

# Application and Utility of Psychodynamic Principles in Forensic Assessment

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Effective practice of forensic psychiatry is dependent on a clinical recognition and understanding of core psychodynamic principles and theory. Practice guidelines, rooted in the ethics-based imperative to strive for honesty and objectivity, demand that practitioners remain vigilant to the development of bias and appreciate interpersonal dynamics that may be re-enacted in the forensic setting. Although it is not feasible to maintain complete impartiality, especially when confronted with the nature of certain offenses, knowledge of both conscious and unconscious responses can bolster the intellectual integrity of the clinical assessment. The identification of defense mechanisms within both the evaluator and evallee and attention to transference and countertransference are essential for an accurate conceptualization of an offender's psychological functioning, vulnerabilities, and risk of reoffense. In this article, we review psychodynamic concepts and their potential impact in the forensic setting and underscore interventions that may aid in the elucidation and management of these processes.

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Forensic psychiatry operates at the interface between the law and psychiatric practice. Because of various practical and ethics-related problems that can arise out of this context, specific practice guidelines for forensic practice have been proposed.<sup>1–4</sup> They are rooted in the ethics-based imperatives of honesty and striving for objectivity, truth, and intellectual integrity.<sup>1,5</sup> The principal model for the forensic evaluation has historically consisted of five sequential processes, including preparation for a case, data collection, data analysis, preparation of the forensic report, and forensic testimony. At all points in the evolution of a case,

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the forensic practitioner may be confronted with a potential for bias and threats to impartiality. These processes often occur at an unconscious automatic level and may compromise a clinician's credibility in the forensic setting. Similar to the interpersonal experience and affect that may develop in the therapeutic model of clinical psychiatry, forensic practitioners may be exposed to powerful feelings inherent in transference and countertransference and the subtle recreation of immature relational styles and defense mechanisms by the individuals whom they evaluate. In this review, we elucidate the principal defense mechanisms used in the forensic population and discuss the nature of emotional responses to forensic work. We highlight how a psychodynamic understanding of an individual can enrich the forensic interview, specifically in terms of risk assessment and theoretical interpretations of the criminal act and motives for violence. We also provide a review of practices that may mitigate the intensity of emotional responses in criminal and civil settings.

**Table 1 Hierarchy of Defense Mechanisms—Adapted from Vaillant<sup>6</sup>****Level I (pathological)**

1. Delusional projection: delusions about external reality, usually of a persecutory type; includes the perception of one's own feelings in others and then acting on the perception
2. Denial: denial of external reality
3. Distortion: reshaping external reality to accommodate inner needs

**Level II (immature)**

1. Projection: attributing one's own feelings to others
2. Schizoid fantasy: tendency to use fantasy to resolve conflict; may be associated with global avoidance of interpersonal intimacy
3. Hypochondriasis: transformation of reproach or aggressive impulses toward others into complaints of pain and somatic illness
4. Passive-aggressive behavior: indirect expression of aggression toward others through passivity and masochism
5. Acting out: direct expression of an unconscious impulse or wish in order to avoid awareness of affect that accompanies it

**Level III (neurotic)**

1. Intellectualization: thinking about instinctual wishes in affectively bland terms, paying attention to irrelevant detail to avoid expression of inner feelings
2. Repression: an unconscious process in which the expression and perception of instincts and feelings are prevented
3. Displacement: redirection of feelings toward a less cared for person or situation than those arousing feelings
4. Reaction formation: enacting behavior or exhibiting affect that opposes an impulse
5. Dissociation: temporary, drastic modification of personal identity to avoid emotional distress

