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# Understanding countertransference reactions to forensic clients with a personality disorder diagnosis: an empirical study using the Countertransference Questionnaire.

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## Contents

# Project Proposal

## Title

Understanding countertransference reactions to forensic clients with a personality disorder diagnosis: an empirical study using the Countertransference Questionnaire.

## Overview - Importance of the topic

Within secure mental health services in England there are more than 3,500 individuals currently detained under a forensic section of the Mental Health Act, with nearly 1,000 new admissions being received each year (Health & Social Care Information Centre, 2008; Health & Social Care Information Centre, 2015; Rutherford & Duggan, 2008). Secure mental health services are specialist services with a range of physical, relational and procedural measures in place such as controlled-access doors, specific staff-to-patient ratios and procedures for searching patients/visitors (Department of Health, 2012). Forensic mental health services are a specialist service for those with a diagnosis of a mental disorder who have either a history of criminal offending or are at risk of offending in the future (Mullen, 2000).

A vast proportion of those who commit criminal offences present with a diagnosis of personality disorder (PD), most commonly Antisocial PD and Borderline PD (Coid, Kahtan, Gault, & Jarman, 1999; Registrar, Fox, & Coxell, 2006; Willmot & Gordon, 2010). A PD is characterised by persistent and problematic behaviours causing impaired functioning across a variety of personal and social contexts and relationships (Ministry of Justice, 2011). It is estimated that around a 36 – 67% of inpatients within secure services have a diagnosis of PD (Guzzetta & de Girolamo, 2012; National Institute for Mental Health in England, 2003).

The behaviour of patients with PDs can make building a therapeutic alliance difficult for clinicians due to the strong feelings these patients tend to elicit in those

around them (Ward, 2004). Countertransference is generally defined as the conscious and unconscious reactions, emotions and attitudes a clinician may experience towards a client during the course of therapy (McIntyre & Schwartz, 1998). Clinicians may find that they feel strong positive or negative emotions towards a client, some may even become romantically attracted to a client leading the professional boundaries of the therapeutic alliance to become blurred.

Managing countertransference can present a significant challenge to therapists who can feel overwhelmed when working with a client with PD (Gabbard & Wilkinson, 2000). Some personality disordered clients may behave in ways that make their therapist feel angry, anxious, or guilty (Gabbard, 1993; Meloy & Yakeley, 2014). Considering the high prevalence of PD within forensic and clinical settings it is therefore important to understand how countertransference affects clinicians working with such clients – and to further ascertain how countertransference may impact upon the effective delivery of treatment in inpatient settings.

For therapists, understanding how countertransference reactions may influence their practice can have valuable implications for improving the quality of their client work. Negative expressions of therapists' countertransference have been found to be related to lower ratings of therapeutic alliance by clients and therapists alike (Rosenberger & Hayes, 2002). A strong therapeutic alliance is seen to be a significant predictor of positive treatment outcomes, regardless of the type of therapy used (Hilsenroth, Cromer, & Ackerman, 2012; Lingiardi, Tanzilli, & Colli, 2015).

This study is intended as both a replication and extension of the existing body of research into countertransference reactions when working with clients with a PD diagnosis. A majority of the current research focuses on experiences with clients with a 'Cluster B' diagnosis (e.g. Borderline PD, Antisocial PD) (Rossberg, Karterud, Pedersen, & Friis, 2007). It is hoped that the proposed research will acquire data to cover all

three clusters (A, B and C) as existing research for cluster A and C disorders has often been contradictory (Colli & Ferri, 2015). To the best of the researchers' knowledge, there is currently little empirical research into the countertransference reactions of practitioners working specifically in forensic settings therefore this is an important area to expand upon (Barros, Rosa, & Eizirik, 2014; Friedrich & Leiper, 2006).

## Research Question(s)

- Is there any association between a client's PD diagnosis and the countertransference (CT) reactions of the clinicians working with them?

And:

- What patterns of CT are prevalent in those working with clients with particular PD diagnoses (or clusters)? (e.g. Borderline)

If the data collected allows for it, we may also look to answer the following:

- Is there any association between the setting in which a clinician is working in and their CT reactions? (e.g. prison vs. secure hospital)
- Is there any association between the clients' index offence and the practitioners' CT reactions?

## Proposed Methods

### *Participants*

I intend to acquire a sample of practitioners working in a therapeutic capacity within inpatient settings in the UK. Those eligible to participate would be using psychologically informed therapy to work with clients on a 1:1 basis (e.g. Cognitive Behavioural Therapy, Dialectical Behaviour Therapy, Mindfulness). Some examples of those eligible may be psychologists, assistant/trainee psychologists, nurses, IAPT/PWP practitioners. Those taking part would be required to provide information about themselves and about a client they have recently been working with (e.g. their diagnosis). They would

then be required to answer the countertransference questionnaire with their particular client in mind. The questionnaire uses items such as "If s/he were not my patient, I could imagine being friends with him/her" and "I dread sessions with him/her" to elicit how the therapist feels about working with that client.

Participants will be obtained through the use of online forums e.g. BPS, ClinPsy.org.uk, LinkedIn, Research Gate and through word of mouth and contacts within my workplace.

### *Measures*

The Countertransference Questionnaire (Zittel & Westen, 2003) is a 79 item self-report questionnaire designed to provide a normed and valid instrument to assess clinicians' cognitive, emotional and behavioural responses when interacting with a particular client. Results from the questionnaire are linked to 8 domains of countertransference:

1. Overwhelmed/disorganised – includes strong negative feelings such as dread, resentment and repulsion.
2. Helpless/inadequate - feelings of inadequacy, incompetence, hopelessness and anxiety.
3. Positive – experience of a positive therapeutic relationship and a close connection with the client.
4. Special/overinvolved – captures aspects of boundary violations such as self-disclosure, over running sessions and feeling responsible or overly concerned with the patient, relative to other clients.
5. Sexualised – marked by sexual feelings towards the client or experiencing sexual tension with a patient.
6. Disengaged – feeling distracted, withdrawn, annoyed or bored in sessions with the client.

