Countertransference in Conflict: One Client or Two?

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The concept of countertransference (CT) reaction has undergone dramatic changes in definition since its inception at the turn of the century. No longer viewed as a hindrance to effective therapeutic interventions, it has become central to building the therapeutic alliance. However, CT can interfere with the therapeutic task, and this is especially true in forensic settings in which one must help particularly difficult clients. In these cases, the CT must split into two parts in order for the therapist to be clinically effective. The therapist reacts to the individual as both an offender who has violated a societal law and as a client who needs help, separating the client from the behavior. Although not recognized explicitly in the forensic literature, the effects of the dual CT underlie investigations of therapist-offender relationships. This article reviews the concept of CT with specific reference to forensic settings and develops the concept of dual CT.

Odie et amo: quare id faciam, fortasse requiris. Nescio, sed fieri sentio et excrucior. (I hate and I love: why I do so you may well ask. I do not know, but I feel it happen and am in agony.) (Carmina, lxxxv. by Catullus)

Traditional accounts of countertransference (CT) have generally considered it a unified concept, a whole unto itself. The recognition that the therapist's CT reaction is dynamic and can change as the therapeutic relationship develops has added to its utility. Expanding on this view, it is my thesis that the CT can split into two distinct parts that can (and do) function independently. This schism is not only possible, it is necessary if the clinician is to be effective in helping certain clients. Although this process can occur in various therapeutic relationships, the most obvious one is the forensic setting: the relationship between the therapist and the client/offender. As a law-abiding member of society, the clinician may find the criminal reprehensible because of his/her illegal behavior. However, to be therapeutically effective, the clinician must build a positive relationship with this individual that is characterized by a certain level of trust and safety. The therapist must also recognize that the client is an offender whose criminogenic needs must be addressed. Therefore, the therapeutic relationship in forensic settings is in a constant state of flux between splitting and reintegration.

Despite compelling arguments favoring conservative definitions of CT,[1,2] a broad definition of CT is used here and includes

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the conscious and unconscious reactions of the therapist to the client. Furthermore, the terms therapist and clinician are used interchangeably to refer to any professional who provides treatment (psychiatrists, psychologists, social workers, adjunctive therapists, nurses, etc.) to the offender. Finally, the terms client and offender are also used interchangeably. However, the concept of dual CT can be generalized to nonoffender client groups. Thus these concepts may be useful to professionals working outside forensic settings.

In order to develop and integrate the concept of dual CT into the broader literature, I will briefly review related issues. A short discussion of the importance of CT and of the therapeutic alliance in mental health treatment begins the paper. A review of CT in forensic settings follows, integrating the concept of dual CT into this literature. The final section addresses the relationship between dual CT and effective correctional rehabilitation.

The Therapeutic Relationship: The Active Ingredient of Change?

Regardless of the setting, the problem, or the theoretical school of thought, therapy is essentially an interpersonal relationship between the therapist and the client. The personal investment of both players in this unique relationship can be indicated as the main force of change in the client's behavior.[3, 4] The therapeutic relationship is a complex interplay of the interpersonal style and history of client and therapist. As a subaspect of this interplay, CT has enjoyed somewhat of a renaissance during the past 40 years.[5–9] Originally viewed by Freud as a neurotic reaction on the therapist's part, the concept of CT was expanded by Winnicott[10] who distinguished between subjective (therapist-induced) and objective (client-induced) CT. The CT concept further evolved with the realization that analysis is an interpersonal process with two active participants.[5, 8, 11] Thus CT is no longer viewed as an impediment but as an important source of information that aids case conceptualization and the therapeutic task.[7, 8, 12, 13]

In order to maximize the utility of this information source and not jeopardize the therapeutic relationship, therapists must open themselves to their own CT.[13, 14] By acknowledging and using this information source, the clinician not only improves diagnosis but also develops an important entrée into the therapeutic transaction and method of effecting change.[9, 14] Concerning the evaluation of clients, Kalpin[12] indicates that the CT provides valuable information about the therapeutic alliance and the client's motivational level. On the treatment front, Loewald[15] concludes that the therapist's emotional investment is a decisive factor in the curative process. Thus the therapeutic relationship seems to be central to positive change, a statement that is borne out by empirical research.[16]

