

# Countering Countertransference, II: Beyond Evaluation to Cross-Examination

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Countertransference is a clinical term introduced by Freud in 1909. For years, despite mounting criticism, forensic psychiatrists borrowed this clinical concept to explain their emotional experiences and responses to examinees' emotions and behavior. The authors describe the impact of examinee and nonexaminee factors during evaluations and beyond, including during trial and while providing forensic testimony. The suggestion is made that using the term countertransference in forensic psychiatry can be problematic. The authors delineate the complexities of the term as related to forensic psychiatry and consider modified terms to provide a better explanation of these concepts in forensic contexts.

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The concepts of transference and countertransference have been the bedrock of clinical psychiatry since their introduction by Freud in 1909.<sup>1</sup> However, the original definition of countertransference as the therapist's unconscious response to the patient, based on the therapist's unresolved conflicts has undergone significant modifications. Winnicott<sup>2</sup> broadened the use of countertransference to include all of the reactions of therapists toward their patients. For years, forensic psychiatrists have used this clinical concept to help explain their emotional responses to examinees' emotions and behavior.<sup>3–9</sup> However, in forensic psychiatry, the use of the term countertransference has been criticized because it reflects the clinical underpinnings of the doctor-patient treatment relationship.<sup>10</sup> In forensic psychiatry, even though the interactions of the examinee and examiner are differentiated from a clinical relationship,<sup>11</sup> examin-

ees respond emotionally to their forensic examiners, while forensic examiners respond to the emotions of examinees. These responses have the potential to impair the neutrality and objectivity of forensic examiners, who are generally expected to rise above their feelings of countertransference, as they pursue and seek the truth.<sup>12</sup> In an earlier paper,<sup>13</sup> we described the complicating effects of countertransference on the prospects of an unbiased and objective forensic evaluation. Our experience suggests, however, that the risk of compromising the neutrality and objectivity of forensic opinions due to countertransference is present not only during the evaluation but also beyond. These feelings of countertransference may arise well after the completion of the evaluation phase of forensic work, such as during trial, presentation of testimony, and cross-examination.

In forensic psychiatry, the term countertransference has been used to refer to feelings that are evoked in the examiner in response to the examinee. However, in this article, by using the example of a forensic evaluation and the ensuing forensic testimony during trial, we identify several nonexaminee variables that have the potential to have a similar impact on the neutrality of the forensic opinions. Also, we try to grapple with the question: are these feelings that po-

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tentially have an impact on the objectivity of forensic opinions and testimony, a type of countertransference?

### Case

The sample case involves a defendant who was charged with attempted murder of his girlfriend's infant child. Even though much of the information regarding this case is available through the media, identifying information has been disguised to preserve the confidentiality of the defendant and the parties involved.

The defendant was a young man who suffered from major depression with psychotic features (DSM-IV criteria).<sup>14</sup> He had been hospitalized twice in the recent past because of psychotic symptoms. Just before the alleged incident, he reportedly missed two follow-up appointments with his psychiatrist and stopped taking his antipsychotic medications. Soon after, he started experiencing auditory hallucinations, which he described as God's voice commanding him to kill his girlfriend's baby because the baby was "the devil's reincarnation and should die." Collateral reports also suggested that the defendant demonstrated odd behavior, appearing isolated, distant, and distracted. On the day of the alleged incident, he woke up in the morning and, on not finding his girlfriend there, was filled with rage. He went looking for her and found her with the baby in the adjacent room. He became enraged because he thought that she "preferred" the baby over him. When she was looking away, he grabbed the baby and ran to the bedroom, locking the door. His girlfriend, realizing what had happened, ran after him but could not stop him. She started yelling and screaming and banging the door. She called her neighbors for help. Together, as they broke down the door, they saw that the defendant had his hands around the baby's neck as he choked the infant. On seeing the door being broken, the defendant left the unconscious baby on the floor and ran out of the room before he could be stopped. He was later found hiding in a nearby building.

