Forensic Mental Health Evaluators' Unprocessed Emotions as an Often-Overlooked Form of Bias

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There has been robust interest in the influence of cognitive and implicit biases that can hamper a forensic mental health evaluator's ability to provide objective opinion evidence. By contrast, literature exploring the biasing effects of the examiner's unacknowledged and unprocessed emotions has been scanty. Borrowing from concepts originating from psychodynamic treatment literature, this article explores how a forensic mental health evaluator's emotional and transferential reactions can affect the assessment process and formulation of findings. We make the case that forensic mental health evaluators are not impervious to their own mental health concerns, including vicarious trauma. We ultimately argue for a cultural shift in forensic practice that acknowledges the unavoidable existence and influence of a forensic evaluator's human emotions, personal reactions, and conflicts, so that strategies can be developed for compassionate but careful management in training programs, supervision, and beyond. We suggest that self-reflection, sometimes with the aid of consultation and psychotherapeutic support, is not only important for clinical trainees but also could serve forensic practitioners throughout their careers, especially during challenging junctures in their personal and professional lives.

J Am Acad Psychiatry Law 51:551–7, 2023. DOI:10.29158/JAAPL.230077-23

Key words: bias; countertransference; forensic mental health assessment; training and consultation; vicarious trauma

Forensic mental health assessment (FMHA) is not a monolithic practice, and the skills and knowledge required for different types of assessments depend on the setting and psycholegal question at hand. A unifying and distinguishing feature of FMHA compared with clinical work, though, is that forensic mental health evaluators (FMHEs) are required to provide unbiased opinions, to the extent that this is possible. Evaluator bias can be highly problematic given the potential reach of FMHEs' opinions proffered in reports and testimony.

Published online September 25, 2023.

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Disclosures of financial or other potential conflicts of interest: None.

The subject of cognitive bias in forensic assessment has stirred professional interest.[1,2] Two types of cognitive bias commonly cited in the literature on FMHA include confirmation bias and the fundamental attribution error. The former is the tendency to seek out data that align with an evaluator's initial impressions or hypotheses while ignoring disconfirming data, and the latter reflects the tendency to emphasize stable and personal factors above contextual factors when judging the behaviors of others.[3] The problematic influence of relying on cognitive heuristics in forensic mental health practice has inspired efforts to think through ways of reducing the biasing effects of such strategies.[4]

There is an effort in the fields of psychology and psychiatry to make efforts to consider the human rights and dignities of justice-involved individuals who often have marginalized identities.[5,6] With this, there has been a growing interest in another form of bias; that is, implicit or unconscious biases or faulty assumptions

made by evaluators that are based on evaluees' race or ethnicity. There is burgeoning literature aimed at exploring methods to reduce implicit biases.[7]

One area that has been glaringly absent from the literature on bias is the influence of an FMHE's emotions as they affect the assessment process and their opinions. The profound influence of a clinician's emotional conflicts in clinical work is well recognized and has been studied and discussed for more than a century in terms of transference and countertransference.[8,9] Scholars appear to evince a reluctance, though, to bring concepts originating from clinical practice into the forensic setting, perhaps owing to a desire to not conflate these two necessarily distinct roles.[10]

Psychodynamically-trained clinicians dealing with the vicissitudes of psychotherapy are taught to work with transference; that is, when the patient attributes to the treater characteristics or affects from a figure in the patient's past. Transference is usually described as an unconscious process but may be fully conscious in some contexts. Dynamically-trained clinicians also recognize the phenomenon of countertransference, meaning a transference toward the patient by the treater, which commonly takes two forms.[9] One form is the treater's response to the patient's transference, where the transference evokes responses (as before, unconscious or conscious) in the treater. A second form is a transference toward the patient's overt behavior as may occur during the session. Observations of practice indicate that these dynamic factors are ubiquitous. Further, research suggests that the degree to which transferential reactions are addressed and managed affects treatment outcome.[11]

