Countertransference on the Witness Stand: A Flight from Self?

DIANE H. SCHETKY, MD*
EDWARD M. COLBACH, MD**

In his 1971 article "The Retreat from Patients," Lawrence Kubie strongly chastised those psychiatrists who apparently "flee" from the painful, growing experience of prolonged one-to-one contact with patients.[1] He pointed out that treating patients "always stirs up pain, and pain always triggers an impulse to run away." He further said, "My impression is rather that most of those who run away from treating psychiatric patients are unwittingly running away from themselves, i.e., from those aspects of themselves with which the psychotherapeutic entanglement confronts and challenges them. It is this self-confrontation which disturbs the psychotherapist most deeply, whether young or old."

Kubie specifically mentioned the areas of psychiatric research, teaching, administration, and the application of psychiatry to social problems as safe havens for the fleeing therapist. He did not mention forensic psychiatry. But, were he writing today after the advent of the American Board of Forensic Psychiatry, he most likely would have included this subspecialty also. No doubt he would have viewed the witness stand as a more comfortable place to be than the inner office.

With a contrary outlook, one of us (D.S.) has commented that many psychiatrists retreat from the legal arena.[2] The adversarial system is often mistrusted and misunderstood, with cross examination perceived as being particularly disagreeable. Many psychiatrists seem to prefer the company of their own appreciative patients, who do not challenge their authority quite so blatantly.

One of us (E.C.) has also spoken of the threat to a psychiatrist's intellectual integrity in a courtroom setting.[3] The various factors that bring about such a threat include a desire to please a judge, anger at a defendant, an unwillingness to spend the time necessary to understand the statute in question, a simple need to be asked back again for economic necessity, and various ego factors, such as a desire to be in the limelight. Indices such as the Contrary Quotient (how often do I *not* give the side that hires me what they want?) and the Validity Percentage (how often does a judge or jury agree with me?) have been discussed as possible ways of checking oneself.

*Private Practice, Child and Adult Psychiatry, Wilton, CT; Assistant Clinical Professor, Yale University Child Study Center.
**Private Practice, Portland, OR; Associate Clinical Professor of Psychiatry, University of Oregon Health Sciences Center; Diplomate American Board of Forensic Psychiatry.
Address correspondence to Dr. Colbach, 2970 S.W. Schaeffer Rd., West Linn, OR 97068.
Presented at the Twelfth Annual Meeting of the American Academy of Psychiatry and the Law, San Diego, CA, October 15-18, 1981.

Rada notes that countertransference reactions extend to our feelings about the legal system, legal profession, and specific participants in the legal process, including clients and colleagues.[4] He reminds us that the latter often involves issues of sibling rivalry. Both he and Bazelon comment on the problem of overadvocacy and the expert who is convinced of the accuracy of his or her own findings and cannot entertain the possibility of error.[5]

This article looks at the feelings of the psychiatrist in a forensic setting. Is the witness stand a place to flee to or a place to flee from? What are the dangers to a psychiatrist's "selfhood" in going to court? How can these dangers be minimized?

In individual work with patients, the terms transference and countertransference are well recognized. They also have usefulness in the forensic setting.

To review, the term transference is used to encompass the range of feelings the patient has both for and against the therapist, feelings based not so much on what the therapist actually is but on what the patient's past experiences color the therapist to be.[6] Countertransference refers to similarly based feelings on the part of the therapist toward the patient. Like transference, countertransference can be either positive or negative, and in either case it behooves the psychiatrist to be aware of these feelings.

In studying the psychiatrist in the courtroom, his or her countertransference distortions of the process are of great concern. It's not always easy to determine whether a particular reaction is or is not the result of countertransference. An important question to ask is whether the so-called average person might react in a similar way. For example, if the average person were introduced to a very large man with a deep and booming voice, he would initially experience some caution and even perhaps some intimidation. The average person, however, probably would not begin to shake and stammer and break out in a cold sweat. To do so might be a distortion based on past experiences.

Both transference and countertransference tend to be automatic, unconscious processes that are difficult to prevent. Much of individual therapy is based on the therapist's ability to point out to the patient his or her transference distortions, especially the negative ones. When therapy fails, it is often due to a failure to deal with the negative transference. A main reason these negative transferences are poorly handled has to do with the therapist's countertransference difficulties.

