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# Countertransference in forensic inpatient settings: An empirical examination of staff responses to patients with psychotic disorders

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## Abstract

**Objective.** Countertransference in forensic inpatient settings has received little empirical attention despite frequent emotional reactions in staff members, such as anger, disgust, or fear. In this exploratory study, we investigated countertransference in two forensic medium-secure units for patients with psychotic disorders.

**Method.** We measured countertransference using the Therapist Response Questionnaire (TRQ) and measured staff personality using the Ten Item Personality Inventory (TIPI). Our design allowed all staff members to participate anonymously.

**Results.** A total 134 TRQs, along with data on patient and staff characteristics, were collected. Staff characteristics such as profession, experience, and personality were associated with different countertransference reactions. Psychologists and psychiatrists tended to report more countertransference feelings than nursing staff. Patient and staff variables (such as patient having committed violent offenses or a diagnosis of personality disorder and staff experience or gender) were associated with more negative countertransference feelings and subscale scores, and less positive countertransference feelings such as parental, protective, and satisfying countertransference feelings. Some

patient and staff variables (such as patient cooperativeness, staff personality trait agreeableness) had the inverse effect on countertransference feelings.

Conclusion. We discussed several conceptual problems inherent to measuring countertransference (in forensic inpatient settings) and the clinical implications of our findings.

Keywords: countertransference, emotional reaction, schizophrenia, forensic, transference

## Background and literature review

The concept of countertransference has gained widespread acceptance outside psychoanalytic literature (Hayes, 2004). The classic definition of countertransference is the “therapists unconscious, conflict-based reactions in response to the patient’s transference” (Hayes, 2004, p. 22). This narrow definition has expanded over the years to what is now known as the “totalistic” definition of countertransference (Gabbard, 2014; Hayes, 2004; Hayes & Gelso, 2001). The latter states that countertransference comprises “all therapist reactions to a client, whether conscious or unconscious, conflict based or reality based, in response to transference or some other material” (Hayes, 2004, p. 22). Clinicians have come to acknowledge countertransference as an important source of information about the patient, to which both patient and therapist contribute. Countertransference in forensic inpatient settings has not been widely studied empirically despite frequent emotional reactions to patients such as anger, disgust, or fear in forensic staff members (Friedrich & Leiper, 2006; Knoll, 2009; Oswald, 2011)<sup>1</sup>. Although empirical data on countertransference in (forensic) inpatient settings is

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<sup>1</sup> Although related to countertransference, this paper does not deal with group countertransference (e.g., (Gabbard, 2014), post-traumatic emotional reactions to assaults, or dissociated transference.

relatively rare, an increasing number of studies have been published in the last 20 years (e.g. de Vogel & Louppen, 2016; Holmqvist & Jeanneau, 2006; Rossberg & Friis, 2003). The results of these studies, despite different methods, are consistent with more established research threads with outpatients.

At the patient level, recognizing countertransference is diagnostically informative (Tanzilli, Colli, Del Corno, & Lingiardi, 2016) and prevents acting iatrogenically (Groves, 1978; Rossberg & Friis, 2003). Previous studies have reported several ways in which unaddressed countertransference affects treatment. Negative countertransference (where feelings such as anger, fear, sadness, disorganization dominate) might lead staff to react by acting out (Norton & Dolan, 1995; Zaninotto et al., 2018) and use more coercive or punitive measures (Lion & Pasternak, 1973), which in turn can evoke even more distress in not only patients but also staff members (Sequeira & Halstead, 2004). Negative countertransference increases staff burden (Gordon & Kirtchuck, 2008; Holmqvist & Jeanneau, 2006; Zaninotto et al., 2018) and can result in discouragement, burnout, loss of confidence in clinicians, and helplessness (Holmqvist & Jeanneau, 2006; Lion & Pasternak, 1973; Zaninotto et al., 2018). Identifying countertransference patterns at the staff level helps preventing adverse staff reactions such as splitting and disagreement (Gabbard, 2014; Rossberg & Friis, 2003). For example, negative countertransference toward a patient might build up in staff members, which then unconsciously provokes aggressive behavior in the patient. Countertransference might affect risk assessments and decision making (de Vogel & de Ruiter, 2004; Lion & Pasternak, 1973; Rogers, 2000; Sattar, Pinals, & Gutheil, 2004) such as a patient who evokes negative feelings might be rated as more prone to violence, or conversely, risk of violence might go unrecognized in patients who elicit positive countertransference. On the other hand, positive countertransference (where feelings such as satisfaction, protection, sympathy, closeness, domination) might lead to blind spots and failure to intervene when necessary (Marmor, 1976)