7. Parental/protective – wanting to protect and nurture the patient in a parental manner.
8. Criticised/mistreated – captures feelings of being unappreciated, dismissed or devalued by the patient.

## Ethical Considerations

Participants will complete the survey online so no direct contact with staff or service users is required. No personally identifiable information is required about the individual completing the questionnaire. Those taking part would be required to provide some information about a client they have recently been working with for the purposes of categorising their data. This will include things such as the diagnosis and index offence of the client. No contact with or personally identifiable information is required about the service user.

At the start of the survey participants would be provided with a list of criteria for taking part and an information sheet which outlines the nature and purpose of the survey along with the contact details for the lead researcher and research supervisors. Participants would be required to tick a box confirming their understanding and acceptance of the information provided to them before they could continue with the survey. All questions would require completion before a participant can move to the next page of the survey, although a 'finish later' option is provided if they need a break. Respondents who click on finish later are given a 'finish later' URL. They can either bookmark the URL in their browser, or ask for the URL to be emailed to them (emailing is optional in order for participants to maintain anonymity). Survey responses are not saved automatically so a participant is free to exit the survey at any time and their data will not be saved. Participants are reminded on the last page of the survey that through clicking 'Finish' their responses will then be saved. At the end of the survey participants are reminded that they may contact the researcher(s) if they

have found the study distressing or that they should seek supervision from their workplace supervisor or an experienced colleague.

The survey is hosted through the Bristol Online Survey (BOS) website. Survey responses are collected over encrypted SSL (Secure Sockets Layer) connections. SSL is the standard technology for establishing an encrypted link between a web server and a browser. It ensures that sensitive information can be transmitted securely. All communications within the onlinesurveys.ac.uk website are also sent over SSL encrypted connections. BOS issues a cookie to store session information when registered users log in. The session cookie does not include user information and is not retained once the browser is closed. No cookies are used when survey respondents complete surveys. Only the lead researcher(s) has access to the BOS online account and the raw data collected from the survey. BOS support and technical teams can only access data at the request of the client concerned or for investigations required by law.

For some, thinking about personal feelings they may have for a client can be confusing or distressing. First and foremost, we would encourage participants to seek supervision from their workplace supervisor or an experienced colleague if they feel the content of the survey has affected them. It is important to consider that whilst some see countertransference experiences as negative, many also note how acknowledging and appropriately managing one's feelings can provide clinicians with valuable insight into their patient enabling them to become a better therapist (Bateman, Brown, & Pedder, 2010).

Contact details for the primary researcher and the research supervisor would also be provided should the participant have any further concerns.

## Expected Outcomes

Understanding how countertransference affects psychologists and other practitioners has important implications for training and supervision. The management of

countertransference behaviours can lead to improved therapeutic alliance and better treatment outcomes for clients (McIntyre & Schwartz, 1998).

Most recently, Colli, Tanzilli, Dimaggio and Lingiardi (2014) found that paranoid and antisocial PDs were related to the criticised/mistreated domain of countertransference. Whilst borderline PD was linked to the helpless/inadequate, overwhelmed/disorganised and special/overinvolved domains. The disengaged domain was associated with schizotypal and narcissistic PDs whilst dependent and histrionic PDs were negatively associated with the same domain. Schizoid PD was associated with the helpless/inadequate domain. Positive, parental/protective and special/overinvolved CT responses linked to those with avoidant PD. Finally, obsessive-compulsive PD was negatively associated with the special/overinvolved domain.

Given the lack of existing empirical research into the CT reactions of practitioners specifically working with forensic PD clients it is difficult to predict the possible outcomes of the proposed study. Due to the 'moral conflict' that may be experienced by those working therapeutically with individuals who have committed violent or sexual offences, we believe that a clients' offence history is likely to result in negative CT reactions in practitioners (Knoll, 2009). Barros, Rosa and Eizirik (2014) found that forensic psychiatrists working in the assessment of sex offenders experienced countertransference feelings of disgust/repulsion. Whilst Friedrich and Leiper (2006) found that therapists working with incestuous sexual abusers encountered feelings of anger and hostility and reported feeling controlled and deceived.

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# Ethics Approval Letter

E-mail: FMHS-ResearchEthics@nottingham.ac.uk

**Faculty of Medicine and Health Sciences**

Research Ethics Committee
C/o Faculty PVC Office
School of Medicine Education Centre
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30th May 2017

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Dear Ms Wright

| | |
|---|---|
| **Ethics Reference No:** S200317 – please always quote | |
| **Study Title:** Understanding countertransference reactions to forensic clients with a personality disorder diagnosis: an empirical study using the countertransference questionnaire. | |
| **Chief Investigator/Supervisor:** Dr Shihning Chou,Assistant Professor & Forensic Psychologist, Centre for Forensic & Family Psychology, Division of Psychiatry & Applied Psychology. | |
| **Lead Investigators/student:** Laura Wright, MSc Forensic & Criminological Psychology student. | |
| **Type of Study:** PG student, online questionnaires, qualitative | |
| **Proposed Start Date:** 03/3/17 | **Proposed End Date:** 08/17 5 mths |
| **No of Subjects:** 10+ | **Age:** 18+years |
| **School:** Medicine | |

Thank you for submitting the above application which was considered by the Committee at its meetings in March 2017and the following documents were received:

- FMHS REC Application form and supporting documents version 1.0: 03.03.2017

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion is given on the understanding that the conditions set out below are followed:

1. You should follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).
2. You must notify the Chair of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp

**Professor Ravi Mahajan**
**Chair, Faculty of Medicine & Health Sciences Research Ethics Committee**

# Understanding countertransference reactions to forensic clients with a personality disorder diagnosis: an empirical study using the Countertransference Questionnaire.