During his competency and criminal responsibility evaluation with a forensic trainee, the defendant initially came across as arrogant, distant, and rude. He was uncooperative, curt, and very irritable. His initial presentation made an objective evaluation difficult. Trying to talk to him was irritating and frustrating. He also projected a demeaning look that was intimidating. All of this had an initial result of his

being labeled a "psychopath," which further impaired the possibility of a comprehensive, thorough, and unbiased evaluation.

The defendant's behavior caused the trainee to become irritated and frustrated, leading to the formation of a premature diagnosis, which, if not recognized by the trainee and the supervisors, could have had a serious impact on the evaluation, testimony, and perhaps even the eventual outcome of the case.

### Countertransference During Forensic Evaluations

The emotional responses depicted in this case are typical examples of a form of countertransference that can impair neutrality and objectivity of forensic evaluations.<sup>12</sup> The feelings of frustration and anger that are aroused in evaluators are fairly common. Whereas relatively novice forensic experts may believe they encounter this more often, those with more experience are not immune to the development of similar feelings during the course of evaluations.

Even though in forensic settings countertransference generally refers to the examiner's feelings evoked in response to the examinees' actions or behavior as seen in the example, several other aspects of the case can also affect the forensic expert's feelings and emotions and can have an effect on the objectivity of the evaluative process. For example, the type of crime involved in a case can evoke a strong emotional response. Also, the witnesses who may be interviewed to provide collateral information can generate strong emotional responses. Even the victim and the victim's family members may evoke a strong emotional response.<sup>12</sup> More recently, attorneys have also been identified as a source of strong emotional responses that may impinge on objectivity during forensic evaluations.<sup>15,16</sup> In such cases, forensic experts are not responding to the examinee's words, actions, or behavior but to external nonexaminee variables that can have a substantial impact on the objectivity of these evaluations. The responses would undoubtedly vary according to the evaluator's own background and past experiences, much like countertransference. What remains at issue, however, is whether all of the emotional responses that potentially have an impact on the objectivity of forensic evaluations are types of countertransference or whether they are reflective of some other forensic or psychoanalytic concepts. That these emotional responses influence variables beyond

the evaluation, up to and including the trial, is also worth considering. These possibilities are discussed in the following account of the forensic testimony during the trial of the defendant described earlier.

### Forensic Testimony

The defendant was on trial for attempted murder. His mental illness became an issue during trial, and the forensic trainee, who had evaluated the defendant, was called to testify on the question of criminal responsibility.

In preparation for testimony, the trainee read the relevant documents. As suggested elsewhere,<sup>17</sup> he made sure that he wore comfortable clothes and arrived at the superior court with ample time to spare. The trainee wandered in the corridor to pass the time. He walked by a group of people who appeared somber. Their unmistakable resemblance to the defendant was recognized immediately. One of these men, who appeared to be the defendant's brother, consoled an older woman who appeared to be their mother. The man said, "Don't worry, Mom, he is mentally ill. They can't send him to jail. They need to send him to a hospital or something."

The family had never seen the trainee before, and he did not intend to stop and introduce himself, as there seemed no clear rationale for doing so at that point. So he simply kept walking. The impact of this conversation was not lost on him. He bought some coffee and walked back to the courtroom deep in thought about the case, his upcoming testimony and its potential impact on the case, and the eventual fate of the defendant.

The proceedings started on the arrival of the judge. Another expert testified first, while the trainee waited patiently outside the courtroom for his turn. During this time, members of the defendant's family walked in and out of the courtroom, at times tearful. Again, the trainee felt a heaviness in his heart. He knew that the job of deciding the eventual outcome of the case belonged to the jury and the judge; however, he was also aware that his testimony might have an impact on them. He remained mindful of his wish to strive for objectivity and consoled himself that he was only going to state the facts as he knew them and would state his opinion based on these facts. Eventually, the time for his testimony arrived, and he was duly administered the oath. No amount of practice prevented his first words from coming out muffled. As the questions started, he also noticed the presence

of a journalist. He could not stop thinking, "Now everyone will be reading my testimony." Despite the fact that the case was already in the local news, the presence of the journalist was surprising and intimidating to the trainee.