as may be the case with superficially charming patients with narcissistic or psychopathic personalities.

Forensic settings are reported to intensify the countertransference already described in non-forensic inpatient settings (Knoll, 2009; Mulay & Cain, 2018). This is attributed to several major factors: (a) the severity of crimes committed such as sexual abuse or murder (Friedrich & Leiper, 2006; Knoll, 2009; Mulay & Cain, 2018); (b) the probable impact of legal or clinical decisions on patients such as deprivation of liberty or imprisonment; (c) personality and/or pathology not often encountered outside forensic settings such as psychopathy or paraphilia's (Mulay & Cain, 2018); and (d) the legal responsibility of staff members in forensic settings (Lion & Pasternak, 1973). Furthermore, the higher prevalence of aggression among forensic inpatients than other clinical populations, such as outpatients or non-forensic mental health services, could also contribute to greater countertransference reaction.

Negative countertransference is predominant in forensic settings (e.g., anger, hostility, or criticism, Friedrich & Leiper, 2006). Staff members might feel controlled or deceived, with countertransference potentially becoming so strong that they struggle to maintain a therapeutic relationship with the patient (Friedrich & Leiper, 2006). Staff may feel on guard, rejected or overwhelmed by (aggressive) patient behaviour. Patient self-harm leads to staff members' feelings of inadequacy and being overwhelmed (Lion & Pasternak, 1973; Rossberg & Friis, 2003). The patient's personality style has been reported to be the dominant predictor of specific countertransference reactions (Lingiardi, Tanzilli, & Colli, 2015). Although symptom severity can be a mediator, its effect is less sizable than personality style. Psychosis, as diagnosis, is not associated with a particular type of (counter)transference feeling (Rossberg & Friis, 2003), although many case studies suggest that (counter)transference deploys itself in a particular manner in inpatient settings (Oury, 2003). Transference in psychosis is thought to deploy in more or less fragmented and secluded threads. A patient might refrain from engaging

emotionally with his psychologist because of paranoid ideas or locate his/her suffering with a particular staff member, but might feel secure and nurtured by his/her psychiatrist because the patient has negative transference reaction to others. To our knowledge, no empirical study has reported on countertransference in psychotic patients in inpatient settings.

Countertransference reactions have been repeatedly linked to staff gender differences (de Vogel & Louppen, 2016; Rossberg & Friis, 2003) and clinical experience (de Vogel & Louppen, 2016). For example, de Vogel and Louppen (2016) found that staff members (irrespective of their gender), when asked about their most complex patient, reported to be more anxious, threatened, and overwhelmed by their male patients and more accepting, helpful, and receptive toward their female patients. In the same study, staff experience was inversely related to the magnitude of countertransference feelings and difference between patient gender in their countertransference reactions.