## ABSTRACT

### *Aims*

This study sought to investigate the relationship between the countertransference (CT) reactions of therapeutic practitioners working in forensic services with clients with a personality disorder (PD). It examined the relationship between CT reactions and client PD as well as the influence of the client's offending background and the service in which the practitioner was working.

### *Method*

A sample of practitioners (N=17) who had recently engaged in 1:1 psychologically informed work in a forensic service with a client with PD were invited to complete an online survey. The survey used the 79-item Countertransference Questionnaire (CTQ) (Zittel & Westen, 2003) alongside demographic questions about the practitioner and their client. The CTQ results placed practitioners into one of eight CT 'domains'.

### *Results*

Chi-square analyses of relationships between CT and client PD diagnosis, client offence history and service setting were utilised. None of the tests were statistically significant.

### *Conclusion*

Lack of statistical significance suggests that the CT reactions of forensic practitioners are not necessarily directly related to their client's pathology or their working environment. The results provide interesting suggestions for future research to better understand the work of forensic practitioners and their clients in comparison to their non-forensic counterparts.

## INTRODUCTION

An individual is considered to have a personality disorder if they present with chronic patterns of maladaptive behaviours, thoughts and emotions that cause significant distress or impairment in their own lives and in their relationships with others (Alwin et al., 2006). The DSM-5 lists 10 specific personality disorders organised across 3 clusters based on their descriptive similarities. Cluster A (the 'odd or eccentric' disorders) comprises of paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder. Cluster B ('dramatic, emotional or erratic') consists of antisocial, borderline, histrionic and narcissistic personality disorders. Finally, Cluster C (the 'anxious or fearful' disorders) includes avoidant, dependant and obsessive-compulsive personality disorders (American Psychiatric Association, 2013).

Within secure mental health services in England there are currently more than 3,500 individuals detained under a forensic section of the Mental Health Act, with nearly 1,000 new admissions being received each year (Health & Social Care Information Centre, 2008; Health & Social Care Information Centre, 2015; Rutherford & Duggan, 2008). A vast proportion of those held by a forensic section present with a diagnosis of personality disorder (PD), most commonly Antisocial PD and Borderline PD (Coid, Kahtan, Gault, & Jarman, 1999; Registrar, Fox, & Coxell, 2006; Willmot & Gordon, 2010). Estimates range between 36 – 67% for the proportion of inpatients within secure mental health services that have a diagnosis of a personality disorder (Guzzetta & de Girolamo, 2012; National Institute for Mental Health in England, 2003). Working with clients with a PD diagnosis can be complex and emotionally challenging for inpatient staff (Moore, 2012). Some staff report feeling that PD patients are more difficult to manage than those with a mental illness diagnoses and present with more manipulative behaviours and can therefore elicit less empathy from staff (Deans & Meocevic, 2006; Lewis & Appleby, 1988).

In forensic services in particular, staff can struggle with the demands of maintaining both a therapeutic and custodial relationship with service users (Kurtz & Turner, 2007). Forensic staff require specialist training and staff supervision in order to mitigate against the risks of stress and burnout that can result from extended periods of interaction with this client group (Freestone et al., 2015).

### *Countertransference*

Countertransference is generally defined as the emotional reaction of a therapist to their client, often a result of transference (when a person in therapy redirects their feelings towards others onto their therapist). Countertransference was initially viewed as being detrimental to treatment outcomes. However, over time, understanding the conscious and unconscious emotional reactions within the therapeutic relationship has come to be recognised as a potential aid for improving treatment (Betan, Heim, Zittel Conklin, & Westen, 2005). If managed correctly, the thoughts, feelings and behaviours that a client triggers within the therapist can reveal valuable information about the clients' internal feelings and their interpersonal relationships (Tanzilli, Colli, Del Corno, & Lingiardi, 2016). Transference Focused Psychotherapy (TFP) was even developed out of the idea that understanding the dynamics of the therapeutic relationship gives clues to the clients' internal conflicts (Yeomans, Delaney, & Renaud, 2007).

### *Current countertransference research*

Different patient groups have been found to elicit a variety of countertransference reactions amongst therapists. The behaviour of patients with personality disorders can make building a therapeutic alliance difficult for clinicians due to the strong feelings these patients tend to elicit in those around them (Ward, 2004). For example, a client who feels persecuted and afraid of those around them may cause a therapist to take on a 'protector' role to keep the patient safe from the danger they perceive. Research has found that therapists displayed mostly positive reactions towards patients with

depression compared to those with borderline personality disorder after reading clinical vignettes about the patient (Brody & Farber, 1996).

Considering the high prevalence of personality disorder diagnoses within forensic and clinical settings it is therefore important to understand how countertransference can affect practitioners working with this client group and also to further ascertain how countertransference may impact upon the effective delivery of treatment.

### *Current measures of countertransference*

In a significant study by Betan, Heim, Zittel Conklin and Westen (2005), clinicians working with patients with a Cluster A (odd/eccentric) diagnosis felt unappreciated and devalued by such clients. The researchers theorised that this may be due to the difficulties patients within this cluster have in establishing meaningful social relationships. Meanwhile, those with a Cluster B (dramatic/emotional/erratic) diagnosis often experience strong fluctuating emotions and distorted perceptions of themselves and others – it was proposed that the social and emotional complexity of such clients elicited feelings of helplessness and led clinicians to feel overwhelmed, those studied also described feeling overly concerned and overinvolved with these clients which led to problems maintaining boundaries. Cluster C (anxious/fearful) present with intense anxiety and are often preoccupied by a fear of rejection in relationships which can led to a desire to protect and take care of the client.