The direct examination started, and the attorney asked the trainee if he had reached a diagnosis of the defendant's mental illness. The trainee restated his opinion that the defendant suffered from a particular psychiatric illness. A brief discussion of the diagnostic criteria and prognosis for this condition followed. The attorney then asked if the trainee had reached the opinion that the defendant suffered from a major mental illness, to which he answered, "Yes." He asked if the defendant's symptoms were such that, at the time of the alleged incident, he lacked substantial capacity to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law. The trainee hesitated momentarily and then answered, "Yes." No sooner had the words been spoken, when a woman in the courtroom screamed, "How can you do this? He's a murderer!"

The entire courtroom was aghast at this unexpected emotional outburst. A young woman, with arms flailing and tears in her eyes, was ushered out of the courtroom by another woman. The judge asked for order in his courtroom and urged the trainee to disregard the emotional outburst and return to his testimony. The trainee again attempted to provide a rational basis for his opinion with objective data, but as he spoke he found himself thinking, "Did I miss anything in the evaluation? Was I right in reaching my conclusions, was the defendant really mentally ill, or was I just misled by some other ulterior or unconscious motive?"

The trainee was distracted enough that he needed to refresh his memory with the written report. While reviewing his report, he again reasoned that he had been objective during the evaluation. He also consoled himself by recalling that several supervisors had been consulted during this case. He reasoned, "Surely, even if I had missed something or made a mistake, my supervisors would have picked up on it." On the surface, the trainee continued his verbal presentation, but in his mind he conducted a trial of his motivations during the evaluation and testimony.

At the end of the direct examination, the judge ordered a brief recess before the cross-examination. The trainee wanted to get a drink of water but was too afraid to leave the room, in case the woman who

screamed was still outside. He felt guilty, as if he had done something wrong.

On cross-examination, the state's attorney asked several questions about mental illness and its potential effects on judgment and decision making abilities. He asked if hearing God's voice was a relatively serious psychotic symptom. The trainee said it was. The attorney then asked how someone could have symptoms that were so serious as to impair judgment, yet be able to conduct the coordinated activities of picking up a child, running into a room, locking the door, and then running out and hiding in a building to avoid being caught. The trainee explained that the nature of psychosis is such that the delusional thinking may be limited to a particular area of thought. While the rest of the mind reacts to the psychotic delusions as if they are reality, cognitive abilities can remain intact. After a few more questions, the cross-examination ended. The trainee left the witness stand and walked out of the courtroom. As he left, he saw the woman who had screamed earlier and thought she was glaring at him.

### Countertransference During Testimony

Even though there is no empirical research suggesting the prevalence of countertransference during forensic testimony, several articles have suggested that countertransference may play a part in courtroom proceedings.<sup>4,18</sup> Experts may be affected by examinee and nonexaminee variables during testimony, with resultant emotional responses that could impinge on the objectivity of the expert. The expert's emotional responses are probably normal responses to the stress of courtroom procedures. However, in thinking about these emotional responses to situations that move beyond the examinee, the question arises as to whether these responses of experts also qualify as a type of countertransference.

Psychiatrists have always been encouraged to gain awareness of their own feelings because they often are a reflection of the patients' emotions. The need for training in the conscious recognition of patients' emotions is based on the professional obligation to care for the sick. The patient-physician relationship is fundamentally asymmetrical.<sup>19,20</sup> In the idealized professional model, the needs and interests of the patients are intended to be the sole focus of the relationship, while physicians' feelings are extraneous. However, in reality, physicians' feelings are an inevitable part of the doctor-patient relationship and, if

not acknowledged, can lead to unintended consequences.<sup>21,22</sup> Forensic psychiatrists are no different in the fact that they are also humans who react to the actions, words, and behavior of others.