In this study, we explored countertransference in forensic medium-secure units for patients with psychotic disorders. This study is largely explorative and no specific hypothesis was generated. However, we investigated whether differences in countertransference exist between nurses and psychologists/psychiatrists. Although nurses and psychologists/psychiatrists treat the same patients, they do so in very different therapeutic situations. Nursing staff are at the frontline of services for groups of patients who have been severely traumatized and where contact with difficult-to-process emotional material occurs unpredictably (Aiyegbusi & Tuck, 2008). Nurses handle a wide variety of tasks and situations concerning the patient (e.g. motivational interviewing, organizing patient's schedules, serving food, caring for personal hygiene) (Pols, 2006). Therefore, (counter)transference sources or material can differ widely across professions. (Kelly, 1998; Miles & Morse, 1995). In addition, nursing staff members are not routinely trained in recognizing and working with (counter)transference and nurses, while psychologists and psychiatrists have more control over their exposure to patients and are more

trained in recognizing and handling countertransference. Patients also perceive psychologists and psychiatrist to have more impact on decisions regarding their treatment and discharge than nursing staff members. This might induce a more desirable attitude from patients, which might create a more positive countertransference reaction.

We also investigated whether staff gender was associated with differences in countertransference (both in magnitude and in the nature of the feelings). Finally, we also examined whether variables such as staff personality, patient's offenses, diagnosis, and cooperativeness were associated with countertransference.

## 1 Method

### **Participants**

Data were collected in two forensic medium-secure units (MSUs) in Belgium (Centre Hospitalier Jean Titeca, Brussels, and Centre Neuro Psychiatrique Saint. Martin, Namur). Patients at both sites are similar due to identical inclusion criteria for admission: a primary diagnosis of schizophrenia or psychotic disorder with or without comorbid substance abuse and personality disorders. Sexual disorders<sup>2</sup> and psychopathy are exclusion criteria. The Belgian forensic mental health services and characteristics of patients admitted to these MSUs have been described in depth in a previous study (De Page et al., 2018).

A total of 49 staff members responded and provided a total of 134 TRQs. Only three envelopes came back blank (94% response rate). About 69% (n = 33) of the respondents were women, 29% were men (n = 14), and 2% had missing information (n = 1). Regarding participants' profession, 56% were nurses (n = 27), 17% were psychologists or psychiatrists (n = 8), 25% were other professions (n = 12), and 2% had missing information. As one of the

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<sup>2</sup> Although sexual disorders form an exclusion criterion, some patients have committed a sexual offense without meeting the criteria of a sexual disorder. See also (Oswald, 2011).

reviewers pointed out, that nurse preparation in Belgium differs from other countries; there are no recognized specific training program for (forensic) psychiatry with thorough education about (counter)transference. Nurses most likely learn about (counter)transference in the field. Other professions included occupational therapists, social workers, and criminologists. There were significantly more women among the nurses ( $\chi^2 = 6.7, p = .03$ ). About two-thirds of the staff members had 15 years of experience in psychiatry or less, and about 77% of staff members had less than 10 years of experience in forensic psychiatry.

Most patients were men (97%,  $n = 130$ ), and 84% were between 26 and 55 years of age (13% were between 18 and 25, and 3% were over 55). About 55% had received their “not guilty by reason of insanity” (NGRI) judgment less than 5 years ago. The presence of four *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition* (DSM-5, American Psychiatric Association, 2013) diagnostic categories was recorded: Schizophrenia and other Psychoses, Substance Abuse, Mental Retardation, and Personality Disorders. The most prevalent DSM-5 diagnostic category was Schizophrenia and other Psychoses (87%), 43% had a personality disorder diagnosis, 56% substance abuse, 10% mental retardation, and 11% other diagnoses. Known violence antecedents included "violence against persons" (70%), "crime against property" (51%), and "sexual offense" (12%). Victims of previous violence included women (34%), men (48%), and children (12%), and 21% of offenses were non-violent crimes such as theft or vandalism.