**Level IV (mature)**

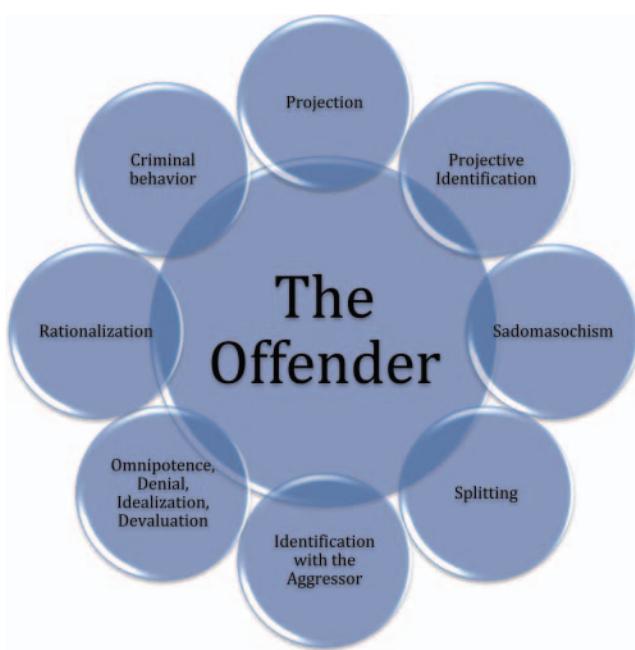
1. Altruism: vicarious gratification of impulses through service to others
2. Humor: expression of feelings without personal discomfort and unpleasant effect on others
3. Suppression: conscious diversion of attention from conflict
4. Anticipation: goal-directed planning for future inner discomfort
5. Sublimation: modification and direction of acknowledged impulses toward more appropriate activities

## Defense Mechanisms

In undertaking an exploration of psychodynamic principles and their role and influence in the forensic setting, it is first necessary to evaluate the role and impact of defense mechanisms. Vaillant<sup>6</sup> described defense mechanisms as habitual, unconscious, and sometimes pathological mental processes employed to resolve conflict among external reality, instinctual needs, and internal prohibitions. Building on the seminal work of Sigmund and Anna Freud, Vaillant devised a hierarchy of ego defenses that ranged from level I (narcissistic) to level IV (mature) functioning. Vaillant underscored the role of defense mechanisms in keeping affect within bearable limits and maintaining psychological homeostasis by postponing increases in biological drives. In later research studies, Vaillant *et al.*<sup>7</sup> proposed that defensive style provides an independent dimension of mental health and is best appreciated by using life-span observation. Perry and Bond<sup>8</sup> asserted that clinical attention to defense mechanisms in long-term psychotherapy may mediate improvement in functioning and symptoms. For a summary of Vaillant's hierarchy and associated definitions, refer to Table 1.

As internal moderators that minimize psychic conflict between wishes and reality, defense mecha-

nisms are important diagnostic tools in the forensic evaluation process. A high degree of underlying disturbance found in forensic evaluatees, coupled with a general use of more pathological defenses, is likely to be drawn into the interview and projected in the transference. The forensic evaluation process itself is also inherently stressful, and it should be emphasized that not all of a defendant's responses and behaviors are explained by identification of pathological defenses. More paranoid, rigid processes are often evident, and a forensic clinician may be treated as a persecuting figure who must be controlled.<sup>9</sup> It is theorized that the psychopathological aspects of defense arise from an offender's narrative of loss, abuse, psychological trauma, and disorganized attachment styles.<sup>9,10</sup> The complex process of psychobiological attunement between a caregiver and an infant is the model of all future relationships for the infant; arrests in development may have a negative impact on formation of future attachment patterns and internal working models (object relations), and the development of the self. This dynamic is represented in the insecurely attached infant, who has been emotionally deprived or abused and relates to others in a predominantly hostile manner. Bowlby<sup>11</sup> theorized that defenses reflected different patterns of attachment; secure attachment would provide positive primary



**Figure 1.** Defense Mechanisms in the Forensic Population—Adapted from Protter and Travin.<sup>22</sup>

defenses, whereas unreliable or rejecting attachment figures tended to lead to development of pathological defenses. Violence may accordingly be encountered in the context of insecure or ambivalent attachments.