We subscribe to the notion that all forensic practice rests, or should rest, on a clinical foundation that not only includes knowledge about the various forms of mental illness but also includes training on the skillful management of complex intrapersonal and interpersonal dynamics. We propose that transference and countertransference forces may be found in forensic work as well as clinical practice. In the former context, these forces have the potential to insert bias in the assessment, including during interactions with examinees and when forming and communicating assessment findings. We also describe how transferences in forensic work may go beyond the evaluator's response to the examinee alone and may even expand to include, as objects, the attorneys. We ultimately argue for a cultural shift in forensic practice that acknowledges the unavoidable existence and influence of human emotions and strong personal reactions and conflicts, so that strategies can be developed for compassionate but careful management. As with clinical practice, the evaluator's emotional responses do not need to exert a biasing influence; in fact, when acknowledged and processed, these reactions could provide additional assessment data and could cue the effective management of the complex interpersonal demands of FMHA.

FMHEs as Human

Self-Selection into Mental Health Disciplines

Whether one is a psychologist or psychiatrist, the trajectory to become an FMHE typically begins with seeking out general clinical training in a mental health-related discipline. It has long been suggested that some mental health professionals might pursue clinical training to conduct "me-search"[12] and to resolve their own emotional wounds.[13] Indeed, evidence points to the possibility that a number of individuals entering into mental health disciplines could be described as "wounded healers"[13,14] or, at the very least, are struggling with the same difficulties that afflict the general population. A recent article titled "Only Human: Mental Health Difficulties among Clinical, Counseling and School Psychology Faculty and Trainees" reported that more than 80 percent of their 1,692 respondents reported a lifetime history of mental health difficulties (diagnosed and undiagnosed) and nearly half reported a diagnosed mental health-related disorder.[15] Although no parallel studies could be found on psychiatrists or psychiatry residents, some psychiatrists have bravely written about their own psychological struggles.[16,17] Ironically, mental health professionals may feel pressure to avoid disclosing these challenges because of existing stigma in the field.[14] That said, a clinician's personal history and emotional vulnerability can interfere with that individual's professional effectiveness.[18] To address this potential interference, clinical training programs often suggest, or in some cases stipulate, that students receive personal psychotherapy as part of training.[19]

Emotional Perils of Forensic Work

Although the research is lacking in terms of data on the types and severity of psychological challenges among forensic psychologists and forensic psychiatrists, a takeaway from the findings among clinical

mental health professionals is that such difficulties likely exist. Further, FMHEs face distinct challenges in their professional work. Whether in criminal or civil contexts, forensic assessments can be distressing, if not vicariously traumatizing. The emotional hardships experienced by professionals working with victims of violence and perpetrators of violence are well documented.[20] Victims and offenders are rarely dichotomous groups in that both groups often experience high degrees of trauma, the particulars of which are often explored in detail over a short period of time by the FMHE during the FMHA.[21,22] FMHEs may be distinctly at risk for vicarious trauma owing to their exposure to highly traumatizing material as part of FMHAs.[17,23]

Characteristics of the FMHE might affect the likelihood of developing vicarious trauma. A recent study conducted on FMHEs working with sexual offenders revealed that an FMHE's feeling of indifference, as well as less mature defense mechanisms, were associated with greater experiences of vicarious trauma.[24] Qualitative data revealed that exposure to traumatic content at work led to changes in an FMHE's professional identity, worldview, and beliefs related to personal safety and the trustworthiness of others. An evaluator's limited professional experience and a lack of personal therapy were suggested to be relevant to the evaluator's development of vicarious trauma.[24]

Research related to vicarious trauma among legal professionals has addressed how ongoing stigma led lawyers to minimize or deny their own challenges both to themselves and others.[25] In a parallel way, the pressure to be (or at least to present as) emotionally healthy might be great for FMHEs who are often trained to be sufficiently dispassionate and objective and rely on scientific rather than emotional reasoning.

