of working with youth in forensic settings makes the effective use of countertransference even more important for successful treatment.

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