In the forensic setting, the most common defenses include splitting, projection, and projective identification (a process in which an evaluator may be drawn into another individual's projections and feel subtle pressure to behave in a certain way), sadism, identification with the aggressor, and the manic defenses of omnipotence, denial, idealization, and devaluation (Fig. 1). Blackman<sup>12</sup> noted that defenses also occur in clusters, as with the constellation of prevarication (conscious exaggeration and misrepresentation of facts), projective blaming, and rationalization in criminal psychopathy. Mature defense mechanisms are generally absent, as the criminal act itself may be conceptualized as a breakdown and failure in emotional regulation, healthy defense adaptation, and ego functioning.

Splitting, a defense mechanism that refers to the division of an object into good and bad, may lead to a developmental conflict in which an individual will tend to regard others and the world as being one-dimensional. Splitting is often associated with projection and projective identification. By unconsciously using projection and projective identification, an offender disowns feelings of persecution

and humiliation and projects them onto his victim or the forensic evaluator. Having freed himself of intolerable emotion, he gains a sense of omnipotence and triumph, while the victim experiences the feelings of persecution that the offender initially disowned. This dynamic may be seen in sexual crimes, including rape, as the offender projects disturbing internal experiences onto the victim and obtains sadistic excitement, omnipotence, and a sense of triumph in the process. Some offenders may also feel intense self-hatred for their crimes and attempt to induce such feelings in others.<sup>13</sup> A lack of vigilant attention to these dynamics may subsequently cause the forensic clinician to act in response to his countertransference. The offender may also employ identification with the aggressor in particularly violent crimes, as the criminal act recapitulates abuse that he may have received as a child.

Defenses may cluster together and coalesce into a more rigid defensive style. This dynamic is represented by the manic defenses of omnipotence, denial, idealization, and devaluation. As a unit, they function to distort reality and are characterized by feelings of control, contempt, and triumph. For the offender, this triad serves to limit dependence on, and need for, an individual who is valued, to avoid guilt and a feeling of loss. The need for another individual may often be projected and interpreted by the offender as outside of the self. Yakeley and Adshead<sup>10</sup> described how perpetrators of violence often have derogatory attitudes toward vulnerability and human dependency. Employment of the manic defenses in the offender population may be seen with pedophiles, who rationalize that they are showing paternal affection to the children with whom they form relationships. Internally, the pedophile fantasizes that he may omnipotently become a child again and repair earlier trauma. He may idealize the relationship he has with the child, describe how it is beneficial for the child and experience a relationship in which dependency is accepted and controlled.

### The Criminal Act and Transference

The psychodynamic approach to understanding individual distress empowers the clinician to focus, not only on overt symptoms of illness, but also on the context out of which the symptoms and, for our purposes, the criminal act are born. The narrative and life history of the evaluated individual are founded on a series of developmental progressions through stages

of his life, which are themselves influenced by innate capacities and object relations experiences. The psychodynamic model maintains the importance of seeing the criminal act as part of a larger narrative and in part caused by early traumatic sensitizing experiences that have been repressed in the offender's unconscious. In understanding the criminal act and conceptualizing criminal behavior as the final outcome of early developmental arrest and a pathological upbringing, the forensic clinician gains powerful data about the offender's past, current, and future ability to mobilize positive resources in periods of distress. The criminal act can, in itself, provide critical information about the offender's unconscious internal world and vulnerabilities and can enable the forensic clinician to opine more accurately on the likelihood of future risk and dangerousness. Yakeley and Adshead described how a perpetrator may experience intense feelings of rage and shame in response to new triggers, noting that "these emotions are too much for the affect regulation system of the offender, who then has to find a way to manage them by getting another person (the victim) to experience them, by dissociating from them, or by acting out vengefully" (Ref. 10, p 39). In this manner, unmetabolized emotions of childhood explode out of proportion, and without apparent meaning, to a new provocation.