Both theory[17] and research[16, 18, 19] suggest that a therapeutic alliance is necessary for therapeutic change. Gaston[16] indicates that the therapeutic alliance can play three major roles in psychotherapy: (1) it can be therapeutic by itself (e.g., Rogerian therapy); (2) it can provide the groundwork to allow effective interventions; and (3) it can interact with thera-

peutic interventions and thereby increase the chances for success. Without espousing any one of these views of therapeutic alliance, it is apparent that the alliance is an important aspect of therapy. Given the importance of this relationship and its associated CT feelings, the presence of a negative CT is notable. A negative CT could seriously jeopardize the development of a strong therapeutic alliance, possibly reducing success. Aviv and Springmann[20] examined CT with clients who have severe psychopathology and showed that a negative CT was related to lower levels of improvement. Research studies that examine psychopathology in therapy support this view and show that pretreatment symptomatology adversely affects the therapeutic alliance.[18]

This presentation of the role of the therapeutic relationship and alliance is far too brief to fully explore the complexities of this process (for a more comprehensive review see Gaston[16]). However, the salient issue is that the interpersonal aspect of therapy is a key element in therapeutic change. As such, therapists must monitor and use their CT for the benefit of the client, if possible. This is true not only for our more traditional client groups but also for offenders. Unfortunately, the reputation of offenders as being difficult clients causes many clinicians to avoid this group.[21, 22] However, the offender is both a client and a criminal, and this dichotomy is central to how they are treated by therapists.

Offenders: Clients or Criminals?

Although there is debate about whether the label "difficult client" is valid,[21] most studies report the existence of a negative CT when therapists work with offenders. Forensic staff report negative feelings such as hopelessness, helplessness, anger, fear, indignation, vengeance, and sadism. With respect to psychopaths, Meloy[23] suggests that these feelings typically undermine treatment and recommends against rehabilitative efforts under these circumstances. However, this representation gives a skewed view of CT in forensic settings.

In an attempt to identify all types of CT in forensic settings, Protter and Travin[24] distinguished among four types of reactions: "mad or bad," moralistic-punitive, periodic negative, and aggression/violence. The therapist exhibiting a "mad or bad" response set may dismiss the offender as untreatable because he/she is a "psychopath" or beyond hope. Under the moralistic-punitive response set, the therapist reacts to the client's criminal status and adopts an ultrajudgemental attitude, which interferes with treatment. In the third response set, the therapist may experience a periodic-negative response in reaction to specific client behaviors. Finally, similar to the earlier review of negative CT, the therapist who has an aggression/violence response set reacts to the client's external aggressive nature. This reaction causes feelings of fear, resentment, anger, helplessness, or responsibility.[24]

An aggression/violence CT can cast the therapist into the role of victim. Springmann[25] viewed this revictimization as a defensive action by the client who tries to settle painful internal tensions by inflicting pain on others. It is not surprising that

such acting-out behavior can arouse a negative, or even a sadistic, reaction in the therapist.[23] Given this negativistic view, the neophyte (or even veteran) therapist will likely be apprehensive about working with offenders. This negative beginning can subtly influence how the relationship unfolds and can result in a negative relationship.[26] In the case of offenders, the therapist typically knows their criminal history beforehand. This information is important for effective rehabilitation; however, it may set in motion a negative CT before the clinician meets the offender. A strong negative reaction can effectively nullify the possibility of a positive therapeutic relationship. At a minimum, such a reaction can influence the therapist's way of listening to and thinking about the client, the treatment plan and execution, and the issues surrounding termination. This negative reaction can be threatening to therapists who typically have a self-concept of being helpful, strong, kind, and well meaning.[27, 28] Lacocque and Loeb[22] believe that client labels of "aversive" or "difficult" exist to mask the degree of anxiety that is often felt by the therapist as a result of their negative CT.