## 1.1 Instruments

The Therapist Response Questionnaire (TRQ, Betan et al., 2005) is a 79-item scale that assesses emotional, cognitive, behavioral, and interpersonal markers of countertransference (CT). We used the eight factor analytic subscales initially derived by the scale (listed in Table



1). The TRQ has been used to explore associations between CT and psychopathology and personality pathology (Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Lingiardi, Tanzilli, & Colli, 2015; Tanzilli, Colli, Del Corno, & Lingiardi, 2016). Because this questionnaire was validated with many clinicians, it transcends the obvious limitations of conceptualizations of countertransference made by one clinician based on his/her countertransference experiences or one theoretical approach. The TRQ was translated into French using a back-translation procedure with independent translators (De Page, Thiry, de Villers, Boulanger, & Saloppé, 2016). As can be seen in Table 1, we found good reliability (Cronbach's alpha > .70) for six subscales and acceptable reliability for one scale (Cronbach's alpha > .60). The sexualized countertransference subscale had insufficient internal consistency.

The Ten-Item Personality Inventory (TIPI; Gosling, Rentfrow, & Swann, 2003) is a very brief measure to assess the Big Five personality traits (Neuroticism, Agreeableness, Extraversion, Conscientiousness, and Openness). The Big Five personality traits have been found to be reliable, cross-cultural, and overarching normal personality traits (Strack, 2006). The TIPI has been used in previous studies regarding burnout in mental health professionals (Zaninotto et al., 2018). In this study, the TIPI was used to assess the staff members' personalities.

## 1.2 Procedure

Staff members were given identical white envelopes containing five blank TRQs. They were informed about the purpose of the study in person, and they were told that their participation would remain completely anonymous and that the researchers had no way of identifying them based on the information collected. They were asked to complete between one and five TRQs, but they could also return them blank without the researchers knowing who refused to participate. As in the original study, the staff members were asked to complete the TRQ based on the last patient(s) they had seen in an individual session to avoid selection biases

(Betan et al., 2005). Each patient has one primary nurse, one psychologist and one psychiatrist. Staff members were asked not to disclose the patient's identity whose information they used to complete the TRQ. Instead, we asked staff members to describe themselves and their patients using broad categories, e.g., age groups of 18-25, 26-30, etc. The researchers could not identify the patient whose information was filled in the TRQ or the clinician who completed the questionnaire. However, we could only obtain coarse descriptive statistics on the patients and staff members because of this methodological choice.

Therefore, some patients might have been selected by multiple staff members; that is, two or more individuals might have rated their countertransference about the same patient. This possibility of multi-nested data was not considered an impediment because a) we were primarily interested in the countertransference feelings experienced by the staff rather than in the patient dynamics that induced them, b) the possibility of overlap is limited because this study was carried out across two sites (e.g. there is only one psychiatrist per MSU, many nurses and several psychologists at each site, and every participating staff member was limited to five TRQ's and limited to patients for whom they had the primary care), and c) staff members from other professions were excluded in comparisons according to profession.

Considering that a single patient might have been rated twice by two independent staff members, the statistical assumption of observations' independence can be questioned. In this study, we considered countertransference, as measured by the TRQ, as a “snapshot” of a unique dyadic process and therefore subject to a relative independence of observation. However, this remains an arguable interpretation of empirical material (see limitations hereunder).

This study was approved by the Grand Ethics committee of CHU Brugmann (Ref No CE 2018/15).

### 1.3 Data analysis

We collected the following data about staff members: gender; profession in three categories—nursing staff, psychologist/psychiatrist, or other; and experience in psychiatry and experience in forensic psychiatry (in categories of age). Patient-specific variables were: age (in categories of age), gender, index offense type, victim characteristics (male, female, children, or nonviolent), diagnostic categories, and cooperativeness. Patient cooperativeness was rated on a self-constructed 3-point anchored Likert scale and included an assessment of participation in ward activities, attitudes toward counseling, medication adherence, and engagement in the rehabilitation program. The question and responses/anchors were worded as follows: “Is the patient cooperative regarding treatment?” “No, he/she refuses treatment, counseling, activities and social rehabilitation”, “Moderately, he/she accepts part of the treatment possibilities”, and “Yes, he/she accepts to whole of treatment possibilities”.