In the forensic arena, the concept of transference, as described above, predicts that the forensic clinician will become the target of intense emotional stances through mobilization of immature defenses, including projection and projective identification. This process occurs as the offender projects aspects of his internal world and state of affairs onto the evaluator. Freud<sup>14</sup> identified transference as a phenomenon based on repetition compulsion, a process through which old conflicts and relationships are re-enacted with the unconscious goal of finding a solution. Attempts at resolution of this conflict are often dominated by a preoccupation with revenge and persistent grievance against early adverse childhood experiences and neglect. This sense of sadistic revenge is aimed at an early caretaker who is perceived to have failed and deserves cruel punishment. This drama is replayed in individuals who are random victims of crime and vindictive criminal behavior. In addition, in working with offenders in whom sadomasochistic tendencies are active, the clinician may come to view himself, through projective identification, as a sadistic figure in return.<sup>9</sup> This cruel figure would repre-

sent a projected critical superego. Similarly, the clinician may unconsciously adopt a masochistic stance and accept the role of victim. Vigilant attention to the role and presence of transference serves as a powerful impetus for the forensic clinician to regulate affect and maintain objectivity when confronted with the disturbed world of the offender's psyche.

## Countertransference

Since Freud<sup>15</sup> first introduced the concept of countertransference, its meaning has expanded alongside improved theoretical understanding and clinical application in both the analytic space and forensic interview. Freud characterized the countertransference as an undesirable development and the result of a patient's influence on the therapist's unconscious feelings, noting that psychoanalysis had "nearly come to the point of requiring the physician to recognize and overcome this countertransference in himself." (Ref. 16, p 91). His definition narrowly referred to the analyst's transference to the patient or response to the patient's transference. Freud conceptualized countertransference as evidence of unresolved conflicts in the analyst's unconscious. Heimann<sup>17</sup> defined countertransference as "all the feelings which the analyst has toward the patient," (Ref. 17, p 81) and concluded that there is an important communication between the patient's unconscious and the analyst's unconscious. Winnicott<sup>18</sup> described an alternative type of countertransference, objective hate, which captures the natural reaction a therapist might have to a patient's behavior. He theorized that this reaction is objective, in that most individuals would react similarly. Kernberg<sup>19</sup> opined that a broader definition of countertransference, encompassing a therapist's total emotional reaction to the patient, would ultimately serve as a powerful diagnostic and therapeutic tool in understanding an individual's internal world.

In the forensic setting, the practitioner must identify early the presence of both negative and positive countertransference and gain mastery over a variety of intense cognitive and emotional responses that are evoked. Such dynamics may arise if the clinician is exposed to reprehensible criminal behavior, leading to the development of negative feelings, such as hopelessness, helplessness, indignation, anger, and fear.<sup>13</sup> The clinician may experience equally problematic positive countertransference, as evidenced by an expert's exhibitionistic need for credit and recog-

