Countertransference, Defense Mechanisms, and Vicarious Trauma in Work with Sexual Offenders

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In their article about countertransference and vicarious trauma in work with sexual offenders, Barros and colleagues highlight the importance of awareness of risk for vicarious trauma in forensic psychiatrists and psychologists. This commentary supports the need for more research related to the risk of vicarious trauma and posttraumatic stress disorder (PTSD) in forensic experts. Also, forensic mental health professionals need to be aware of the level of risk to which they are exposed in their work evaluating and treating sexual offenders. As more knowledge has developed about PTSD and the diagnostic criteria have evolved between the fourth and fifth editions of the Diagnostic and Statistical Manual of Mental Disorders, there is also more awareness of the effects of traumatic exposure on different professional groups and laypeople. For example, judicial authorities in Canada have recently become aware of the traumatic impacts of evidentiary material on jurors, including testimony, print, and video material. Workplace exposure to trauma in inpatient psychiatric centers has received limited research focus. Actual or threatened death or sexual violation in these settings can result in compassion fatigue and burnout. Exposure to video material in the workplace, particularly in forensic settings, can result in PTSD.

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In this issue of The Journal, Barros and colleagues[1] bring to our attention a significant risk for forensic mental health professionals in their work with sexual offenders. In their study, the authors highlight both qualitative and quantitative factors associated with the risk of developing vicarious trauma and possibly posttraumatic stress disorder (PTSD). They also emphasize that these risks for forensic mental health professionals have not been well studied or stressed in the trauma literature. The main findings of the study are the associations between vicarious trauma and indifference (as countertransference and immature defense mechanisms). The authors also point out that this seems to be particularly true for forensic evaluators without personal psychotherapeutic experience. The article emphasizes the importance of personal psychotherapy to deal with these countertransference-based reactions and defense mechanisms. Obviously, although this could be of help, it would be interesting to assess if professionals with less vicarious trauma had other forms of support, other than personal psychotherapy. This topic could be explored in terms of overall support in their personal lives, discussions with colleagues who work in the same area of practice, and support from the institutions where they work.

Occupational PTSD has received considerable attention in the scientific literature for many years related to military personnel and veterans and more recently with first responders such as firefighters, police, paramedics, and other frontline health staff. The volume of scientific literature is enormous; a Google Scholar Search for "PTSD in a psychiatric setting" produced 134,000 results in 1.2 seconds. Using Google Scholar and the keywords "PTSD" and

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"forensics" yielded 22,700 results in 0.08 seconds. In contrast, PubMed's Medline produced one article using the keywords "PTSD" and "forensic psychiatrist," and two articles using keywords "PTSD" and "psychiatrist."

The scientific literature related to forensic psychiatrists is extremely limited concerning PTSD. PTSD symptoms in psychiatric workers are similar to what is seen in first responders.[2] The staff of psychiatric facilities, including nursing staff, allied health staff, and physicians, have a history of being exposed to critical events and developing PTSD symptoms.[3] In another study looking at the contribution of critical incidents and chronic stressors to PTSD symptoms among psychiatric workers, PTSD proved to be a significant concern for psychiatric staff.[4] Critical events were defined as meeting the clinical diagnostic criteria for PTSD in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), and eight events were included: physical assault by a patient with no bodily injury sustained; physical assault by a patient that resulted in injury or death; injury of a staff member while restraining a patient; sexual assault by a patient; the threat of death or serious injury to staff; the threat of death or severe injury to staff or family; violent or accidental death; and suicide or a near-fatal attempted suicide.[4,5]

When forensic and nonforensic units are compared, there are differences related to PTSD symptoms in the nursing and clinical staff. In a recent study, Rodrigues *et al.*[4] examined critical exposures, stresses arising from patient care, and other aspects of a workplace environment that could be associated with trauma. A sample of clinical staff (i.e., 68% nursing and 70% female) who provide day-to-day clinical care for patients either worked in a forensic unit (57%) or a non-forensic unit (43%). Forensic staff reported more direct exposure to a wide range of traumatic incidents and chronic stressors (74%) compared with nonforensic staff (66%).[4] Using the PTSD checklist, 22 percent of forensic staff and 11 percent of nonforensic staff met the criteria for possible PTSD.[4] This study indicated that clinical staff (principally nursing) in forensic units face a more stressful work environment than staff in nonforensic units. It follows, then, that forensic staff members who are psychologists and psychiatrists would also be exposed to an environment with chronic stressors and critical incidents, putting them at risk to develop PTSD or vicarious trauma in the forensic setting.