### *Possible impact of countertransference on treatment*

Therapeutic alliance refers to the working relationship between a therapist and their client (Martin, Garske, & Davis, 2000). A strong therapeutic alliance is believed to mitigate against negative countertransference reactions and lead to better treatment outcomes (Scranton, 2002). Recognising how countertransference reactions may influence therapeutic practice can have valuable implications for improving the quality and outcomes of a practitioner's work with their client. Negative expressions of

therapists' countertransference have been found to be related to lower ratings of therapeutic alliance by clients and therapists alike (Rosenberger & Hayes, 2002). A strong therapeutic alliance is seen to be a significant predictor of positive treatment outcomes, regardless of the type of therapy used (Hilsenroth, Cromer, & Ackerman, 2012; Lingiardi, Tanzilli, & Colli, 2015). Left unmanaged, strong countertransference feelings can hinder the development of a positive therapeutic alliance (Gabbard & Wilkinson, 2000).

### *Hypotheses*

The current study is intended as both a replication and extension of the current body of research into countertransference reactions when working with clients with a personality disorder diagnosis. A majority of the current research focuses on experiences with clients with a Cluster B diagnosis (e.g. Borderline PD, Antisocial PD) (Rossberg, Karterud, Pedersen, & Friis, 2007). It is hoped that the proposed research will acquire data to cover all three clusters (A, B and C) as existing research for cluster A and C disorders has often been contradictory (Colli & Ferri, 2015). To the best of the researchers' knowledge, there is little empirical research at present regarding the countertransference reactions of practitioners working in forensic settings with clients with a PD diagnosis therefore this is an important area to expand upon (Barros, Rosa, & Eizirik, 2014; Friedrich & Leiper, 2006).

Primarily, the current study is intended to answer the following question:

- Is there any association between a client's PD diagnosis and the countertransference (CT) reactions of the clinicians working with them?

If the data allows for it, we would also like look to answer the following:

- What patterns of CT are prevalent in those working with clients with particular PD diagnoses (or clusters)? (e.g. Borderline)

- Is there any association between the setting in which a clinician is working in and their CT reactions? (e.g. prison vs. secure hospital)
- Is there any association between the clients' offence history and the practitioners' CT response?

## Method

### *Participants*

Participants were 17 practitioners who completed an online survey advertised via relevant forums and social media (e.g. Clinpsy.org.uk, LinkedIn, Twitter, Facebook). Those eligible to take part confirmed they had, within the last year, used psychologically informed therapy to work with a client with a personality disorder diagnosis on a 1:1 basis within a forensic setting. One participant was excluded as the client they were working with did not have a personality disorder diagnosis leaving 16 eligible participants.

Demographic information obtained through the questionnaire included: age, gender, highest level of qualification obtained, current job status, main client group and setting (e.g. inpatient or prison). Participants also provided demographic information on a client they had recently worked with who had a personality disorder diagnosis. This included: age, gender, current diagnosis, offence history, the setting in which the clinician was seeing them in and the nature of their treatment.

### *Procedure*

The survey was hosted online through the Bristol Online Surveys website. The survey used the term 'emotional reactions' in place of 'countertransference' to allow for ease of understanding and to avoid any of the negative connotations some hold surrounding the concept of CT. Participants were asked initial demographic questions about themselves and their working status. Many of the participants stated they worked

across more than one setting or service concurrently so they were asked to state which they considered their main setting.

Participants were then provided with DSM criteria for personality disorder diagnoses (American Psychiatric Association, 2013). Later, for the purpose of data analysis, in cases where a client was described as having two personality disorder diagnoses (e.g. ASPD and BPD) the first was assumed to be their primary diagnosis. Some were described as having, for example, 'BPD with antisocial traits'. In such cases BPD would be taken to be their primary diagnosis as opposed to ASPD. Participants were also asked to list the most prominent symptoms of their clients' current presentation and this was compared against the DSM-5 criteria as a final resort when the first two methods could not resolve discrepancies.

To minimise any selection biases, the participants were asked to recall only the most recent client they had seen who met the DSM criteria for a 'personality disorder' diagnosis (Betan, Heim, Zittel Conklin, & Westen, 2005). In addition to the DSM criteria the client selected should also be over the age of 18 and not have been experiencing psychotic symptoms when the clinician last met with them.

Participants were then asked to provide some details about their client including age, gender, current diagnosis (alongside which symptoms were most pronounced to ensure we could categorise their diagnosis correctly), the setting in which they worked with the client, the nature of the treatment, their index offence (if relevant) and how many sessions they had had with the client. No personally identifiable information was collected about the participant or their client from the survey.

### *Measures*

Countertransference Questionnaire (Betan, Heim, Zittel Conklin, & Westen, 2005) – After providing details about themselves and their client, participants were then presented with the 79 items of the Countertransference Questionnaire. The items ask

about the feelings, thoughts and behaviours of the clinician towards their client. E.g. 'I feel annoyed in sessions with him/her', 'I look forward to sessions with him/her' and 'I find myself discussing him/her more with colleagues or supervisors than my other patients'. The results of the questionnaire will then place participants into one of eight countertransference domains.