## Psychodynamic Principles in Forensic Psychiatric Assessment

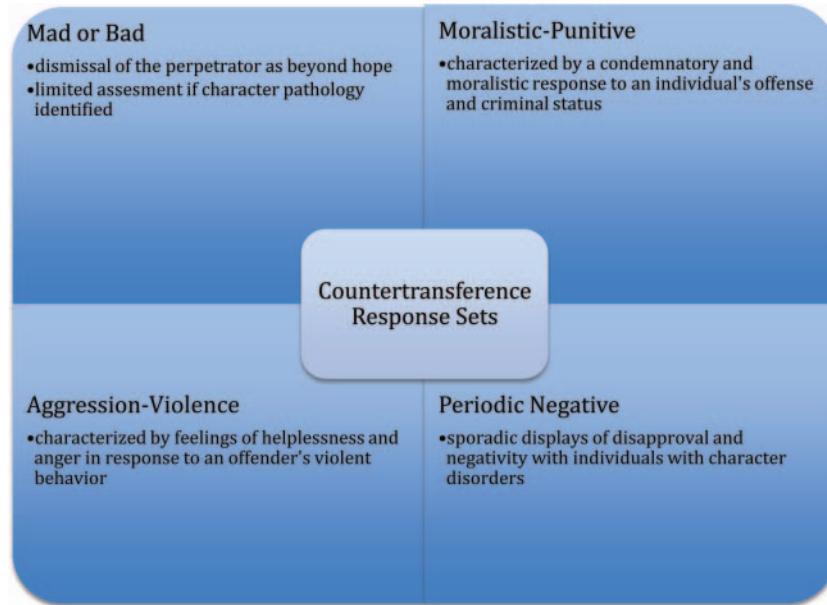


Figure 2. Four Types of Countertransference Response Sets—Adapted from Prott and Travin.<sup>22</sup>

nition, overinvestment in the outcome of a case, or eagerness to consult on a case where he may not be qualified.<sup>20,21</sup> Travin and Prott<sup>22,23</sup> used the term triadic countertransference to depict the interaction of the forensic practitioner, offender, and the legal system. They postulated that dynamic forces between each could not only affect but also threaten objectivity in an evaluation by contributing to the development of bias. Failure to perceive countertransference may lead to inaccurate recall of interview data and distorted perceptions of evaluatees. According to Dietz,<sup>24</sup> the inexperienced forensic psychiatrist may not appreciate the extent of countertransference and its influence on his interview and assessment. The forensic clinician may be caught between institutional and societal demands for punishment and the pressure to provide an honest and impartial assessment. This conflict, coupled with diffused responsibilities between the forensic clinician and other individuals involved in a case, may prove unduly challenging.

When confronted with the powerful emotions and thoughts that inevitably arise while conducting a forensic assessment, an evaluator may have difficulty appreciating whether his responses to a particular offense or evaluatee are normative and objective or are idiosyncratic and countertransferrential (i.e., reflect his own specific life history, attitudes, and cultural identity). Some commentators have suggested that one approach to this problem would be to consider

any emotional response to be countertransferrential. Giovacchini<sup>25</sup> divided countertransference into two general categories, homogeneous countertransference and idiosyncratic countertransference. Homogeneous countertransference refers to average, expectable reactions to objectionable or provocative behavior (e.g., negative feelings that arise after hearing about child abuse or a violent offense). In contrast, idiosyncratic countertransference refers to unique, exaggerated, or distorted reactions to an evaluatee. Because many attitudes and biases are unconscious, unexamined, or minimized, such a dichotomous definition may be more useful in theory than in practice. Regardless, we suggest that evaluators at least be mindful of this conceptualization as they go about formulating their opinions. We also suggest that they routinely conduct mental self-audits, not only for the presence of bias in general (e.g., bias owing to which side in a legal case has retained the evaluator), but also for the presence of both types of countertransferrential reaction.

Prott and Travin<sup>22</sup> identified four types of countertransference “response sets” in the forensic setting: mad or bad, moralistic-punitive, aggression-violence, and periodic negative (Fig. 2). The mad-or-bad reaction, often experienced in the evaluation of individuals with antisocial personality disorder and severe psychiatric disturbance, is depicted by the clinician’s dismissal of the offender as a “psychopath” or beyond hope. In this setting, the clinician has been

made to feel controlled by the individual's behavior and may cease to probe further into his psychiatric history once characterological pathology is identified. In addition, the clinician may focus on the maladaptive personality structure as a defense against feelings of helplessness aroused by the individual's core psychiatric disturbance. If the individual is referred through the criminal justice system, the clinician may have the expectation of antisocial behavior, to the detriment of an objective assessment.

The moralistic-punitive countertransference response set is characterized by an overly condemnatory and moralistic reaction to an individual's offense and criminal status. Being intimately involved with the legal system and having typically been provided with explicit accounts of the heinous details of an offender's crimes, the forensic practitioner may be biased by his personal values and disapproval of antisocial behavior. A moralistic viewpoint would necessarily impede and negatively impact the evaluation.