This loss of professional identity is an important feature of forensic CT inasmuch as these clients can use several methods to manipulate the therapist.[23, 27] First, by using projective identification and provocation, clients can disown feelings of guilt, shame, rage, etc., and these feelings may be internalized by the unknowing therapist.[3, 27–29] Second, the client may also foster feelings of "supertherapist" (i.e., all-loving, all-good, and always correct). The super-therapist dynamic convinces the clinician that it is wrong to have a negative CT reaction and thus protects the client from criticism.[3, 23] The super-therapist dynamic may explain the predominance of therapist self-blame regarding negative CT.[25]

Furthermore, despite the warning of Protter and Travin[24] that therapists should not expect dramatic gains, the therapist may feel compelled to believe in such gains. In fact, it is not unusual to see so-called gains at the beginning of treatment that later disappear.[28] The therapist may allow such super-therapist ego stroking and may develop an introjection of being different or special.[3] This results in the therapist's downfall; the client who fails in treatment effectively says "I knew you weren't as good a therapist as you said!" and dismisses future therapist initiatives.

Such interactions between the supertherapist and the resistant client make it difficult to foster a good therapeutic alliance. Meloy[23] suggests that the lack of a "real relationship" when treating psychopaths prevents the formation of a therapeutic alliance. Paradoxically, the therapist can use the hate that is engendered as a basis for the alliance.[30] Frederickson[31] suggests that a therapist's feeling of hate for the client can be affirming and can build a therapeutic alliance. The therapist may give voice to the client's earlier feelings toward others (e.g., hating an abusive parent). As members of society, some clients may also feel self-hatred for their crimes against society and may attempt to manipulate the therapist into also hating them.[10, 31] Imhof and colleagues[28] indicate a similar dynamic among drug abuse

patients: "defense mechanisms [used by the patient] serve to unconsciously induce the therapist to experience the intense range of negative and hateful emotions that exist within the patient." In these cases, the therapist should not voice these feelings but should use them to gain greater understanding of the client's inner state.[31]

It is this attending to the CT that is important. Heimann[11] cautions that the therapist's ignorance of the CT (whether positive or negative) can reduce the therapist's ability to assess the client's transference. Travin,[32] writing specifically on psychiatric expertise and sex offenders, agreed: "It surely behooves the forensic clinician to monitor his [her] subjective reactions when evaluating sex offenders." As professionals working with offenders, we must be aware of the reasons behind all decisions; ignoring our CT increases the likelihood that we will make bad decisions on the basis of these feelings.[32, 33]

Monitoring of the CT is extremely important in forensic settings; however, very few authors have explicitly examined the incidence of so-called positive reactions. Springmann[25] wrote that offenders can be seen "as glorified sex objects, idealized and desirable because they have defied authority, and possibly have been victimized by it." Also regarding the offender's pleas of victimization, Travin[32] wrote that the clinician must be wary of minimizing the offender's risk to reoffend. Finally, Wasyliw and colleagues[34] discussed therapist reactions when working with mentally disordered offenders and suggested that positive CT may manifest through the clinician's need to observe clinical progress and thus may cloud accurate judgment.

Despite these incidents of so-called positive CT, it is apparent that working therapeutically with offenders is no easy task. Thus the issue of why therapists work with offenders is central to CT. Kottler[35] viewed the "challenge" of difficult clients as the main motivating factor. Springmann[25] supported this view: "Psychotherapy with criminals seems to be unique in that the person who administers the therapy runs a greater risk of incurring psychological (or physical) harm than its recipient." This perspective sets forensic clinicians apart from their colleagues in other settings. However, Schultz-Ross[36] presented a less optimistic view. He hypothesized that correctional staff have an unconscious need for punishment and cited "gallows humor" and adoption of an institutional argot as support for his hypothesis. He also suggested that staff have "both feelings of power over the inmates and a sense of being trapped with them." Thus forensic staff may gain something from these feelings of power and punishment, perhaps a complex form of Protter and Travin's[24] moralistic-punitive CT.