1. Criticised/mistreated – captures feelings of being unappreciated, dismissed or devalued by the patient.
2. Helpless/inadequate - feelings of inadequacy, incompetence, hopelessness and anxiety.
3. Positive/satisfying – experience of a positive therapeutic relationship and a close connection with the client.
4. Parental/protective – wanting to protect and nurture the patient in a parental manner.
5. Overwhelmed/disorganised – includes strong negative feelings such as dread, resentment and repulsion.
6. Special/overinvolved – captures aspects of boundary violations such as self-disclosure, over running sessions and feeling responsible or overly concerned with the patient, relative to other clients.
7. Sexualised – marked by sexual feelings towards the client or experiencing sexual tension with a patient.
8. Disengaged – feeling distracted, withdrawn, annoyed or bored in sessions with the client.

The Countertransference Questionnaire is an empirically valid and reliable measure of clinicians' countertransference reactions that can be utilised across a range of clinical populations (Levy & Ablon, 2008).

A copy of the full online survey including information and consent pages, question layouts and debrief can be found in Appendix A.

## RESULTS

### *Sample Characteristics*

One participant was excluded from the sample as the client they were working with did not have a personality disorder diagnosis leaving 16 eligible participants for analysis.

Those who took part were between the ages of 23 – 53 (M = 33.8), six were male and the rest female. Almost all of those who took part were working as psychologists, this included assistants, trainees and senior/lead psychologists (N = 14). One participant was working as a 'Case Manager' and one was working as a 'Psychotherapist'. A majority of the participants worked primarily in inpatient services (N = 8). Table 1 presents descriptive statistics for the selected sample.

***Table 1 – Participant demographics (N = 16)***

| | | |
|---|---|---|
| Age | 23 – 53 (mean = 33.8) | |
| Gender | Male | 6 |
| | Female | 10 |
| Highest level qualification | Undergraduate | 3 |
| | Postgraduate (e.g. MA, MSc etc.) | 7 |
| | Doctorate | 6 |
| Time qualified (years) | Less than one year | 2 |

| | | |
|---|---|---|
| | One to five years | 8 |
| | Five to ten years | 3 |
| | Ten years or more | 3 |
| Current job title | Trainee/Assistant Psychologist | 7 |
| | Forensic/Clinical Psychologist | 4 |
| | Senior/Lead Psychologist | 3 |
| | Other – Case Manager | 1 |
| | Psychotherapist | 1 |
| Current/main work setting | Inpatient – Locked Rehab | 1 |
| | Low Secure | 2 |
| | Medium Secure | 5 |
| | Prison – Category A | 2 |
| | Young Offenders Institute/Secure Training Centre | 2 |
| | Community | 4 |

With regards to the clients that the participants had in mind when answering the questionnaire ten were males and five were females aged between 18 and 45 years old (M = 29.6). Five clients had a diagnosis of Antisocial Personality Disorder (ASPD), ten had a diagnosis of Borderline Personality Disorder (BPD) and one was diagnosed with Narcissistic Personality Disorder (NPD). Ten of the clients were seen in an inpatient setting. Two were seen in a category A prison, one within a young offenders service and three were seen in the community. Four of the participants were undertaking cognitive behavioural therapy (CBT) with their client whilst seven were using dialectical behaviour therapy (DBT). Two were delivering schema therapy whilst the remaining

three participants were using other psychologically informed therapies such as mood diaries and mindfulness with their clients.

Fourteen of the clients described had committed an offence for which they had received criminal charges for, the offences ranged from theft and arson, to violent and sexual offences and one of murder. Table 2 summarises the demographic information for the client sample. Table 3 presents the mean scores for practitioners on each of the 79-items of the Countertransference Questionnaire.

Participants had conducted an average of 16 sessions with their client at the time of completing the survey (S.D = 13.07).

***Table 2 – Client demographics (N = 16)***

| | | |
|---|---|---|
| Age | 18 – 45 (mean = 29.6) | |
| Gender | Male | 10 |
| | Female | 6 |
| Current diagnosis | Antisocial Personality Disorder | 5 |
| | Borderline Personality Disorder | 10 |
| | Narcissistic Personality Disorder | 1 |
| Current setting | Inpatient – Locked Rehab | 1 |
| | Low Secure | 3 |
| | Medium Secure | 4 |
| | High Secure | 2 |
| | Prison – Category A | 2 |
| | Young Offenders Institute/Secure Training Centre | 1 |
| | Community | 3 |

| | | |
|---|---|---|
| Nature of Treatment | CBT | 4 |
| | DBT | 7 |
| | Schema Therapy | 2 |
| | Other (e.g. Mood diaries, Mindfulness) | 3 |
| Offence History | Yes | 14 |
| | No | 2 |

***Table 3 – Mean scores on the 79 items of the Countertransference Questionnaire.***

| Item | Mean | Std. Deviation |
|---|---|---|
| 1. I am very hopeful about the gains s/he is making or will likely make in treatment. | 3.00 | 1.155 |
| 2. At times I dislike him/her. | 2.50 | 1.414 |
| 3. I find it exciting working with him/her. | 3.06 | 1.063 |
| 4. I feel compassion for him/her. | 3.94 | 1.181 |
| 5. I wish I had never taken him/her on as a patient. | 1.19 | .403 |
| 6. I feel dismissed or devalued. | 1.81 | 1.047 |
| 7. If s/he were not my patient, I could imagine being friends with him/her. | 1.75 | 1.065 |
| 8. I feel annoyed in sessions with him/her. | 2.44 | 1.209 |
| 9. I don't feel fully engaged in sessions with him/her. | 1.50 | .632 |
| 10. I feel confused in sessions with him/her. | 2.13 | .957 |