Data were analyzed using linear correlations<sup>3</sup> and ANOVA. Analysis was computed at the group, gender, and profession level. Correlation coefficients were interpreted as follows: > .10 small, > .30 moderate, and > .50 large (Cohen, 1988). Effect sizes of ANOVAs were reported using Eta squared statistic ( $\eta^2$ ), which we interpreted as suggested by Cohen (Cohen, 1988): > .01 small, > .06 moderate, and > .14 large.

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<sup>3</sup> Because there was no reason to expect linearity in countertransference feelings, we also computed non-linear correlations. It appeared that the majority of non-linear correlations corroborated the findings of the linear correlations.

## 2 Results

### 2.1 Countertransference feelings, gender, and profession

Raw data indicated that positive/satisfying countertransference feelings were the most reported feelings, followed by parental/protective feelings (Table 2). When reading Table 2, readers must remember that 134 TRQs were filled in by 49 staff members, and 67 of these TRQs were completed by nursing staff, and 58 TRQs were completed by male staff members. The overall positive CT feelings were followed by helpless/inadequate, disengaged, and hostile/mistreated feelings. Psychologists and psychiatrists reported more parental/protective, overwhelmed/disorganized, and special/overinvolved CT feelings than nursing personnel:  $F(1,95) = 9, p < .01, \eta^2 = .09$ ;  $F(1,95) = 6.27, p = .01, \eta^2 = .06$ ;  $F(1,95) = 12.23, p < .01, \eta^2 = .11$ , respectively. Men reported more special/overinvolved CT feelings ( $F(1,132) = 6, p < .05, \eta^2 = .04$ ). Sexualized CT was the least endorsed TRQ subscale. We tested for interaction effects between gender and profession; female psychologists and psychiatrists reported higher positive/satisfying feelings than their male counterparts ( $F(1,93) = 4.4, p < .05, \eta^2 = .04$ ). All variables had a moderate or high positive skewness (absolute skewness values  $> .50$ ), except for positive CT (positive/satisfying and parental/protective). The modal answer was “1 = Not true” for 88% of all profiles, suggesting that the participants had a strong tendency to deny the item-content. This might indicate a ceiling effect or an answer bias.

### 2.2 Countertransference according to staff characteristics

Staff experience. We found small positive correlations between staff experience and hostile/mistreated feelings ( $r = .23, p < .01$ ) and sexualized feelings ( $r = .18, p < .05$ ). Staff experience was moderately associated with positive CT feelings in psychologists and psychiatrists (i.e., positive/satisfying, parental/protective, and special/overinvolved subscales), while it was associated with negative CT feelings in nursing personnel.

Correlations in female staff revealed positive associations between staff experience and hostile/mistreated and sexualized CT ( $r = .31, p < .01, r = .21, p < .05$ ) and negative associations between staff experience and positive/satisfying feelings ( $r = -.31, p < .01$ ). Upon closer inspection of the items comprising the sexualized CT subscale, it appeared that two items accounted for the correlations (item 24 “I feel guilty about my feelings toward him/her” and item 32 “His/her sexual feelings toward me make me anxious or uncomfortable”). We inferred that female staff members reported higher discomfort with the patient’s sexuality with more experience. There were no such associations between staff experience and CT for men.

Staff personality. Extraversion in staff members was associated with less overwhelmed/disorganized and special/overinvolved feelings ( $r = .25, p < .05; r = -.26, p < .05$ ). Most moderate to strong associations between staff personality and CT were found for psychologists/psychiatrists. Emotional stability in staff members was strongly negatively associated with parental/protective feelings ( $r = -.54, p < .01$ ). Conscientiousness in psychologists/psychiatrists was negatively correlated with helpless/inadequate feelings ( $r = -.39, p < .05$ ) and positively associated with positive/satisfying CT feelings ( $r = .40, p < .05$ ). Agreeableness in psychologists/psychiatrists was negatively associated with special/overinvolved and disengaged CT feelings ( $r = -.53, p < .01$  and  $r = -.44, p < .01$ , respectively).

