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The Disgruntled Examiner:
Countertransference in the Forensic Setting

As forensic psychologists we are often confronted with examinees who elicit in us powerful emotions and cognitions. These examinees can be evasive, seductive, oppositional or even disorganized. Our psychological response to these persons can include, what in the psychoanalytic and psychodynamic traditions, is known as countertransference. First recognized and theorized by Freud as a barrier to effective treatment (Freud, 2012), our recognition and use of countertransference has expanded. It now includes understanding it as a natural response to a person's outrageous behavior, what Winnicott termed "objective hate" (Winnicott, 1947). It is also useful clinical data that aids in diagnosis (Kernberg, 2000). Understanding the role of countertransference will permit examiners to fulfill guidelines set by our profession regarding forensic practice (American Psychological Association, 2003).

Recently licensed or board-certified clinical psychologists may have been provided scant education and training in the tradition of psychodynamic theories and practice, including their use in forensic practice. The traditions may seem out of date and ill-suited for contemporary forensic practice. Yet, as the late Ernest Jones noted, psychodynamic and cognitive-behavioral therapies have more in common than not (Jones, Pelos, 1994).

Countertransference, simply put, is the experience of using another person for unconscious/out of awareness purposes (Stein, 1990). In the forensic setting this can emerge as private feelings of grandiosity in providing opinion on a complex and high stakes case, or feelings of boredom and disinterest when faced with routine and clinically insignificant test performance. It can also serve as a source of potential bias in forensic examinations. The legal requirements for admissible evidence in *Frye and Daubert* require that counter-transference and bias be effectively addressed by the examiner (Scott, 2013).

Examinees present with a variety of behaviors in a forensic setting. They do not take their prescribed medications on the date of the exam, they arrive late, and they are seductive, oppositional or even openly critical of the examiner. These behaviors can effectively be dealt with in psychotherapy. In contrast, the forensic examiner has one and usually only one appointment to understand the examinee's behaviors and formulate a reasonable opinion.

Case Illustration

The case involves a 48-year-old female working at a "Big Box" type superstore. She had worked at the site for many years; in fact, she was the oldest employee on the shop floor. Her longevity and experience contributed to her being highly regarded by her fellow employees; in my initial examination her Base Rate score on the Millon Narcissism scale was highly elevated. Hence her self-image was likely

dependent on her work image. Subsequent events would prove this self-image to be fragile.

The examinee suffered a single fall on an icy and slippery concrete floor in which she first struck her back and then the back of her head. She suffered concussive symptoms for a period of time, then psychosomatic symptoms, including stuttering. Her treating primary care physician concluded that her speech and cognitive symptoms were greater than anticipated given her mechanism of injury. She underwent an MRI and a neurological exam and both were unremarkable. She was referred to a psychiatrist for treatment who questioned whether she was malingering as a result of her poor response to antipsychotic medication. She was then referred to a neuropsychologist colleague who conducted a full assessment. He concluded that the patient had "good rehab potential." Nonetheless, her memory was impaired. This neuropsychologist conducted scant effort and symptom validity testing as part of the examination.

In response to this clinical picture she was referred to me for a medical-legal examination. At the time of the examination she demonstrated further functional decline. At one point in the case there was a time lapse of one and a half years between my examinations. During that time, she was terminated from her psychiatrist's office due to threatening behavior. She returned back to work in an accommodated fashion for a short period of time. However, conflict arose with a supervisor and there was threat of violence. The claimant announced to her treating neuropsychologist that she was going to "do violence" towards this man." She was terminated from the job. She had major surgery for an intestinal blockage.

She then returned to me for examination. Her performance on assessment was abysmal. On simple questions from the WAIS-IV she demonstrated obvious poor effort if not exaggeration. For example, she reported that 30 seconds comprised a minute and that the year was 2019. Her story recall on Logical Memory was virtually nonexistent. At that point I was disgruntled and exacerbated by her performance. What was the reason she was behaving so poorly? Was she trying to confuse me or herself and what was were motives for such poor performance?

I began to ask myself what information my countertransference of disgruntlement if not disdain provided. Was this woman trying to induce me to do to her what was done to her by others - her psychiatrist, her parents who shipped her out in her teenage years to a private school or her former employer. That is, since they had "kicked her out" was she perhaps unconsciously "testing" me to see if I would do the same thing. It was also evident that the examinee had collapsed into a major depressive episode. When she was not permitted to return back to work, as her examining neuropsychologist remarked, "things went south." Thus, my countertransference was a reenactment of some of the scenarios. If left unexamined I would view her as malingering. With some reflection and research, I conceived of an alternate formulation. The woman was presenting in a fashion that clinical neuropsychologists have termed a Cogniform Disorder (Delis, Wetter, 2007). The patient came to believe that she had more memory deficits that could be objectively caused by the original mechanism of injury. She was also acting out in a regressive manner in the face of the loss of her valued working work. She was behaving in a manner to permit others to become angry at her rather than allowing herself to experience emotions related to the loss of her job.

Conclusion

We have at our disposal professional resources to address counter-transference. Psychological and neuropsychological test data can serve as an important corrective to the adverse effects of the countertransference. That is, the numbers typically "don't lie" and an astute and competent examiner will use the clinical data, integrate it with the subjective experience of the examination and present a reasonable formulation. Personal education and training on bias is also an important resource at our disposal. Lastly, we should regularly consult with colleagues on cases to ensure that we have looked under

all of the rocks related to a case so that our formulations and opinions are valid.

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