| | | |
|---|---|---|
| 11. I don't trust what s/he's telling me. | 2.75 | 1.125 |
| 12. I feel criticised by him/her. | 2.13 | 1.204 |
| 13. I dread sessions with him/her. | 1.63 | .806 |
| 14. I feel angry at people in his/her life. | 2.38 | 1.455 |
| 15. I feel angry at him/her. | 1.88 | 1.147 |
| 16. I feel bored in sessions with him/her. | 1.50 | .730 |
| 17. I feel sexually attracted to him/her. | 1.13 | .500 |
| 18. I feel depressed in sessions with him/her. | 1.38 | .806 |
| 19. I look forward to sessions with him/her. | 3.13 | .885 |
| 20. I feel envious of, or competitive with him/her. | 1.06 | .250 |
| 21. I wish I could give him/her what others never could. | 2.44 | 1.315 |
| 22. I feel frustrated in sessions with him/her. | 2.75 | 1.342 |
| 23. S/he makes me feel good about myself. | 2.00 | .894 |
| 24. I feel guilty about my feelings toward him/her. | 1.19 | .403 |
| 25. My mind often wanders to things other than what s/he is talking about. | 1.19 | .403 |
| 26. I feel overwhelmed by his/her strong emotions. | 2.19 | 1.328 |
| 27. I get enraged at him/her. | 1.63 | .885 |
| 28. I feel guilty when s/he is distressed or deteriorates, as if I must be somehow responsible. | 1.69 | .793 |
| 29. S/he tends to stir up strong feelings in me. | 2.38 | 1.204 |
| 30. I feel anxious working with him/her. | 1.94 | .854 |

| | | |
|---|---|---|
| 31. I feel I am failing to help him/her or I worry that I won't be able to help him/her. | 2.63 | 1.258 |
| 32. His/her sexual feelings toward me make me anxious or uncomfortable. | 1.44 | .892 |
| 33. I feel used or manipulated by him/her. | 1.63 | 1.025 |
| 34. I feel I am "walking on eggshells" around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out. | 2.19 | 1.377 |
| 35. S/he frightens me. | 1.69 | 1.078 |
| 36. I feel incompetent or inadequate working with him/her. | 2.00 | .966 |
| 37. I find myself being controlling with him/her. | 1.75 | .931 |
| 38. I feel interchangeable—that I could be anyone to him/her. | 1.69 | .793 |
| 39. I have to stop myself from saying or doing something aggressive or critical. | 1.56 | .892 |
| 40. I feel like I understand him/her. | 3.00 | 1.211 |
| 41. I tell him/her I'm angry at him/her. | 1.50 | 1.033 |
| 42. I feel like I want to protect him/her. | 2.25 | 1.483 |
| 43. I regret things I have said to him/her. | 1.13 | .342 |
| 44. I feel like I'm being mean or cruel to him/her. | 1.31 | .602 |
| 45. I have trouble relating to the feelings s/he expresses. | 2.19 | 1.424 |
| 46. I feel mistreated or abused by him/her. | 1.44 | 1.031 |
| 47. I feel nurturant toward him/her. | 2.38 | 1.088 |
| 48. I lose my temper with him/her. | 1.06 | .250 |
| 49. I feel sad in sessions with him/her. | 2.19 | 1.223 |

| | | |
|---|---|---|
| 50. I tell him/her I love him/her. | 1.06 | .250 |
| 51. I feel overwhelmed by his/her needs. | 2.06 | 1.181 |
| 52. I feel hopeless working with him/her. | 2.13 | .885 |
| 53. I feel pleased or satisfied after sessions with him/her. | 2.69 | 1.352 |
| 54. I think s/he might do better with another therapist or in a different kind of therapy. | 1.69 | .704 |
| 55. I feel pushed to set very firm limits with him/her. | 3.00 | 1.366 |
| 56. I find myself being flirtatious with him/her. | 1.06 | .250 |
| 57. I feel resentful working with him/her. | 1.06 | .250 |
| 58. I think or fantasise about ending the treatment. | 1.63 | 1.025 |
| 59. I feel like my hands have been tied or that I have been put in an impossible bind. | 1.38 | .619 |
| 60. When checking my phone messages, I feel anxiety or dread that there will be one from him/her. | 1.06 | .250 |
| 61. I feel sexual tension in the room. | 1.19 | .544 |
| 62. I feel repulsed by him/her. | 1.31 | .793 |
| 63. I feel unappreciated by him/her. | 1.81 | .750 |
| 64. I have warm, almost parental feelings toward him/her. | 1.75 | 1.000 |
| 65. I like him/her very much. | 2.06 | .772 |
| 66. I worry about him/her after sessions more than other patients. | 1.81 | .981 |
| 67. I end sessions overtime with him/her more than with my other patients. | 1.38 | .719 |

| | | |
|---|---|---|
| 68. I feel less successful helping him/her than other patients. | 2.06 | 1.237 |
| 69. I do things for him/her, or go the extra mile for him/her, in ways that I don't do for other patients. | 1.44 | .727 |
| 70. I return his/her phone calls less promptly than I do with my other patients. | 1.00 | .000 |
| 71. I disclose my feelings with him/her more than with other patients. | 1.00 | .000 |
| 72. I call him/her between sessions more than my other patients. | 1.00 | .000 |
| 73. I find myself discussing him/her more with colleagues or supervisors than my other patients. | 1.81 | .911 |
| 74. S/he is one of my favourite patients. | 1.50 | .632 |
| 75. I watch the clock with him/her more than with my other patients. | 1.13 | .500 |
| 76. I self-disclose more about my personal life with him/her than with my other patients. | 1.06 | .250 |
| 77. More than with most patients, I feel like I've been pulled into things that I didn't realise until after the session was over. | 1.38 | .719 |
| 78. I begin sessions late with him/her more than with my other patients. | 1.00 | .000 |
| 79. I talk about him/her with my spouse or significant other more than my other patients. | 1.19 | .544 |

Note. The Countertransference Questionnaire uses a scale of 1 through to 5, where 1=not true at all, 3=somewhat true, and 5=very true.