### 2.3 Countertransference and patient characteristics

Diagnosis. Staff members reported higher hostile/mistreated feelings in working with patients with a diagnosis of personality disorder ( $F(1,122) = 3.7, p < .10, \eta^2 = .03$ ). A diagnosis of psychosis was associated with higher positive/satisfying feelings ( $F(1,127) = 3.5, p < .10, \eta^2 = .03$ ). A substance abuse diagnosis had no effect on CT scores; neither did the number of diagnoses.

Previous offenses. Staff members reported lower positive/satisfying CT feelings when working with patients having committed an offense against a person ( $F(1,127) = 6.48, p < .05, \eta^2 = .05$ ). For nursing personnel, such an offense was also associated with hostile/mistreated ( $F(1,62) = 7.7, p < .01, \eta^2 = .11$ ) and helpless/inadequate feelings ( $F(1,62) = 4.14, p < .05, \eta^2 = .07$ ). These results were also observed in all male staff. An offense against property did not affect CT feelings.

Victim characteristics. Whether patients had victimized men, women, or children appeared to have low impact on countertransference. Having offended against a woman was associated with lower positive/satisfying CT feelings for nurses and psychologists/psychiatrists ( $\eta^2$  respect. .16). Having offended against a man was associated with higher hostile/mistreated CT at group level ( $F(1,123) = 5.47, p < .05, \eta^2 = .04$ ) and tended to diminish positive/satisfying CT ( $F(1,123) = .25, p < .10, \eta^2 = .02$ ).

Age, duration of compulsory care, and length of treatment. Patient age was not associated with CT feelings. However, duration of compulsory care and length of treatment were associated with more hostile/mistreated feelings ( $r = .20, p < .05$ , and  $r = .32, p < .01$ , respectively). Patients who had been in compulsory care longer appeared to elicit less positive/satisfying CT feelings ( $r = -.21, p < .05$ ).

Cooperativeness. At the group level, cooperativeness was associated with less hostile/mistreated feelings ( $r = -.39, p < .01$ ), helpless/inadequate feelings ( $r = -.34, p < .01$ ), overwhelmed/disorganized feelings ( $r = -.29, p < .01$ ), and feelings of disengagement ( $r = -.19, p < .05$ ). Cooperativeness was positively correlated with positive/satisfying CT feelings ( $r = .28, p < .01$ ). This pattern was especially present for nursing staff and nearly absent for psychologists and psychiatrists. The same diverging patterns were found for women and men,

respectively, suggesting that these correlation coefficients at the group level were mainly attributable to female nursing staff.

### 3 Discussion

In this study, we explored countertransference in forensic patients' rehabilitation, most of whom had a diagnosis of schizophrenia or other psychotic disorders. The study was designed to make it impossible for the researchers to identify the patients and staff members, which helped protect their confidentiality and promote openness regarding one's countertransference feelings. We first examined the group level, and we then analyzed differences by gender and profession (nursing staff vs. psychologists and psychiatrists). Differences in countertransference according to profession were expected because of nursing staff and psychologist/psychiatrists are exposed to very different aspects of the patients, and have different levels of training in recognizing and working with (counter)transference. Nurses handle a wide variety of tasks in different situations while psychologist/psychiatrist work mainly by appointment in their offices.

Staff reported positive feelings more than negative feelings, which corresponds with Rossberg and Friis (2003) results. Our results further indicate that psychologists and psychiatrists reported more parental/protective, overwhelmed/disorganized, and special/overinvolved countertransference feelings than nursing personnel. Two kinds of explanations for these differences: authentic quantitative differences in countertransference (substantive explanations) and/or a response bias (stylistic explanations). Possible substantive explanations include: a) nurses and psychologists/psychiatrists experience different amounts of countertransference feelings due to their qualitatively different exposure to patients (e.g. psychologists/psychiatrist don't deal with "front line" such as catching out a patient who abuses drugs or patients picking a fight), b) parental/protective