Schultz-Ross's[36] view may explain the concerns expressed in forensic CT literature about therapists becoming guards, thus emphasizing the importance of addressing the CT.[37–39] Kaufman[40] criticized forensic psychiatrists for becoming correctional agents rather than therapists. Ironically, this punitive stance could be viewed as an attempt to maintain their self-concept as good therapists.[20] This is a process similar to therapeutic nihilism, the belief that all criminals are alike

and untreatable,[23] and thus the therapist should not waste time in treatment initiatives.

Travin and colleagues[24, 32] use the term "triadic CT" for this interaction of client, therapist, and legal system. The dynamic interplay of these three players affects both assessment and treatment, and therapists must increase their awareness of how external pressures influence decision making. These external pressures also coalesce in societal demands for accurate risk assessments,[41] which increase pressure on the therapist to identify with the criminal (i.e., use their CT).[36] Triadic factors and administrative demands may account for why staff in institutional settings typically ignore CT issues.[42] Such diffused responsibility between different individuals and departments renders the assessment of CT even more difficult.[43] This triadic relationship may result in the therapist having a CT to the legal/correctional system, to other professions, and to those who work within these systems.[44–46] Raelin[47] wrote about how such conflicted relations can have a dramatic negative effect on the professional and thereby on treatment.

In conclusion, most authors have concentrated on the negative aspects of CT in forensic settings. Those who have addressed the issue of CT do not seem to capitalize on the information carried in such emotions. Most authors address how judgement can be clouded by the CT and how awareness can increase clarity, but non focus on its dynamic nature and utility in directing interventions. The following sections review the concept of forensic CT as a dynamic force that changes and influences treatment. Importantly, the final section describes how the CT relates to traditional correctional treatment initiatives.

Dual Countertransference

Within this framework of forensic CT and the therapeutic relationship, I am proposing the dynamic concept of a dual CT reaction. The dual CT occurs as the result of the triadic nature of forensic CT: institutional and societal demands for punishment conflict with the professional (and personal) demands of providing treatment. These forces place the clinician in a position of extreme stress. Incorporated into this interaction are the personality and role expectations of the client, as expressed by the transference.

Dual CT is a splitting of the therapist's reaction to the client. On the one hand, the therapist reacts to the offender, creating an offender CT (O-CT) dynamic. Knowledge of their criminal history, experience with similar clients, and personal/societal views have an effect on the therapist before he/she meets with the offender. This sets up an initial CT toward the offender that may be characterized strong emotions such as moral outrage, revulsion, anger, or fear, which influences the developing relationship.[26] Left unchecked, this can sabotage the development of a positive therapeutic alliance.

The other side of the split, termed the client CT (C-CT), typically begins after the initial meeting wherein the clinician begins to form an evaluation of the offender as a client. However, the clinician may also have a preexisting positive C-CT (e.g., empathy for the predicament/

need of the client for treatment). In order to be effective, the clinician must work with the client to build a therapeutic alliance. The specific skill required is the ability to look beyond the client's criminal behavior, and to interact with the person in order to identify potential areas of positive change. Concentration on these areas allows the clinician to foster an alliance and to use it to influence other, more criminal, aspects of the client.

It is important to note that these are two independent CT dynamics with much overlap. To be truly effective in addressing criminogenic needs, the therapist must reintegrate these two aspects. To treat the individual only as an offender would likely lead to a negative O-CT and destroy any possibility of a positive relationship. This negative O-CT ultimately results in one of the dynamics identified by Protter and Travin.[24] To treat the individual as a client without special consideration for criminal status could lead to a C-CT that may blind the clinician to the client's criminogenic needs. Any treatment efforts solely on the basis of the C-CT will likely fail to reduce (and may possibly increase) recidivism.[48] Through the synthesis of these two aspects of the CT, the therapist can treat the whole client/offender and possibly reduce recidivism and improve the client's coping abilities.

