

The Significance of Countertransference and Related Issues in a Multiservice Court Clinic

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The types of patients seen in a multiservice criminal court psychiatric clinic and the conditions under which this occurs may pose difficulties for the mental health professional. When such antisocial behavior as manipulativeness, aggression, and criminal activity are combined with gross psychiatric disturbance or severe personality disorder, a variety of intense emotional and cognitive responses can be evoked in the clinician. Understanding these countertransference responses can illuminate unrecognized aspects of the phenomena that engender them. This may aid the forensic practitioner in improving mastery over his or her clinical tasks. This approach is closely allied to the most recent use of the countertransference concept as it has been developed in the contemporary psychoanalytic and psychiatric literature.¹

Briefly, this more "totalistic" view of countertransference includes the full array of subjective responses the patient evokes in the treating therapist. By not confining the countertransference notion to simply neurotic-type responses that somehow have to be expunged, the subjective responses of the clinician become not simply problematic autobiographical data but, if carefully understood, can be used as a helpful tool in the diagnosis and treatment of the patient. Kernberg² and others^{3,4} have developed this "diagnostic tool" into a refined skill. Recently, other authors have expanded the application of the countertransference concept from that of the psychoanalytic situation to such age groups as children,⁵ such settings as a family court clinic,⁶ and to the short-term transaction of the psychiatric differential diagnostic examination in which the present authors adapted the term "response set."⁷ This term referred to a constellation of reactions that are likely to be evoked in the clinician by a particular patient presentation in the forensic context.

Forensic Countertransference Response Sets

Mad-or-Bad Response Set A recurring theme in forensic psychiatry has been the complex interrelationship of "sickness" and criminality. This "mad-or-bad" issue has practical ramifications as it impacts on the specific tasks of the clinician in forensic settings. A certain type of patient is increasingly being encountered in such settings because of a variety of

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sociopsychiatric factors.⁸ This patient psychiatrically presents with antisocial behavior with an underlying severe psychiatric disturbance.

The present authors became cognizant of this phenomenon when patients whom they had known as being quite disturbed were dismissed in one fashion or another as "just psychopaths." While it is generally known (but perhaps not sufficiently acknowledged) that schizophrenic patients may have accompanying antisocial traits and act in purposeful, manipulative, antisocial ways, the subjective countertransference response factor in the misdiagnosis of such severely disturbed patients is particularly incisive.

The antisocial presentation acts, metaphorically speaking, like a bi-polar magnet. On the one hand, the clinician is likely to feel controlled or undercut by the antisocial behavior and to react by dismissing the patient as a "psychopath" and, thereby, minimizing the possibility of detecting further underlying psychopathology. This process often has an emotional accompaniment of anger and withdrawal, and a formal label of antisocial personality disorder may be assigned. On the other hand, there is something appealing to this antisocial veneer. To focus on it to the exclusion of the more severe disturbance can be a way of colluding with the patient and keeping at a distance the underlying chaotic disorder that may arouse feelings of inchoate anxiety and helplessness in the clinician.

For such patients in ongoing treatment, this response set operates in a more muted sense, and the antisocial elements may distort our view of the psychodynamic processes. Some have commented that the therapist may overly identify with the antisocial features to the detriment of effective treatment.^{9,10}

When the patient is referred through the criminal justice system, this mad-or-bad response set may operate as a bias before the patient is formally examined. An expectation of an antisocial "set" or focus often results. Elements of this phenomena also would be applicable to such an issue as malingering. Aspects of suspected or detected malingering do not, of course, rule out the coexistence of severe psychopathology though it may distract the interviewer from considering this possibility.

In summary, the antisocial presentation can "hypnotize" us by its compelling and attractive qualities. These persons who often prefer the lesser stigma of the "bad role" rather than the "mad role" are not likely to obtain needed psychiatric intervention.

Moralistic-Punitive Response Set An honest expression of one's values and the disapproval of antisocial-criminal-type behavior is natural, understandable, and can even be therapeutically effective. However, if this stance becomes too overly moralistic and condemnatory, it can short-circuit the capacity to effectively intervene in the patient's psychiatric disorder. The most effective intervention methods are the ones that tap into the patient's positive resources; the most sound clinical relationships are the ones that respect the basic integrity of the patient. Honesty and full disclosure about such matters as limits of confidentiality, purpose of evalua-

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tion and/or nature of therapeutic relationship, make sense clinically as well as forensically. The patient gets a consistent message, and the forensic clinician has defined his or her own role clearly as well as establishing the boundaries of the interaction. In all likelihood, most of these messages were missing or deficient in the client's personal development. On the other hand, the worst outcome occurs when the forensic practitioner, acting out countertransference issues (for example, helplessness, anger, condemnatory moralism) misuses his or her role for punitive reasons.