For trainees (as in the example given herein) and more experienced experts, the layers of emotions that can impair objectivity become quite complex. Feelings that evolved but were controlled during the evaluation may be retriggered during testimony. This may happen for various reasons, such as when the trainee or seasoned expert comes into contact with the examinee again in the courtroom. Depending on whether countertransference was positive or negative, testimony may be "adjusted" unconsciously in response to these emotions. Trainees may be dealing with issues associated with their status as a "junior" forensic psychiatrist, which may cause them to question their own capacities and opinions. During testimony, this may be perceived by the judge and jury as a lack of confidence in rendering the expert opinion. The more seasoned clinicians, on the other hand, may be perceived by the judge and jury as having more confidence, which can then, in turn cause the experts to experience feelings of superiority and thus reject any question about the validity of their opinions.

As illustrated by the testimony example, the presence of a journalist may also affect the forensic trainee in several different ways, all of which may impinge on his or her objectivity during testimony. Trainees may think that because their supervisor "approved" their work, it "must" be right. This can lead to a false feeling of confidence that could also have an impact on the eventual testimony. Then there is the presence of the supervisor in the subconscious mind of the trainee. The trainee may constantly compare his or her testimony with what the supervisor would have said. This may affect the confidence with which the opinion is rendered. On the other hand, a trainee may resent the supervisor for any praise or authority that is given to the supervisor rather than to the trainee, especially in high-profile cases. This resentment may lead to the trainee's becoming oppositional and having a "don't care" attitude about the need for objectivity while providing testimony. Further, in extreme cases, this hostility may lead to either conscious or unconscious attempts at influencing the outcome of the case in an effort to tarnish the image of the supervisor. As the case at hand illustrates, these countertransference-like feelings have the potential

to impair the neutrality and objectivity of forensic work, not only during evaluations, but also when forensic opinions are being rendered during testimony.

### Problems With the Use of the Term Countertransference

Even though the existence of countertransference-like feelings in forensic psychiatry is an undeniable fact, use of the word countertransference to describe these feelings has raised concerns, and experts disagree about what does and does not constitute countertransference in forensic settings.<sup>23</sup> One definition suggests that countertransference includes all feelings, whether conscious, subconscious, or unconscious, that are evoked in forensic examiners during evaluation or testimony, in response to examinee and nonexaminee variables that have the potential to have an impact on the objectivity of their forensic opinions.

Use of the term countertransference to describe these emotions may be problematic, however. Countertransference, which originated as a treatment-related concept, was thought to occur during therapy within the therapeutic alliance. Although forensic work utilizes clinical experience for effectiveness, it is not intended to be therapeutic or to establish a therapeutic alliance. In clinical treatment, countertransference represents a “counter” response of the clinician to the patient’s transference in a dyadic relationship. When used in forensic psychiatry, countertransference may still misleadingly suggest that the examiner’s emotions are a counter-reaction to forensic examinees in a dyadic relationship. However, forensic relationships extend beyond a dyadic relationship, and the expert’s feelings may be the result of several nonexaminee factors, as described earlier. Further, in some cases, the forensic expert may not be countering someone else’s emotional response, but may be the actual source of these emotions.

There is also concern that in forensic settings countertransference may be used inappropriately, because “true countertransference” is usually unconscious and not something that the examiner is aware of instantly.<sup>23</sup> If this is true, it raises further questions about how to classify emotions that are conscious or semiconscious (and can be brought out with some self-reflection). These emotions, like the “true un-

conscious countertransference” may affect the examiner in profound ways, including the ability to maintain objectivity, as described earlier.