Likewise, in a courtroom setting, the challenge for the forensic psychiatrist is to be aware of his or her countertransference. Awareness makes it easier for the expert not to act on the feeling, such action being inappropriate to the reality of the situation. Sullivan and Kernberg have written about the usefulness of analyzing one's own internal experiences in more effectively approaching the individual patient.[7,8] So countertransference can be a help as well as a hindrance.

The courtroom setting has been described as a drama and battle.[9] Books

have been written about how physicians might survive and conquer in this emotional arena.[10,11] In a time of such heightened emotionality, one is especially vulnerable to uncontrolled countertransference. Some examples follow:

Positive Countertransference

Case 1 A psychiatrist is testifying for the defense in a criminal responsibility matter. He does a good job of speaking to the jury, even getting them to laugh on occasion and to look appropriately sad on other occasions. On cross examination he handles the prosecution's challenges well. When he leaves the courtroom he feels euphoric with self-confidence.

Later that day he finds that the jury agreed with his opinion. That night he boasts to his wife about how he *won* a difficult case. He tells her how he made the prosecutor look foolish at times by his clever answers to certain questions.

In the morning, working with patients in his office, he contrasts the slow process of therapy with the heady feeling of his court appearance. He begins to long for another attorney to call. This desire grows even stronger when he sees his name in the paper that night.

Here, of course, it is clear how this expert's exhibitionistic need for recognition, based perhaps on some self-worth problems caused him to get inappropriately carried away. He even blurred his role as one who "won" the case. Certainly there is some appropriate pleasure in doing a job well. However, in this case the element of positive countertransference took over, to the detriment of this man's individual practice and perhaps his objectivity in court. His eagerness to repeat the experience is a threat to his intellectual integrity and clear judgment the next time an attorney calls.

If this man could recognize this, it might be useful to him. Why is he bored with his patients? Is he perhaps a bit depressed? Did his courtroom histrionics really do credit to him and the legal process?

Case 2 A childless female psychiatrist is asked to evaluate an unmarried welfare mother and her two-year-old son for possible termination of parental rights. The child has been in foster care for six months because of alleged neglect. The psychiatrist takes an immediate liking to the child, estimating his intelligence to be quite high. She likes his looks and has the fleeting fantasy that if she had ever married and had a son, he would be like this boy. She is also impressed with the care and affection shown by the foster parents, who remind her of her own parents. The foster parents are childless, like the psychiatrist, and offer the child a great deal of intellectual stimulation. They would like to adopt the youngster.

When the psychiatrist evaluates the biological mother, she is vaguely aware that she already has a certain mental set. She really doesn't dislike the mother, who is well-intentioned but handicapped by various personality inadequacies and her low socioeconomic status. At the same time she cannot divorce from her mind the pervasive idea that this appealing boy could be adopted by a caring, intelligent middle-class family. Her final opinion is for termination of parental rights.

Here is a situation where the expert is attracted to some parties more

than others. This is normal in human affairs. But certain deeper issues are at work. Is the psychiatrist acting in the child's best interest or is she allowing free rein to her rescue fantasies? How much does her own middle-class bias blind her to what the natural mother might have to offer in the long run? Having postponed her own wish to have children because of her career and other considerations, is she attaching herself too strongly to the youngster?

Were she aware of these countertransference feelings, she might look more objectively at the biological mother. She might also decide to perhaps make some changes in her own personal life. She might even decide to forego further custody evaluations of this nature.

Negative Countertransference

Case 3 A psychiatrist was raised in a very strict, religious home, deeply imbued with the work ethic. He is frustrated by what he perceives as the breaking down of this ethic in society. He is asked by an insurance company to evaluate a middle-aged truck driver suffering from apparently psychophysiologic back pain and depression related to a relatively minor industrial injury.

During his evaluation the psychiatrist is particularly incensed by the passivity of the claimant, who seems to be asking the world to care for him. At one point the examiner is aware of such rising anger in himself that he has to fight for control. He would like to blurt out to the claimant that he is nothing but a fake and a parasite to society. The expert's report minimizes the man's problem and stresses his lack of motivation, even mentioning some conscious malingering.