Inherent in the aggression and violence response set are the forensic practitioner's feelings of extreme helplessness, reciprocal anger, and denial in the face of an offender's violent behavior. Lion *et al.*<sup>26</sup> noted that clinicians are more comfortable with the introduction of aggressive impulses than with their externalization. When faced with outward demonstrations of violence, they may experience a constellation of emotions that obstruct the accurate assessment, understanding, and exploration of aggressive urges.<sup>27</sup> This response may be particularly detrimental in completion of a thorough risk assessment. Yakeley and Adshead<sup>10</sup> asserted that a psychodynamic understanding of violence may provide important details in risk assessment and aid in uncovering the meaning of a violent act for the perpetrator. A dynamic approach may help the evaluator not only to understand why some individuals relate to others by violent means, but also to appreciate that current antisocial behavior may be a repetition of early adverse childhood experiences. The psychodynamic model treats the offender as an individual with choices, intentions, and agency, and underscores the fact that several risk factors for violence have psychodynamic and relational aspects to them.<sup>10</sup> These include social isolation,<sup>28</sup> disorganized attachment systems,<sup>29</sup> maladaptive and derogatory attitudes toward human dependency and vulnerability,<sup>30</sup> and traumatic childhood memories. Without an appreciation of the personal significance of each risk factor

to the individual, the authors concluded that it is "impossible to obtain anything but a most general assessment of the extent and risk of reoffending" (Ref. 10, p 40). Similarly, if the practitioner were derailed by acts of violence or aggression in the context of the forensic evaluation, data critical to performing a sound risk assessment would be lost.

The periodic negative response set acknowledges the negative feelings that may develop in the evaluation of individuals with severe character disorders. It is postulated that they are the result of exposure to more immature mental operations such as splitting and projection. The forensic clinician should remain vigilant to the development of such powerful emotions and discern whether they are the result of interactions with the offender or internal to oneself.

Countertransference reactions may extend to feelings about the legal system, legal profession, and participants in the legal process.<sup>21</sup> Professional contact with colleagues may involve re-enactment of sibling rivalry, while increasing familiarity with certain judges, attorneys, and court personnel may lead to recreation of a family scene. In a courtroom, a time of heightened emotions in which a forensic witness is more vulnerable to countertransference, feelings about judges and attorneys may emerge.<sup>21</sup> Similarly, in providing testimony that may injure another, as seen in criminal cases of insanity or in civil cases involving child custody and personal injury claims and disability, the forensic practitioner may experience conflict as a result of such acts.

In light of the dynamic influences described above, the forensic clinician most effectively maintains honesty and professional integrity by remaining vigilant to fluctuations in his internal emotional state and attentive to the presence of active defense mechanisms. In the pursuit of truth, defense mechanisms such as splitting, projection, projective identification, denial, acting out, and rationalization, and the phenomena of transference and countertransference may simultaneously act as important pieces of interpersonal data and obstructive influences. In this milieu, several methods have been outlined to counter these responses and mitigate the risk of bias.

First, a possible intervention to defuse negative countertransference is centered on the psychoanalytic principle of "diluting the transference" (Ref. 22, p 226). In this model, the clinician actively seeks out the resources and support of his colleagues, including the use of periodic staff conferences. Protter and

Travin described conferences as providing the “opportunity to integrate, modulate, and neutralize countertransferring data. The clinical conference may serve as a peer supervisory forum” (Ref. 22, p 226). Schetky and Colbach,<sup>21</sup> and King<sup>31</sup> similarly recommended that the forensic expert actively share and discuss cases with colleagues and encourage the practice of listening to others testify so that he can detect bias better. Continued use of validated instruments and scales to collect and analyze data may mitigate influence of personal opinions. Applebaum<sup>32</sup> highlighted the potential benefits of review of testimony by professional organizations, such as the peer review committee of the American Academy of Psychiatry and the Law (AAPL). In a Task Force review of expert testimony<sup>33</sup> the American Psychiatric Association (APA) also articulated the promise inherent in a peer review approach and the need for greater self-regulation in forensic practice.