This separation-reintegration dynamic begs the question: if the goal is reintegration, why not simply conceptualize the CT as a whole with two aspects rather than as two simultaneous CTs? The reason for the schism is primarily theoretical: the division highlights the strength of the respective C-CT and O-CT. One can overpower the other, resulting in a skewed view of the client. Furthermore, the division allows the clinician to examine with greater clarity their O-CT with little interference from their C-CT and vice versa. The clinician may then integrate the two CTs and gain a better picture of how their CT is affecting or interfering with the therapeutic relationship. There is nothing explicitly wrong with viewing the O-CT and C-CT as subaspects of the overall CT; however, I believe that more information will be gained by the split reintegration.

Although it was not mentioned explicitly, Schultz-Ross[36] alluded to the effects of a dual CT when discussing how some correctional professionals (e.g., guards) view the offender as a convict (O-CT) and other professionals (e.g., psychologists) view the offender as a patient (C-CT). However, only group differences and not individual variations were addressed (e.g., psychologists who see offenders as convicts). How correctional professionals view the offender may be the result of theoretical differences, role differences, or even amount of client contact. However, it is at the individual level that the dual nature of the CT is the most powerful. Manifestation of the C-CT/O-CT split provides the clinician with a powerful insight into the client's psyche, into how society views the client, and into how the client views himself/herself.

Thus far I have mentioned transference only in passing. The arguments of both Marshal and Marshall[49] and Loewald[15] convince this author that the CT is inextricably intertwined with the client's transference. Before leaving the concept of

dual CT, the omission of the transference concept must be addressed, if only minimally. Lion *et al.*[50] suggest that staff reactions and morale can be a strong force in alienating clients and can influence their transference. The offender's transference may mirror the dualistic nature of the therapist's CT. The offender may simultaneously view the clinician as a benevolent helper and a trumped-up jailer/judge,[34, 37] thus reflecting the triadic nature of this relationship. In response, the offender may adopt varying degrees of transference from "trusting client" to "solid con," complementing the various therapist roles.

The therapist-as-jailer dynamic is seen primarily at the beginning of the relationship when the client bases his/her view on stereotypes and prejudices. This reinforces the "solid con" role, which some view as resistance to change or low motivation for rehabilitation.[36] Given a positive therapeutic alliance and the presence of a positive C-CT, this negative transference should diminish and allow effective interventions. However, this alliance is constantly assailed by institutional demands (triadic forces) that reinforce the jailer/convict roles (O-CT).[37]

In this instance, this schism occurs because of both internal states and external pressures on the therapist and offender. However, in the earlier formulation of dual CT, I stressed the therapist-induced aspect. This apparent contradiction simply reflects the complex nature of the therapeutic relationship. In fact, it is possible that a dual CT dynamic could be engendered by the client. However, to increase the clinician's vigilance in assessing their CT, I am taking the more prudent course and assuming that therapist characteristics play a large part in the dynamic. This approach has the added benefit of allowing the clinician to examine his/her own reactions in an intensive manner.

Thus far I have discussed the importance of dual CT as an information source for evaluation of both self and client. The dual CT is also important in addressing how one directs rehabilitative efforts. Under an O-CT, forensic professionals may adopt an attitude of therapeutic nihilism: abandon treatment principles and opt for more of a "warehousing" or punitive approach. Under a C-CT, the clinician may focus solely on the client, possibly neglecting criminogenic needs, thereby ignoring society's demands for reduced recidivism. The next section embeds the dual CT dynamic into the continuing debate on treatment effectiveness. In fact, I argue that different treatment efforts are a consequence of dual CT issues.