"Countertransference" and FMHA

During an era in which cognitive behavioral approaches have been touted as "evidence-based" and psychodynamic methods have been criticized (many would say unjustly) for lacking empirical support,[26] it might be viewed as doubly controversial to apply language from psychodynamic treatment literature to FMHA practice. The merging of these two worlds is not new, however.[1,27]

In their discussion of countertransference, Sattar *et al.*[27] reiterate the importance of examiners noticing an intense personal reaction or opinion and to be especially vigilant of feelings of arousal, attraction, fear, or anger. These authors provided a case example of a psychiatry resident tasked with conducting a criminal responsibility evaluation. This resident sought supervision in relation to his strong feelings and judgments about an offender experiencing mental illness who tried to strangle an infant. He was making efforts to tease out his personal feelings as a parent and the degree to which these feelings influenced his capacity to develop rapport with the examinee during the assessment and the formulation of his opinion. Unlike this case example, but consistent with the points we made above, Sattar *et al.* noted that some trainees "may hide or deny their countertransference reactions in an effort to be regarded as valid forensic psychiatrists" (Ref. 27, p 68).

Some scholars have displayed resistance to adopting the term "countertransference" when describing phenomena occurring in the context of forensic mental health assessments based on a view that countertransference should only be applied in clinical settings. Although Sledge[28] saw the inherent value of Sattar *et al.*'s[27] exploration of the FMHE's emotional reactions during the FMHA, he opined that applying the term "countertransference" to the forensic assessment context had the propensity both to broaden and dilute this term and also to imply a therapeutic relationship that does not exist in FMHA. We note Sledge's concerns; however, now, two decades later, "countertransference" reactions are still being explored beyond clinical treatment and have been examined in terms of their influence on both general[29] and forensic assessment.[24] Terminology aside, strong emotional reactions that are both inside and outside of the examiner's awareness are likely pervasive in aspects of forensic work. Despite his reluctance to embrace psychodynamic terminology in forensic practice, Sledge puts it well:

> And neutrality and objectivity would not mean without emotion. For there is no way that a human being can be a forensic psychiatrist, or for that matter, any kind of examiner of the human condition or mental health professional without having emotional reactions. To do so would not be human. However, what "the professional" in these circumstances can do is learn how to recognize his or her own patterns of response and be able to understand how these particular responses enhance or impair objectivity, neutrality, or the elucidation of the truth. (Ref. 28, p 156-7)

Potential Influence of an FMHE's Emotions

Emotional reactions may or may not be based on an evaluator's psychological vulnerability. For example, some examinees (and attorneys) elicit a strong

counter-transferential reaction in most examiners, irrespective of the examiners' personal history.[29] Next, we suggest several realms in which transferential reactions and unprocessed emotions can affect the assessment process and outcome.

Forensic Interviewing

Although assessments are not intended to be therapeutic, they are still a dyadic and dynamic process; there is often a synergistic interaction between the FMHE and the examinee.[30] The emotional states and traits of the FMHE have the potential to influence forensic interviewing. These dynamics can, in turn, affect the quality of the data obtained and the psycholegal opinions rendered. Further, an FMHA is unlikely to be a neutral stimulus for examinees, given the stakes involved. An examiner is often challenged with finding the balance between developing sufficient rapport with an examinee so that the examinee is willing to engage in the assessment, while maintaining boundaries appropriate to the forensic role. Many examinees have had complex relationships with people in positions of authority. In both civil and criminal contexts, some examinees have childhood abuse histories that involve perpetration by people in positions of power.[21]

The nature of an FMHA creates unavoidable power differentials between the examiner and examinee that could make conditions that are ripe for an examinee's projections to be imposed on the examiner; for example, the examinee might view the examiner as rescuer or alternatively as aggressor. In turn, the examiner may react to these transferential projections in any number of ways. The examiner could have a complementary transference[30] to the examinee's desire to be rescued and feel pulled to assume that role. The examiner might have concordant countertransference[31] or overidentify with an examinee and knowingly or unwittingly express more empathy or engage in therapeutic gestures that could blur boundaries and lead to confusion for the examinee.[10,32]