### *SPSS Analysis*

Data analysis was conducted using IBM SPSS Statistics version 24. The variables to be analysed (participant CT domain and client diagnosis, service type and offence history) were tested for normality using Shapiro-Wilk tests. All tests were significant ($p<.05$) meaning the distribution of these variables was non-normal (Field, 2007). The Chi-Square test is robust to assumptions of normality (McHugh, 2013).

No significant association was found between client PD diagnosis and practitioner CT domain ($\chi^2$ (6) = 10.74, $p$ = .091)

No significant association was found between service setting (e.g. prison or secure hospital) and practitioner CT domain ($\chi^2$ (18) = 25.21, $p$ = .091).

No significant association was found between the client's offence history (previous offence(s) vs. no offence(s) committed) and practitioner CT domain ($\chi^2$ (3) = 2.07, $p$ = .767)

## DISCUSSION

The current study sought to expand upon previous literature using the Countertransference Questionnaire by applying it to practitioners working in forensic services with clients with a personality disorder diagnosis. The results of this study and its implications will be discussed forthwith.

Our initial aim was to understand if there was any association between a client's PD diagnosis and the countertransference (CT) reactions of the clinicians working with them. If we collected sufficient data we would also look to identify which patterns of CT are prevalent in those working with clients with specific PD diagnoses (e.g. BPD), if there was any association between the setting in which a clinician is working in and their CT reactions (e.g. prison vs. secure hospital) and finally, if there was any

association between the clients' offence history (i.e. offence history vs. no offence history) and a practitioners' CT response.

Across all four hypotheses the results of chi-square tests did not produce any results of statistical significance. Lack of statistical significance could suggest that the CT reactions of the forensic practitioners sampled were not necessarily directly related to their client's pathology or the service in which the practitioner works. However, as far as the researchers could ascertain, this project is the first of its kind to utilise the Countertransference Questionnaire with a specifically forensic practitioner and client sample. Therefore, the results still hold a number of implications that could be explored in future.

### *Limitations*

Due to time limitations on the project, the study concluded with a very small sample size (N = 16) this made it difficult to produce any tangible results. We had hoped to acquire data from practitioners working with clients across all 10 personality disorder diagnoses as this had not be accomplished previously. However, all those sampled were working with clients with Cluster B diagnoses, which prevented comparison across disorders. We had also hoped to acquire enough data from practitioners working across a variety of settings, yet a majority of our sample were working in inpatient services.

For such a small sample, there was a lot of variance across the participants (e.g. average of 16 therapy sessions conducted with client at the time of survey with a standard deviation of 13.07). Such a wide scope of different responses may have impacted upon statistical analyses. Our participants all held a variety of qualifications and job roles (from undergraduate degrees to doctorates, from trainee psychologists to lead psychologists to psychotherapists). A majority worked in different levels of impatient services (locked rehab to high secure) but some worked within the prison service and some were community based also. The nature of the therapeutic work

being carried out also differed quite considerably, some were undertaking CBT or DBT with their client whilst others were conducting forensic Schema Therapy, relapse prevention and mindfulness training. The nature and content of this therapeutic work would be very different from one approach to the other, making them difficult to compare. DBT and CBT are not uniquely forensic, whilst forensic Schema Therapy would be. Future studies would do well to acquire a greater number of participants meeting each response category to see what results this might produce.

### *Future Research*

Despite failing to reach statistical significance, the results of the current study still provide us with several points of interest that would warrant further study.

Firstly, could it be the case that, whilst forensic clients may present with more complexity and greater levels of risk than those clients in non-forensic services, that those sharing the same PD diagnoses present psychologically, emotionally and behaviourally as very similar regardless of a forensic background? A brief literature search does not seem to yield much research into the similarities in psychological presentation between forensic and non-forensic clients.

It is generally accepted that the forensic client population requires a more specialist skill set in the staff that care for them than non-forensic clients, meaning that staff are often given more rigorous and specialist training and more in-depth training (Maden, 2006; Moore, 2012). Perhaps, due to the arguably greater complexity of the clients they meet with, forensic practitioners are more aware of and more adept at managing their CT reactions than non-forensic practitioners?

Tying in with the above, could such training influence the attitudes of forensic practitioners to their clients? Maybe it is the case that their attitudes differ from those in non-forensic settings. Positive or negative attitudes and prejudices towards the PD

client group could influence the CT reactions of practitioners (Newton-Howes, Weaver, & Tyrer, 2008).

Finally, not all of the clients presented had committed a previous offence. Due to insufficient data, we did not explore in-depth the nature of previous offences and how this could have impacted upon practitioners' CT reactions. Friedrich and Leiper (2006) found that therapists working with incestuous sexual abusers encountered feelings of anger and hostility and reported feeling controlled and deceived. Given this, we cannot dismiss the notion that the nature of previous offending in our PD client sample may have had an influence upon the CT reactions of their practitioners and this should be explored further.

### *Conclusion*

The existing evidence base does suggest that working with clients with a PD diagnosis is a complex and challenging task for practitioners. This can lead to experiences of positive and negative domains of CT which in turn impact upon therapeutic alliance and the outcome of treatment programmes. This study sought to expand the knowledge of CT reactions with clients with PD to a sample of practitioners working in forensic service settings. Despite a lack of statistical significance failing to provide support for an association between the CT reactions of forensic practitioners and their PD clients, on the basis of similar research with these populations we cannot refute the idea that CT reactions in forensic practitioners are not related at all to their client's pathology or their working environment. Such results provide interesting suggestions for expanding upon the current study in future research to better understand the work of forensic practitioners and their clients in comparison to their non-forensic counterparts.