It has been established that nearly every citizen either has been a victim of crime or knows someone well who has been a victim.¹¹ This can result in overwhelmingly negative reactions likely to affect one's attitude and values about crime. The forensic practitioner, as a citizen, holds varying attitudes about criminality. Recent criminologic trends appear to be swinging toward a more neoconservative direction on matters such as determinate sentencing, "just desserts" model of penology, and so forth. There are a variety of reasons for this "rethinking"¹² and many sociocultural and legal critics approval.¹³ It is helpful for the forensic clinician to have thought out his or her stance on such values and issues. An extreme moralistic viewpoint certainly would be obstructive to clinical work, which requires an open-minded and sensitive understanding of the client's life circumstances.

Aggression and Violence Response Set Many patients seen in court settings have significant problems in the appropriate expression and management of aggression. There are few behavioral presentations that can so powerfully affect the clinician as the eruption of aggressive and violent behavior. Lion¹⁴ notes that therapists generally are more familiar and comfortable with the introjection of aggressive urges and impulses than with the externalization of them. Client aggression, or more likely the fear of such aggression, may evoke such responses as extreme helplessness, reciprocal anger, denial, and excessive feelings of responsibility.^{15,16} These responses can obstruct the clinician from accurately assessing, understanding, and openly exploring aggressive behavior and urges. An overly defensive and avoidant clinical approach to aggression is likely to instill a sense of fear and helplessness in the client. The message in such an instance is that aggressive urges, impulses, and behaviors are incapable of being confronted, contained, and controlled — exactly what the client is most terrified about.

The clinician's direct, open, and nondefensive stance is the most helpful, but there also has to be recognition that his or her periodic negative countertransference reactions to aggression and other antisocial actions are not only natural but also may represent diagnostic and therapeutic acumen. For example, trusted and acknowledged fearful responses to a menacing, violence-prone client are likely to lead to a variety of judicious actions, which may include the request for the presence of supportive staff. In not openly recognizing this normal fearful response, the clinician may react in a helpless, defensive, or immobilized manner.

Periodic Negative Response Sets It is to be expected that the clinician will have periodic "negative" countertransference reactions to these dif-

ficult patients. The increasingly sophisticated knowledge of severe character disorders (borderline, narcissistic, impulsive-antisocial types) has illuminated the crucial nature of primitive mental operations such as splitting and paranoid projections.³ These primitive mental operations may evoke in the clinician negative feelings such as anger, rage, repugnance-hate, boredom-fear. It is important, therefore, to distinguish what may be idiosyncratic in oneself, or oneself in interaction with a particular patient. This also includes an awareness of one's own specific threshold of countertransference. If working with a particular patient becomes intolerable, one should have the good sense to refer to a colleague. In more extreme cases this may lead to a decision not to work in this type of setting or, at least, to minimize sustained patient contact. In short, an awareness of these issues would lead to better judgment in regard to treatment intervention.

Countertransference as Data

The more experience one gains in treating these kinds of patients, the more can countertransference be useful as pertinent data in the evaluation and treatment process. These data can reveal aspects of the transference, the therapeutic relationship, more subtle psychodiagnostic processes, and particular defensive operations of the patient. The group of defenses much discussed in recent years known as projective identification — in which patients induce feelings (usually unconsciously) in therapists in accordance with the subject's previous interpersonal patterns or perceptions — are relevant in this context.¹⁷ Certainly, unusual or extreme transformations in the countertransference phenomena should be scrutinized, as this may be the first sign of the development of a psychotic transference in the patient. Sullivan,¹⁸ in a somewhat different context, refers to this development as the "malevolent transformation."

Those countertransference reactions most often acted out by the therapist are those that are not acknowledged or understood by him or her. This is particularly the case when unpleasant or negative feelings are evoked by the patient. The important point about countertransference reactions is that they are to a great extent a matter of learning to use one's personality as an instrument in the evaluation and treatment process. It entails the clinician trusting and understanding his or her reactions in the clinical transaction. The importance of acknowledging and using negative countertransference reactions was made in an early article by Winnicott.¹⁹ He poignantly recounts in his dealings with a difficult, acting-out child, how he "works over" and uses his hateful feelings for therapeutically effective purposes.

Dilution of Countertransference

The principle of "diluting the transference" is a well-known psychoanalytic strategy that can serve as a conceptual basis for the defusing of possible negative countertransference reactions in the forensic clinical arena.

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First, in seeing a difficult patient in group therapy, the therapist may find it easier to handle his or her own negative countertransference rather than see the patient on an individual basis. The therapy group can take the brunt of a particularly difficult patient and may be effective, for example, in setting limits.

Second, with difficult patients it is vitally important to use effectively the resources and support of one's colleagues. The use of periodic staff clinical conferences is very helpful. They may provide the opportunity to integrate, modulate, and neutralize countertransferential data that may not only be more therapeutic for the patient but also for the overall morale in the program. The clinical conference may serve to reality test countertransferential data and, in the best of circumstances, act as a peer supervisory forum. This may lead to a collective agreement on when to refer a patient to a more suitable facility, transfer the patient to another therapist, or use multiple treatment personnel for the same patient.