Although a full exploration of the often-debated topic of forensic empathy is beyond the scope of this commentary, recent literature suggests that empathy is not a unitary construct.[33] Different components in the experience and expression of empathy likely require independent consideration;[21] for example, empathy can be a cognitive or an affective experience, and it can be conveyed verbally or behaviorally, or not conveyed at all. Glancy *et al.*[34] discussed the concept of "detached concern" (which they describe as a type of cognitive empathy. They posit that such a stance could enable the forensic practitioner to balance sufficient sensitivity toward an evaluee with the required measure of emotional distance. By contrast, affective or emotional empathy can be described as feeling for and with the examinee.[35] In modest amounts, such feelings might produce useful information about an examinee's emotional world and reflecting some degree of resonance could improve rapport and information; however, in excess and in the absence of self-awareness, unfettered affective empathy could cloud an evaluator's judgment.[21] It has been suggested that "FMHEs are tasked with striking a delicate balance between experiencing and conveying sufficient empathy while maintaining sufficient distance, restraint, and boundaries. Finding this balance is likely achieved by considering the examinee's context, traits, and emotional state" (Ref. 21, p 5). These authors also suggest that an FMHE's clinical acumen and self-awareness are assets when navigating these tensions.

Less affiliative reactions may also arise in the context of forensic interviewing. For example, in one case a trainee was assessing an exploitative examinee by established criteria. The trainee contrived to transfer the case to another trainee under dubious, perhaps even false, pretenses. Later, in a moment of candor, the first trainee confessed to being unable to stand the examinee because he was "such a crook." As seen in Sattar *et al.*'s[27] example, even subtle expressions of disdain can lead to ruptures in rapport and limit an examinee's willingness to disclose information relevant to the assessment.

Returning back to FMHEs who might be struggling with vicarious trauma or their own trauma history, an examiner's own level of emotional distress can influence how this examiner approaches a forensic interview. For example, in criminal cases, examiners might avoid asking sufficiently detailed questions about a violent index offense; or, in both civil and criminal cases, examiners might not take a sufficiently detailed account of an examinee's trauma history in service of not eliciting their own emotional responses.[21] In both scenarios, such emotional avoidance could contribute to incomplete or inaccurate assessments.

Formulating Opinions

The FMHE is the instrument through which all data are filtered. Cimbora and Krishnamurthy[36] wrote about "psychometrics of the self" (p 29) in

reference to the influence of the examiner's identity and experiences when assessing individuals from diverse backgrounds. They highlighted the importance of evaluator self-awareness to enhance the reliability and validity of observations and opinions, which can assist in combating implicit biases. We add that the concept of "psychometrics of the self" could also speak to the importance of examiners carefully exploring their own personal history and its emotional legacy, to understand and guard against emotional influences affecting their interpretation of assessment data; doing so might be especially important when FMHEs feel pulled in one direction or another by the undertow of their own strong emotions.

In another example, an experienced forensic psychiatrist sought peer consultation with the second author regarding unclear difficulties in evaluating an elderly examinee. After extensive discussion of the details of the case, the nature of the problem still remained unclear. Aware of the consultee's experience with dynamic concepts, the consultant eventually asked, "Who is she to you in the countertransference?" The consultee instantly understood: "I have just put my mother in a nursing home." Recognition of this connection allowed the consultee to contribute more objectively to the case demands.

Adversarial Allegiance

The adversarial nature of FMHA practice is fertile ground for an FMHE to experience strong emotions and competing pressures. Adversarial allegiance,[38,39] or a pull to affiliate[39] with the party that retains the FMHE, can lead to biases that can wield a conscious or unconscious influence on an examiner's opinions and a possible commitment to legal outcomes that favor the retaining party. On a conscious level, the FMHE might be motivated by financial gain or a desire to be retained in the future. Alternatively, evaluators might get caught up in the competition in a case. On a less conscious level, an examiner's personal history and emotional reactions are relevant not only because they influence assessment dynamics with examinees but also because they influence an examiner's dynamics with lawyers.

For example, a consultee of the first author was retained as an expert on a civil case involving a plaintiff alleging harms from historical child abuse that had occurred 30 years prior. In her report, she acknowledged that a limitation in her assessment was a paucity of available collateral data given the time that had passed since the alleged abuse. The retaining attorney called this examiner and admonished her, saying "[y]ou are not going to want to admit in your report that there was no collateral. You'll get ripped to shreds on cross-examination." This consultee described a familiar sense of self-doubt, and she briefly entertained whether to make the attorney's suggested "minor tweaks" to the language in the report. With support, the consultee was able to separate aspects of her reaction that were a byproduct of earlier experiences with the realities of the case at hand, and she stayed true to her own language that honestly reflected the limits of her work.