Reintegration: The Importance of Targeting

Although there is much debate about the effectiveness of correctional treatment,[51–55] recent literature supports the use of psychological interventions.[56–58] Andrews and colleagues examined the issues of treatment effectiveness both theoretically[56] and empirically[48, 59] and found that initiatives that reduce recidivism conform to Andrews' risks/needs/responsivity principles. The concept of dual CT is useful in identifying the underlying factors of this debate.

The risk and needs principles relate to the importance of the O-CT in reintegrat-

ing the CT split. In order to be effective, the clinician must recognize that the client is part of a distinct group (i.e., offenders) with specific needs. In particular, the clinician must attend to the client's criminogenic risk factors (O-CT). Risk factors such as procriminal associates and procriminal attitudes/values/beliefs may increase the likelihood of criminal recidivism.[56] The more of these risk factors that the client has, the more intensive the rehabilitative effort that is needed. If our goal is to reduce criminal activity (i.e., recidivism) rehabilitative efforts must target criminogenic needs.[56] The clinician must identify and address particular characteristics that have brought the individual into conflict with the law. This requires the clinician to be aware of the offender side of the client; to ignore the reason for their incarceration is not only naive, it is also unethical.

The exclusive employment of these two principles may engender a relationship that is dominated by the O-CT, thereby possibly increasing the punishing attitude warned of in the literature.[24, 37, 38, 40] It is the third principle, responsivity, that emphasizes the importance of the C-CT. Responsivity relates to the therapeutic relationship and issues of countertransference by focusing on the manner of treatment delivery. Andrews[56] states that this principle involves "the selection of appropriate modes and styles of service." He emphasizes designing treatments that work with offenders in general and within specific subgroups of offender (e.g., sex offenders). Clinicians deal with individual clients and not just with groups of criminals; thus the C-CT is a reflection of the responsivity principle at the individual level.

There is a need for a balance of the three principles. It is obvious that forensic clinicians cannot simply assess risk/needs without addressing how they deliver the designed treatment in the most appropriate manner, an O-CT dynamic. However, clinicians could focus exclusively on the relationship with these individuals, a C-CT focus (i.e., only apply the responsivity principle). At a surface level, this seems to be the argument of the humanist schools: given the opportunity, all individuals will move toward psychological self-actualization. However, treatments based on these precepts have simply not worked.[48] In fact, I believe the humanist schools are essentially correct; one must treat the offender with dignity and respect to build an alliance within which positive change will occur (C-CT). The risks/needs principles simply focus the forensic clinician's attention on issues that are salient to reducing recidivism, and the responsivity principle addresses relationship issues. These principles do not contend that one should ignore a client focus in rehabilitative efforts, just that it should not be the only aspect of treatment.

Thus dual CT reintegration is essential in order to address the whole client/offender: the risk/needs/responsivity principles and the dual CT concept link to provide clinicians with a useful guide in directing treatment efforts. Therefore, the information gained from the split/reintegration process of dual CT should aid forensic clinicians in fulfilling their professional, societal, and interpersonal roles.

Generalizations and Conclusions

I have attempted to introduce a new way of conceptualizing therapeutic reactions in forensic settings. Ideally, the development of this concept will help forensic therapists understand and address negative CT by providing a firm theoretical conceptional base. Practitioners can also use this base as a guide for addressing countertransference feelings and thereby for improving therapeutic interventions, assessments, and personal satisfaction.

The CT split and reintegration dynamic is applicable to other client groups beyond this presentation. For example, with abuse victims, a split may result when victims confess abusive behavior on their part. Such self-disclosure is a monument to a strong therapeutic alliance; however, it may also be a test of that alliance. Therapists must address this event effectively and therapeutically within the ethical guidelines of their profession. In fact, these dynamics may occur any time a clinician grapples with ambivalence toward a client. Through the use of the dual CT concept and other conceptualizations of CT (for example, who induces the CT), clinicians can better understand their own motives and provide better service to all types of clients. Thus dual CT appears to be a useful clinical heuristic device for both forensic and more traditional therapeutic settings.

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