countertransference feelings might arise more often in psychologists and psychiatrist because they have to deal more with patient histories and childhood experiences in therapy sessions, and c) patients are in contact with many nursing staff personnel daily, they have only one psychologist and one psychiatrist, which might foster particular relation dynamics with the latter. Alternatively, both professions might experience these countertransference feelings to the same extent but report them differently (response biases). For example, psychologists or psychiatrists could be likely to recognize and report them while these feelings would go unreported in nurses because of differences in countertransference training. It is also possible that nurses are equally aware of their countertransference but might try to suppress those feelings because they might feel ashamed or guilty about their negative feelings (Oswald, 2011). When the study was explained to them, a nurse reluctantly told us that she believed that endorsing any of the TRQ items could mean that she could be fired for non-professional attitude. This illustrates a deeply rooted assumption that we must be neutral about patients, and should numb and suppress both positive and negative countertransference feelings. This highlights the need to destigmatize and communicate openly about (negative) countertransference. The overall floor effect in responses (i.e. high rates of “not true” responses), which was also found by de Vogel and Louppen (2016) using another assessment of CT, might further corroborate this difficulty in reporting countertransference feelings. Nonetheless, these potential response bias should not divert our efforts to manage countertransference adequately. As one of the reviewers rightfully pointed out that while positive countertransference was reported more than negative transference (independently of profession, response and training biases), that does not imply a lower likelihood of acting-out. Most countertransference dynamics occur implicitly and unconsciously before they can be acknowledged, it could be that countertransference operates with the same intensity, but goes unacknowledged in less trained staff members. If this is the case, those staff members might



be more at risk for acting out countertransference feelings. Although less reported, there are as much liabilities in positive as in negative countertransference (Gordon & Kirtchuck, 2008, O’Kelly, 1998). With the design that we used in this study, we cannot discriminate between response biases and objective differences in experience (Tanzilli et al., 2016).

Several clinical implications of these findings can be formulated. First, the difference in countertransference between profession suggests we have to be cautious in staff discussions. However, different staff members may treat the same patient, they are exposed to different aspects of the patient, which is associated with different patterns of countertransference. Our results affirm that the bigger countertransference picture is to be obtained by compiling reactions from all professions, genders, and ages. Secondly, staff experience is often thought to be beneficial for treatment, but our results suggest this might come at a personal cost of more negative CT feelings for nursing personnel. Thirdly, independently of the results, conducting this study cued staff members to discuss countertransference more openly in staff meetings, which in turn allowed for a deeper understanding of latent dynamics of patients. It appeared to help reduce the stigma about (negative) countertransference and alert about risks associated with positive countertransference (such as overinvolvement). Fourth, the fact that certain patient variables hitherto influence countertransference (e.g. diagnosis, previous violence) should be acknowledge even before a patient is admitted in order to monitor countertransference proactively. Fifth, staff members should be aware that time and treatment related variables (e.g. cooperativeness, treatment duration) account for countertransference. In order to manage difficult patients effectively and preserve good therapeutic relationships, one should try to prevent “fatigue” by preparing and adjusting treatment and discharge anticipatively.

The effect sizes we found in this study were often small or moderate at best. This might reflect several causes besides response bias and subtle clinical phenomena (Betan et al.,

2005). Self-reported countertransference, similar to the self-reported assessment of psychological defense mechanisms (Hayes & Gelso, 2001), is based on conscious derivatives of unconscious mechanisms. This indirect assessment might account for lower effect sizes. Another plausible explanation for these small effect sizes might be that unmeasured variables such as aggression or antisocial personality traits (cf. limitations) mediate our independent variables (index offenses, diagnoses, etc.). Additionally, the TRQ items and factor structure might not fit the inpatient settings or psychotic patients, as the measure was designed and validated for/with outpatients (Betan et al., 2005). Finally, cautiousness (or resistance) from the staff members (Hayes, 2004) and newness to the scale might have also contributed to these small effect sizes.