When looking at vicarious trauma or PTSD in forensic psychiatrists and psychologists, the definition of a traumatic event is an important consideration. The definition has evolved from Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) to DSM-5.[5–9] In DSM-III, the description of a traumatic event was "a stressor that would be markedly distressing to almost anyone and is outside the range of usual human experience" (Ref. 8, p 250). In DSM-5, there is a separate classification for trauma and stressor–related disorders. This evolution includes disorders in which exposure to a traumatic stress or event is listed explicitly as a diagnostic criterion. These now include reactive attachment disorder, disinherited social engagement disorder, PTSD, acute stress disorder, and adjustment disorders. The definition of the exposure is also broadened under criterion A for PTSD: "Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways . . ." (Ref. 5, p 271). Further, the ways in which the exposure can be experienced were broadened: "1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the traumatic event(s) as it occurred to others. 3. Learning that the traumatic event(s) occurred to a close family member or close friend . . . . 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) . . ." (Ref. 5, p 271). The examples given for repeated exposure are first responders collecting human remains and police officers exposed to details of child abuse. DSM-5 also notes in this final criterion that exposure through electronic media would not apply unless exposure is work-related.[5] The broadening of the definition of PTSD has allowed for a more informed understanding of how a variety of occupations more often result in various degrees of trauma as well as fully developed PTSD.

The publication of this study examining the countertransference induced by evaluating sexual offenders in the development of trauma in forensic psychiatrists and psychologists is timely, especially because this has been neglected in the research literature. As the authors correctly point out, mental health professionals interacting with the victims of sexual violence have been studied from the standpoint of the effect on their own psychiatric and emotional challenges.[10–12] The awareness of the impact of vicarious trauma when working with victims has been in the scientific literature for close to 20 years in a variety of clinical settings.[13–16] In their review of the descriptive and

empirical literature examining vicarious traumatization in therapists treating sexual offenders, Moulden and Firestone[17] reported that the unique factors contributing to the development of vicarious trauma include professional experience, treatment setting, and coping strategies used by the individuals providing treatment. Professional experience and coping strategies were also addressed in the article by Barros and colleagues,[1] but the professional setting was less clear.

It is also evident that the evolution of diagnostic criteria from DSM-III to DSM-5 has allowed the effects of trauma to be examined more closely at levels other than PTSD.[5] Over time, the stigma attached to mental illness has been reduced, and this has been documented in the attitudes of health professionals, with PTSD carrying less stigma compared with other psychiatric conditions such as schizophrenia.[18]

Barros and colleagues[1] describe in psychodynamic terms the impact on the emotional status of forensic psychiatrists and psychologists of evaluating sexual offenders. The focus is on the forensic psychiatric and psychological assessment of sexual offenders. This study looks at the association between countertransference style (closeness, distance, or indifference) and vicarious trauma. The collection of responses to open-ended questions related to the assessment is well documented. The hypothesis was that the style of countertransference could predict that the assessor's professional life, personal life, and belief and value systems would be affected by the impact of sex offender assessment.[1] The findings that both forensic psychiatrists and psychologists experience complex countertransference reactions in forensic settings are relevant. There was an effect on their emotional status in that disinterest, distance, and immobility were associated with vicarious trauma, whereas hostility, fear, and irritation were not. Their recommendations that forensic experts must determine how to manage the emotional effects of the assessments is a significant warning to all forensic experts working with sexual offenders.[1]

From a personal lived experience standpoint, the first author in this commentary developed chronic severe PTSD as a result of exposure to crime scene videotapes of sexual homicides. Although this is a different level of experience than that described by Barros and colleagues, their article points to the need for forensic mental health professionals to be cautious about their interaction with both the in-person evaluation of sexual offenders and exposure to video material. Un-fortunately, mechanisms of reducing such risks do not have strong scientific validity at this time.[6] Nonetheless, strategies of debriefing and peer-support interaction may provide some protection.

From the standpoint of occupational stress injuries in various organizational settings, vicarious trauma organizational readiness guides have been developed to assess organizational responses to first-responder and victim-assistance agencies at high risk for vicarious traumatization as well as PTSD. Hallinan and colleagues[19] have recently evaluated the reliability and validity of such guides. Forensic psychiatric facilities, including outpatient and inpatient assessment and treatment institutions, would also benefit from an assessment of organizational readiness to deal with vicarious trauma.

Jury duty is an important civic responsibility and can be a rewarding experience. In some cases, it can also be very stressful and can lead to vicarious trauma. This point has been recognized in Ontario, where free, confidential, and professional counseling has been provided to jurors through the Juror Support Program since January 2017. This service is available to jurors after they complete jury duty on a criminal trial, a civil trial, or a coroner's inquest.[20] In December 2019, the Senate of Canada introduced Bill S-207 as an amendment to Section 649 of the Criminal Code of Canada. This section creates a criminal penalty for disclosures of jury proceedings by a member of a jury related to any information that was not subsequently disclosed in open court.[21] The bill creates an exception for the disclosure of the information for the purpose of any medical or psychiatric treatment or any therapy or counseling that a juror receives after completing a trial "in relation to health issues that arise out of the person's service at the trial as a juror or as a person who provided support services to a juror" (Ref. 21, Subsection 2(c)). At a federal level, this is an acknowledgment of the need for jurors to seek out psychiatric help under certain circumstances. This exception will allow other provinces to follow Ontario's lead to provide treatment for jurors traumatized as a result of court proceedings and removes a potential barrier to seeking help for trauma.

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