Second, although the experience is no longer universally recommended as part of training and clinical practice, it may be beneficial for the forensic evaluator not only to engage in personal psychotherapy but also to continue to study psychotherapy. These concurrent processes may serve to identify one’s internal vulnerabilities, characteristic defenses, and cognitions that may negatively impact the evaluation process. Third, forensic practitioners should actively focus on anxiety management, self-integration, empathy, self-insight, and conceptualizing skills as factors that may mitigate countertransference.<sup>34</sup> Fourth, it is recommended that the clinician participate in ethics courses throughout his career to understand and maintain the ethics framework of forensic practice.<sup>35</sup> Other strategies may also include keeping a record of recommendations in previous evaluations and use of a self-check questionnaire to track one’s emotions during a case. If a forensic clinician finds that he is unable to process and resolve negative countertransference effectively after employing some of the strategies outlined above, it may be necessary and ethically appropriate to withdraw in extreme cases. This dynamic should be identified and communicated early to prevent unnecessary delays, expense, and procedural problems for all parties involved.

Although we propose that psychodynamic concepts should continue to play a role in the legal setting, especially when a forensic clinician is tasked with helping to make sense of an apparently senseless

act, certain challenges arise within the adversarial setting of the courtroom. Kapoor and Williams<sup>36</sup> described how judges, attorneys, and jurors are more likely to explain criminal behavior in terms of right and wrong, good and evil, and truth and lies. They argued that a forensic clinician opens himself to scrutiny by espousing and arguing for psychodynamic formulations that are inherently gray, nuanced, and difficult to prove. This argument is even more valid at a time when psychological testing, neuroimaging studies, and conclusions based on history and data are able to offer more objective, tangible, and scientific results. While citing the benefit that psychodynamic concepts may bring to the legal setting, the authors acknowledged that psychoanalysis and the law are often an imperfect fit.

## **Bias**

To this point, we have focused primarily on psychodynamic concepts and their appearance and impact in the forensic setting. However, although the forensic evaluator is at risk of undue influence by the powerful emotions associated with transference and countertransference, those are but a few of a larger number of unconscious factors that fall under the rubric of bias. Although a thorough review of bias in the forensic evaluation is beyond the scope of this review, it is critical to highlight that it represents the greatest threat to objectivity. Bias may diminish reliability of information provided to the courts and negatively influence forensic evaluation and recommendations. Scott<sup>37</sup> identified five potential biases that may influence the forensic evaluation process, including anchoring, confirmation, attribution, and observer and hindsight bias. Garb<sup>38</sup> noted the presence of numerous biasing factors that have been found to affect clinical judgment in a variety of contexts, including assessments of personality, predictions of violence and suicidality, treatment decisions and psychiatric diagnoses. In another study,<sup>39</sup> two factors that have been shown to be a predominant influence in the development of bias include how often one choice rather than another is made (i.e., the imbalance of testifying for only one side in criminal and civil cases, and how choices may be rewarded by an increase or decrease in business or popularity or an improvement in fee structure).

Although controlled studies have demonstrated that all assessments are biased to some degree, it appears that forensic evaluators underestimate the ef-