An empirical, correlational study of countertransference raises questions about what is being studied when examining countertransference: is it the tendency in a patient to elicit certain feelings in different staff members or the tendency in a clinician to experience certain feelings in response to different patients? Either way, (statistical) dependence appears to be unavoidable, and there is, to our knowledge, no clinically sound experimental design capable of disentangling this. Further empirical research into the ipsative dependence in countertransference feelings in staff members is needed (i.e., whether a staff member has a certain tendency to experience particular countertransference feelings more than others).

Although our study can be questioned on these grounds, it has the advantage of being ecologically valid: we acknowledge the relatively small staff member sample size, but nearly all staff members of both sites have participated in this study. Also, staff is frequently composed of a majority of nursing personnel.

Finally, in assessing interactional processes, we inevitably stumbled on the conceptual “chicken or egg first problem; which came first?”. There were moderate correlations between countertransference and patient cooperativeness; are negative countertransference feelings

reactive to an uncooperative patient (such as outlined by Norton & Dolan, 1995), or is the patient's uncooperativeness a consequence of negative countertransference feelings (tainted by external causes, such as outlined by Sattar et al., 2004)? One might try to transcend the rating bias using less subjective variables such as institutional behavior or static/actuarial data. However, these methods are also subject to (a) reporting biases, where the staff more readily report the institutional behavior of patients they do not like, or (b) halo biases, where one characteristic overshadows the perceptions of other mitigating features (Hayes & Gelso, 2001).

### 3.1 Limitations and future perspectives

To promote openness and safety when participating in our study, we designed a data collection procedure to protect both patients' and staff members' anonymity. This has the distinct disadvantage that we could only measure coarse and broad variables (otherwise, we would have been able to identify the patient, and thereby the clinician). This has also the disadvantage of potential overlap in our dataset (i.e. nested data). In a subsequent study, we aim to drop this strict anonymity constraint to be able to include variables such as patient aggression, paranoid dynamics, and psychopathic traits. We felt that these variables underlie the understanding and emotional reaction toward index offenses, cooperativeness, victim characteristics, etc. (Rossberg & Friis, 2003). Dropping the anonymity constraint will enable us to run more advanced statistical tests to prevent Type I errors by running multiple tests.

Not measuring patients' personality in depth is a clear limitation given that personality is the predominating predictor of countertransference, even more than symptom severity (Hayes & Gelso, 2001; Lingardi et al., 2015). Female patients were largely underrepresented in our sample. Given the known differences in CT according to patient gender, this is a clear limitation of our study. Nursing personnel is overrepresented compared to psychologists and psychiatrists in this study. Although this is the case in every psychiatric ward, variance in

countertransference in doctoral level staff might be unrepresentative. We also lack TRQ normative data for inpatient settings, and the fit of the factor structure remains to be ascertained in inpatient settings. Further research should include different forensic populations (patients without schizophrenia, women offenders, etc.). Future research should examine the extent to which countertransference responses from the same staff member correlate. This would question “measurement invariance” between raters or perhaps suggest that staff members have tendencies to experience certain CT feelings more than others.

This study highlights the importance of training in the recognition and understanding of countertransference. Educating staff about countertransference and encouraging discussion about countertransference in staff meetings is recommended given our severely traumatized, psychotically and personality disordered forensic patients.

## 4 Conclusion

In conclusion, inpatient data (length of treatment, diagnosis, etc.), forensic variables (length of compulsory care, cooperativeness, etc.), and staff characteristics appeared to influence countertransference feelings in several ways. We repeatedly found that the inpatient/forensic independent variables (e.g. previous violent offense, duration of compulsory care) augmented hostile/mistreated countertransference feelings and diminished positive/satisfying countertransference feelings. Further, we emphasized several conceptual problems inherent to the measurement of countertransference. Although the self-reported countertransference raises questions, we found clinically meaningful results, especially regarding difference in countertransference according to profession. It is important to remember that although all staff members care for the same patients, they deal with different aspects that might evoke qualitatively and quantitatively very different countertransference responses.

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