Tolerance of Limited Success and Gain

A clinician working in a court setting must have limited expectations of success and gain. When the clinical picture is mixed with antisocial and aggressive components, the more traditional psychotherapeutic goals need to be readjusted. Madden¹⁶ writes about the violent patient who attends group therapy on an "as-needed basis" (when he feels out of control), who nevertheless can be helped in a limited way by encouraging him to verbalize rather than to act on his urges. Another important achievement of the court clinic is that this may be the only type facility that provides follow-up treatment of difficult, mentally disordered patients with significant antisocial features. The court clinic is in a position to treat such patients as it is allied to the criminal justice system through the Department of Probation. Even if these patients only receive some degree of object constancy, it is often more than what they might otherwise obtain without the availability of the court clinic. Certainly, one should be cautious about such notions as psychiatric treatment effecting recidivism. It bears mentioning that any kind of treatment intervention for the offender has not been shown to be related to recidivistic outcome.

The staff should be sensitized to the limitation of treatment goals so that phenomena such as pessimism, hopelessness, and staff "burn-out" can be avoided.²⁰ The pervasive issue of client motivation is problematic, and how such factors as poverty and social class adversely affect the degree of active involvement in treatment has been referred to by other authors.^{21,22} A point worth underlining, though, is the pragmatic importance of not seeing motivation as an all-or-nothing issue. Motivational factors act on a continuum across the spectrum of patients in treatment. All patients have some degree of difficulty with motivation — that is how the notion of resistance came into being. Most of the patients seen in the forensic-related settings, though, have significantly more problems with motivation. If the clinician is aware of these motivational issues, then he or she is less likely to set up extreme

expectations or get into unnecessary struggles with patients. As a technique, it may be prudent to "join" and openly acknowledge the resistance or mixed motivation the patient brings into the treatment.²³ A related technique, "paradoxical intention," developed by communications therapists, also has relevance in this context.

Dyadic and Triadic Factors

In addition to "dyadic" factors, which center on the client's clinical presentation in the one-to-one doctor-patient interaction, a variety of "triadic" factors are intrinsic to forensic settings. In the court clinic, patients are seen in a triadic system of conditions and relationships that have been arranged between court, mental health personnel, and individual offender. Such arrangements affect the role of mental health personnel and touch on crucial matters such as confidentiality and coercive or involuntary treatment. How these triadic or variable third party factors affect transference and countertransference are challenging issues and merit a separate and more detailed presentation.

Case Illustration

Mr. A. was referred to the court clinic by the Department of Probation for an evaluation for psychiatric treatment. He had been convicted of attempting to assault his foreman at the autobody repair shop with a tire iron. He was sentenced to five years of probation. There were several previous arrests for petty larceny and disorderly conduct. He had a history of a couple of short-term psychiatric hospitalizations and treatments with Thorazine following violent explosive outbursts. He was socially isolated and had a sporadic work history.

The probationer initially was evaluated by a new staff member relatively inexperienced with the offender population. In the weekly case conference, the probationer was presented as an antisocial individual with explosive features, possibly a borderline personality. It was recommended that the probationer be further evaluated and more information about him obtained. The clinician missed the third scheduled appointment and uncharacteristically failed to inform the appointment secretary that he was detained in a conference. The probationer was rescheduled for another appointment later that week and was seen then jointly by two other members of the evaluative team.

In the next case conference, discussion centered on how frighteningly menacing and intimidating this probationer was perceived by the two other clinicians. It was obvious these observations had been omitted by the first clinician in his initial report of the case. On the other hand, the latter interview had led to a considerably more revealing clinical picture of the picture and the probable sources of his rage. The same frightening and provocative presence of this man in the first instance, which had led to avoidance and denial of his fear by the first doctor, in the latter interview was an impetus to understand the extent of the patient's underlying mental

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operations that were thought to engender these reactions (in the interviewer). These observations were incorporated in the continued treatment of the patient, which included combined individual and group approaches.

Comment

Our impression is that countertransferential phenomena are manifold and operative in a variety of ways in a court clinic. Another outcome of the above scenario (which actually has occurred) is the case of an unseasoned doctor who is unaware of his personal fear and "acts out" by overreacting. He might refer the patient for an unneeded psychiatric hospitalization, often for a misplaced justification. For example, in a recent incident, a patient had been referred for hospitalization on the basis that the patient might hurt himself consistent with some degree of depressive component in his mental state. What had become apparent, through a variety of inputs, was that this patient and the way he presented himself was "objectively" frightening. The initial examiner had not acknowledged this. Out of denied and distorted fear, he panicked and tried to get rid of the patient by the exaggerated justification of self-directed harm rather than more appropriately coping with the real though manageable threat that he potentially posed to others.

Conclusion

The impact of such powerful behaviors as antisocial activity and violence-aggression, when combined with a significant psychiatric disorder, can be unsettling to the clinician. It can lead in the worst of outcomes to faulty evaluation and antitherapeutic effects. The court clinic, as well as other forensic-related facilities, has a significant proportion of such patients who are seen in varying evaluative and treatment capacities. It behooves forensic mental health professionals to become aware and be sensitized to countertransferential factors.

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