Managing Emotional Bias

Whether an FMHE embraces language stemming from psychoanalytic treatment literature or chooses to refer to strong emotional reactions and interpersonal enactments by another name, FMHEs are human. Examiners come with their own wounds, interpersonal legacies, and sometimes psychological difficulties, all of which have the potential to insert bias into the assessment process and the provision of opinion evidence if not attended to carefully.

Eliminating all biasing emotional and transferential reactions from forensic mental health practice is an impossible task. Common sense would dictate, though, that acknowledging the omnipresence of these reactions and making room for honest discourse would be a logical starting point to get a handle on the influence of these biasing reactions. Courses on professional ethics and training on cognitive and implicit bias are necessary but not sufficient. A professional ethos that promotes emotional reflexivity is not only important in training programs and supervision but would also serve FMHEs throughout the duration of their careers.

Given the emotional perils identified in forensic work, it is important to educate trainees on vicarious trauma and inoculate them for this possibility, both to foster their own resilience and to ensure their professional competence.[40] There is substantial research on general risk factors for vicarious trauma (both personal and professional).[41] An article by Pirelli, *et al.*[40] appears to be one of the few that centers on the emotional needs of forensic trainees. These authors acknowledge that, to date, there is no forensic-specific research to draw from when setting forth considerations to prevent psychological disturbance and distress among forensic professionals. A somewhat

consistent finding in the literature is that early-career professionals (both psychiatrists[42] and other forensic mental health professionals[43]) reported higher levels of emotional difficulty than more seasoned FMHEs. This finding has implications for training programs and supervisory relationships. Recommendations were made for supervisors and instructors that support promoting active engagement with, rather than avoidance of, sensitive topics, including but not limited to child abuse and sexual violence. It was suggested that students should be given advanced notice to prepare for these discussions and be provided resources for follow-up post lecture, and that instructors should be prepared to address student disclosures. Additionally, it was recommended that lecturers be mindful of their own reaction to these topics and seek additional support, as needed.[44] Finally, Pirelli *et al.*[40] note the import of engaging in self-care and therapeutic intervention when facing vicarious trauma or other forms of distress related to the demands of the job. We add that, as with clinical training, forensic training might include promoting the utility of professional consultation and psychotherapy. These supports could be a life-long resource used on an as-needed basis, both to manage the emotional demands of the work and to process the potentially biasing transferential and counter-transferential reactions, with the aim of producing more reliable psycholegal opinions.

Leveraging Processed Emotions

On a final note, just as clinicians might use their emotions as data to enhance treatment, FMHEs might also be able to make use of their emotional reactions to enhance their professional work.

For example, when conducting a risk assessment on an individual charged with a sexual offense, the first author's strong negative reaction to the evaluee's interpersonal presentation informed this examiner about how the evaluee was likely to alienate potential supports outside the assessment. This alienation led to the evaluee's enduring sense of loneliness, which in turn appeared to be a driver for some of his offending. Awareness of these negative feelings allowed this examiner to develop increased curiosity about the evaluee's interpersonal relationships and the sufficient compassion and tolerance needed to establish rapport. The interpersonal data gleaned from the assessment was also used to inform the requested treatment and risk-management recommendations.

Our major point then, is that an FMHE's emotions that arise in the context of an FMHA should not be a source of shame or something to be feared or vanquished. A culture that espouses an unwillingness to acknowledge or fails to encourage the processing of the FMHE's emotions could perpetuate conditions that are ripe for emotional bias. By contrast, creating a forensic culture that places value on evaluator self-awareness and promotes the importance on evaluators' ability to understand, modulate, and obtain some degree of distance from their reactions has the potential not only to allow for less bias in FMHA but also to enhance forensic assessment work.

Acknowledgments

The authors acknowledge Dr. Jonathan Gould, Dr. Stanley Brodsky, and Michael Perlin for providing their feedback on this article.

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