There is a hearing before an administrative law judge, a man who has a reputation for being very liberal and sympathetic toward workers. The psychiatrist does not approve of this judge's view of the world and, during his testimony, he tries hard to convince the judge that the claimant is an inadequate fellow who should just be forced back to work. If this man gets away with his act, the expert says, it will be an inducement for everyone to quit the struggle for life.

Finally, based on contrary expert testimony on behalf of the claimant, the judge grants a generous settlement, including extensive retraining, psychiatric care, and physical therapy. When he hears of this, the insurance company examiner rages around his office. He calls his colleague who testified for the claimant a prostitute. He vows to do all that he can to see that this particular judge is not reappointed. He also vows to testify before the legislature to tighten up the worker's compensation laws.

The expert here, like everyone else, has certain personal opinions. It is the intensity of these opinions that signals a countertransference problem. And he thus becomes labelled an "insurance company doctor," thereby losing much of his credibility. If he goes before the legislature, his anger will make him a less effective witness.

How much does he realize that his identification with his own parents colors his professional opinions? How much does his intolerance of his own dependency needs make him unduly harsh with those who have succumbed to theirs? Were he more aware of these things, he might be able to change the tone of his practice for the eventual benefit of all concerned.

Case 4 A young child psychiatrist, in his second year of practice, is called by an attorney to do a custody evaluation. The attorney is unknown to the psychiatrist but explains that he represents the father and has heard that the young expert tends to be "sympathetic" to fathers.

After the phone call the psychiatrist ruminates about the remark. He reviews in his own mind the few custody evaluations he has done, and he realizes he has always recommended the father, even in one case of a daughter's placement. He is quite an earnest and honest fellow, and he is immediately alarmed by this. He seeks out a residency supervisor to talk the matter over. In just a brief session, he quickly becomes aware that he has unresolved harsh feelings about his mother, whom he remembers as a "castrator."

He decides to follow through with this most recent custody evaluation. But he and his former supervisor agree to talk it over before he writes his report. He also begins to mull over the possibility of ongoing supervision and perhaps even some more personal therapy.

This fellow probably will always have to struggle with some of his attitudes. The crucial factors for all of us are how aware and how much in control of them that we are.

Discussion

Anyone with courtroom exposure can readily add to these cases. Our feelings about judges, for example, may be influenced by countertransference phenomena. Some of us may regard them as wise, benevolent parent or grandparent figures. Others may view them as very authoritarian and therefore wish to please them. It has been speculated that physicians who specialize in psychiatry are likely to be anti-authoritarian, and those who specialize in child psychiatry, where there is opportunity to identify with the child, are even more so.[12]

Attorneys also have an aura of authority. One way of handling this would be to ally too strongly with one side to do battle with the other side. A more proper position, of course, would be to strive for some sort of middle ground.

Closely related to authority conflicts are feelings about aggression. By nature psychiatrists tend to be more passive and self-reflective. In therapy time is usually on our side, and a mistake can be rectified at a later date. In court, however, there is a need to be decisive in such issues as criminal responsibility, child custody, will contests, personal injury matters, commitment hearings, and others. Specificity and adherence to an opinion are expected. Often what is said will clearly upset someone in the courtroom. In some ways a psychiatrist on the witness stand is asked to resemble a surgeon in the operating room. At times this can be exhilarating. At other times it can create conflict.

Another facet of court work, alluded to in Case 1, is the public exposure, which is vastly different from private office practice. There is no privacy or anonymity in the courtroom, where one's utterances may end up in the media or imprinted in case law. Again this can be appropriately pleasurable

at times, but it may also be a trap springing on one's unrecognized need for notoriety. Delivery of damaging testimony also brings with it fears of upsetting people, with resultant retaliation. This is especially so in litigation involving paranoid individuals.

The expert witness who frequents the courthouse develops a whole network of relationships with judges, attorneys, social workers, clerks, bailiffs, corrections personnel, and others. In many ways a family scene is recreated, with parents and siblings. There is a constant pull to relive sibling and parental relationships. The essential need to be loved is always present, becoming more powerful with increasing familiarity. Objectivity is constantly threatened from all sides. A judge, for example, may be more influenced by the person testifying than by what is actually said. In appointing an expert a judge may be showing his or her own bias, placing preconceived expectations on the expert.