Another problem with use of the term countertransference is that in clinical settings, it generally refers to a clinician’s feelings that can be worked through and perhaps resolved over months or even years during therapy the clinician-therapist may receive. It also may evolve and shift as the patient’s therapy continues. In forensic work, the opportunity for shifting emotions generally does not occur. Time with a given examinee is more limited, thus precluding the resolution of these problems over a lengthy period. These emotional reactions, however, probably should be worked through quickly, before the end of the evaluation or before an opinion is rendered during testimony, to avoid the risk of having one’s objectivity tainted by lingering emotions. This suggests that the very nature of these conflicts in forensic work and even the way these conflicts are recognized and dealt with are substantially unique from the clinical treatment concepts of countertransference.

As forensic psychiatrists examine their own reactions to examinees and other nonexaminee variables and explore how their reactions have an impact on the work they do, it is worth considering whether the traditional concept of countertransference sufficiently explains what they may be experiencing. Perhaps it would be simpler to move away from a term that engenders images of psychiatric treatment. Perhaps a new label or term would better represent forensic psychiatry’s concept of these emotional responses, which would not be suggestive of the doctor-patient treatment relationship and would include all the feelings evoked from encounters at all stages of evaluation and testimony.

The current literature suggests adding a modifier to the word countertransference, such as “forensic countertransference” in an attempt to add a degree of clarity to this concept.<sup>16</sup> However, this idea should be entertained with a sophisticated understanding of the phrase. First, the use of a core concept related to treatment, even with a modifier, may suggest a therapeutic relationship that does not exist, despite the fact that the practice of forensic psychiatry is an aspect of clinical work. The forensic psychiatrist takes on the challenge of preserving clinical awareness while conducting a forensic evaluation and going outside the realm of treatment. Forensic countertransference then should be understood as encom-

passing reactions experienced by clinicians engaged in unique, multifaceted task. Further, use of the term forensic countertransference may also suggest the examiners' counter-reactions to examinee emotions in a dyadic relationship. As noted earlier, forensic examiners are likely to be reacting to numerous aspects of a given case, going well beyond a two-party construct. Therefore, this type of countertransference should include such aspects as feelings toward the examinee, the attorney, and the judicial system and the facts of the case. Also, adding the specifier "forensic" would not remove the suggestion that the countertransference is the examiner's response to examinee emotions, transposed inappropriately from the past into present relationships, which generally include some necessary power differential. In forensic psychiatry, there generally remains a perceived hierarchy of power between forensic experts and examinees, even though experts discourage examinees from thinking so during their nonconfidentiality warnings by offering them the power not to answer certain questions or even to stop the evaluation at any time.

Until a better term is introduced to explain this concept, the term "forensic countertransference" may be used with the understanding that it is in part borrowed from the literature on psychiatric treatment. Furthermore, the addition of the modifier "forensic" is an attempt to remove the sense of therapeutic relationship from forensic work, while still maintaining the notion of an unconscious or conscious process whereby feelings are evoked and experienced by parties to some type of hierarchical relationship.

## Conclusion

No matter what term is selected to describe the feelings evoked as a response to aspects of forensic evaluations, it is of paramount importance that forensic psychiatrists learn to identify and process these feelings to prevent them from having an impact on the neutrality and objectivity of their forensic work and from tainting the general reputation of the field. As we described in our previous paper, this can be achieved by adequate training during forensic fellowship programs and continuing supervision and consultation beyond formal training. For more seasoned clinicians as well, periodic peer review of forensic work may be helpful, not only for the obviously difficult cases, but also in identifying early signs of loss of objectivity that may be missed by the individual.

Further, in cases where there is repeated concern with loss of objectivity, personal therapy may also benefit. In specific cases, where loss of objectivity cannot be resolved, termination of involvement should also be considered. Only through acknowledging their feelings and identifying the roots of these emotional responses can forensic psychiatrists strive for and hope to achieve objectivity in their forensic pursuits.<sup>13</sup> As for the introduction of additional labels or terms for identifying concepts unique to forensic psychiatry, our understanding of the various factors that potentially have an impact on objectivity in forensic work has evolved sufficiently to enable us to pause and clarify the use of clinical terms that could otherwise be misleading.

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