**Table 2** The Forensic Evaluation Process

	Procedures	Goals	Relevant General and Psychodynamic Concepts and Questions
Preparation for a case	Initial consult with attorney(s), court-system Request all appropriate documentation and collateral data	Determine basic nature of the case and medico-legal question Determine whether referral to another forensic specialist is warranted	Determination of qualifications to provide forensic assistance Discuss fee arrangement Countertransference: examine initial reactions to the case Bias: given initial reactions, is impartiality feasible or would personal vulnerabilities and opinions impede objectivity?
Data collection	Interview with the evaluatee  Interview with any collateral sources where appropriate  Review documentation and request additional information if warranted	Obtain a full psychiatric database  Ensure that sufficient data are available to answer medicolegal question	Transference: how is the evaluatee interacting? How does his current interactional style reflect his developmental history? Does he appear forthcoming or withholding? Countertransference: what is my emotional response to the evaluatee (anger, empathy, fear)? Is this a response to projected emotions, or is it idiosyncratic? Do I feel safe? Do I have unusually strong positive or negative feelings toward an evaluatee? Is my interview with the evaluatee deviating from my baseline or characteristic approach? Developmental history: does the evaluatee's narrative contain past loss, abuse, or psychological trauma? If so, how do these factors affect risk assessment? Characteristics of the ego: strengths and weaknesses, defense mechanisms, relationship to superego Quality of object relations: family and intimate relations Characteristics of the self: self-esteem and self-cohesiveness, self-boundaries
Data analysis	Analysis of interview data	Ensure that focus remains on legal point in question Seek supervision if needed	Countertransference: does the gathered data reflect a balanced approach to the case? Did I gather or include information that might disconfirm my impression of an evaluatee?
Forensic report	Synthesis of the data  Discuss findings with consulting attorney	Provide a logical, integrated and objective assessment  Ensure availability for expert testimony	Determine whether recommendations and clinical impressions reflect all data obtained during an interview Identify and acknowledge possible discrepancies or conflicting information that might alter report conclusions
Forensic testimony	Presentation of the data  Provide formulation of the offense in a clear and coherent manner, without use of jargon	Assist the trier of fact in applying psychiatric expertise to a legal question  Educate court about relevant mental health concerns, including psychodynamic concepts, if relevant Anticipate challenges to testimony in cross-examination; acknowledge limitations of data	Determine whether a psychodynamic understanding of the case at hand assists the trier of fact in explaining a defendant's behavior Understand limitations and challenges of presenting psychodynamic concepts in court  Countertransference: internal response to attorneys, judge and other court personnel in the courtroom; screen for signs of overinvestment in the case (e.g. remaining in court after testimony is complete)

fect of bias and their own conflicts of interest. In a pilot study of perceptions of expert bias, Commons and colleagues<sup>40</sup> administered a 26-item question-

nnaire to 46 forensic evaluators, asking them to rate hypothetical responses of experts to various case outcomes and the biasing potential of different clinical

scenarios for opposing experts. Analysis of the results demonstrated that, although the respondents were exposed to potentially biasing factors, even before they agreed to accept a case, and were influenced by their own specific beliefs or characteristics, they did not regard these factors as a threat to their objectivity. Moreover, the experts believed that other experts were relatively bias free and able to compensate when biasing factors were identified, leading the authors to conclude that there was a state of relative denial among the respondents about the role of bias in decision-making.

### Conclusion

Psychodynamic principles permeate all facets of the forensic evaluation process. From the moment of initial consultation to providing expert testimony in the theater of the courtroom, a complex interplay of thoughts, feelings, and behaviors develops among the clinician and the evaluatee and legal system. Unconscious identification with pathological defenses re-enacted by an offender, and lack of attention to transference and countertransference may lead to revictimization, secondary traumatization of the forensic evaluator, and development of bias. A general approach to the forensic evaluation process, alongside important psychodynamic concepts, is outlined in Table 2. Although presented as a step-wise process, relevant psychodynamic concepts during one phase of the interview may subsequently be encountered in another portion of the interview. Clearly, psychodynamic principles aid in understanding the meaning of a criminal act and offer complementary guidance to the traditional risk assessment process. We believe that it is beneficial for the forensic clinician to evaluate an individual from a psychodynamically informed perspective. Staying true to our empathic, inquisitive roles as physicians may simultaneously enrich the interview, improve data gathering, and empower us to use tools that we would ordinarily employ in clinical practice. Deprived of this rich corpus of knowledge, the forensic evaluator risks the loss of honesty and objectivity in the emotional maelstrom of criminal and civil evaluations.

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