The expert may develop a tendency to see one case as being just like another, and such "boredom" may lead to unfortunate shortcuts. Attitudes can easily become stereotyped. When this happens in individual therapy, the therapist is asked to look within himself or herself. This should also be the case in forensic psychiatry.

We could go on and on, of course, with examples of countertransference in forensic settings. Because of its elaborate trappings, the courtroom is a minefield for the psychiatrist, where countertransference threats to one's "selfhood" are much more omnipresent than in the private consulting room.

Countertransference out of control can be much more devastating in the courtroom than in the private office. In the first place there is always some kind of audience, so what is said is likely to influence more than one other person. Even more important is the potentially wide social impact. In recent years court decisions have proved to be one of our most important social policy mechanisms. What the expert says on the witness stand may, in the form of case law, be passed from lower court to higher court to still higher court, and from jurisdiction to jurisdiction.

The areas where psychiatric expert opinion is requested are burgeoning. So, despite Kubie's admonitions, some psychiatrists are going to end up spending much of their time in court, called there by the simple law of demand. Whether this impedes the expert's personal growth is debatable. The possibility has to be considered, however.

What can the forensic psychiatrist do to control the pitfalls of his or her own countertransference? Expecially he or she has to come to terms with feelings about authority and parents and siblings and sex and aggression. The forensic expert should clearly recognize the diagnostic, predictive, and therapeutic limits of psychiatry, maintaining a clear perspective of being only a small cog in a larger and very complicated legal wheel.

Some sort of ongoing analysis, in some setting, is necessary. The forensic psychiatrist should not succumb to the temptation to stop treating

patients because of scheduling problems and the like. Continuing experience with and study of psychotherapy is essential. The individual therapeutic process has been extensively investigated. The forensic psychiatrist should recognize that this same process is going on within the courtroom doors. Only here the actors are not just doctor and patient but doctor and judge, jury, defendant, attorneys, news media, and others.

At the very least the forensic expert should be involved in some sort of ongoing process of sharing and discussing cases with colleagues. For some, personal therapy or analysis is helpful and may be essential. Reading and writing and presenting should be encouraged. An often overlooked aid is listening to others testify, and it's usually easier to see bias in others than in ourselves. Keeping personal statistics, through the use of such devices as Contrary Quotient and Validity Percentage, can be revealing. Preparing for and taking the American Board of Forensic Psychiatry examination should be viewed as more than a chance to add new credentials. Here is an opportunity to study the field at large and to have one's own viewpoint challenged in depth by senior colleagues.

The first and most important step, though, is the continuing awareness that countertransference, with its threat to self-integrity, is alive but not always well in the courtroom.

References

1. Kubie L: The retreat from patients. Arch Gen Psychiatry 24:98-106, 1971
2. Schetky D: Termination of parental rights and issues of foster care. Presented at Institute of Child Psychiatry and the Law, Amer Acad of Child Psychiatry Oct 15, 1980 Chicago
3. Colbach E: Expert testimony: credibile or incredible? Presented at 11th Annual Meeting of American Academy of Psychiatry and Law, Oct. 19, 1980, Chicago
4. Rada RT: The psychiatrist as expert witness in Law and Ethics in the Practice of Psychiatry, ed. Charles Hofling. N.Y., Brunner/Mazel Inc, 1981
5. Bazelon D: Psychiatrists and the Adversary Process. Scientific American, 230, No. 6, 8-22, 1974
6. Kaplan H, Freedman A & Sadock B: Comprehensive Textbook of Psychiatry III. Baltimore, Williams & Wilkins Co., 1980, pp 2125-26
7. Sullivan H: The Interpersonal Theory of Psychiatry. New York, WW Norton & Co. 1953
8. Kernberg O: Notes on countertransferences. J Am Psychoanal Assoc 13: 38-50, 1965
9. Strick A: Injustice for All. New York, G.P. Putnam's Sons, 1977
10. Horsley J: Testifying in Court: The Advanced Course. Oradell, N.J., Medical Economics Company, 1972
11. Houts M: Courtroom Medicine. New York, Matthew Bender & Co., 1960
12. Work H: Career choice in the training of the child psychiatrist. J Am Acad Ch Psychiatry 7:442-453 p 447, 1968

□