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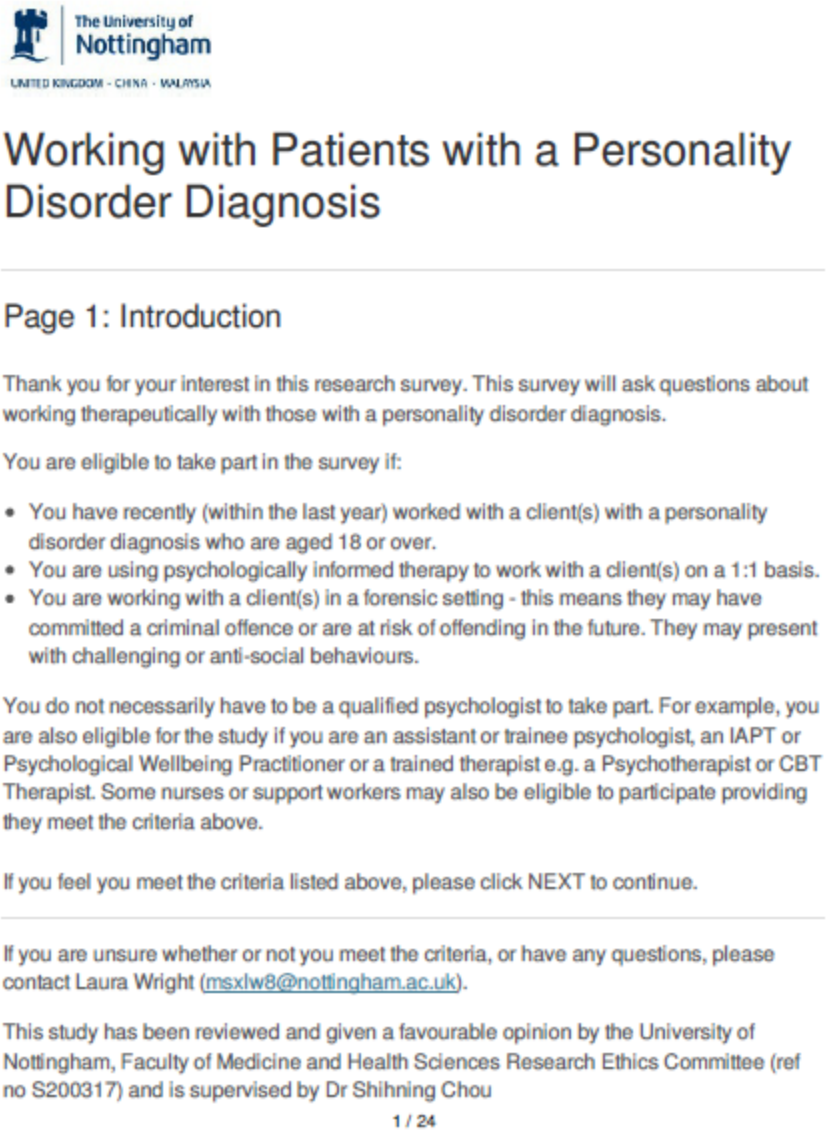
## Appendices

### *Appendix A – Copy of full online survey including information, consent and debrief pages.*



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# Working with Patients with a Personality Disorder Diagnosis

## Page 1: Introduction

Thank you for your interest in this research survey. This survey will ask questions about working therapeutically with those with a personality disorder diagnosis.

You are eligible to take part in the survey if:

- You have recently (within the last year) worked with a client(s) with a personality disorder diagnosis who are aged 18 or over.
- You are using psychologically informed therapy to work with a client(s) on a 1:1 basis.
- You are working with a client(s) in a forensic setting - this means they may have committed a criminal offence or are at risk of offending in the future. They may present with challenging or anti-social behaviours.

You do not necessarily have to be a qualified psychologist to take part. For example, you are also eligible for the study if you are an assistant or trainee psychologist, an IAPT or Psychological Wellbeing Practitioner or a trained therapist e.g. a Psychotherapist or CBT Therapist. Some nurses or support workers may also be eligible to participate providing they meet the criteria above.

If you feel you meet the criteria listed above, please click NEXT to continue.

If you are unsure whether or not you meet the criteria, or have any questions, please contact Laura Wright (msxlw8@nottingham.ac.uk).

This study has been reviewed and given a favourable opinion by the University of Nottingham, Faculty of Medicine and Health Sciences Research Ethics Committee (ref no S200317) and is supervised by Dr Shihning Chou

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(shihning.chou@nottingham.ac.uk) and Dr Thomas Schroder (thomas.schroder@nottingham.ac.uk) from the Centre for Forensic and Family Psychology, School of Medicine, University of Nottingham.

## Page 2: Information for Participants

We invite you to participate in this research questionnaire that looks at the feelings, attitudes and reactions of those working therapeutically with individuals with a personality disorder diagnosis. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the researchers if there is anything that is not clear or if you would like more information.

**What is the purpose of the study?**

This study aims to understand how staff in forensic secure services feel about working with clients with a personality disorder diagnosis. Through this research we hope to further existing knowledge around how these feelings can positively or negatively influence a therapeutic relationship.

**What will happen if I take part?**

If you decide to take part, we will ask you some questions about yourself and the kind of work you do. You will then be asked to think about a client with a personality disorder diagnosis with whom you have recently worked with. Then you will be asked some questions about the client and how working with them has made you feel. You do not have to provide any identifiable information about this client or yourself. We anticipate that the questionnaire will take around 20 minutes to complete.

**What are the possible benefits of taking part?**

We hope that you will find it interesting to take part in this research. The information we get from this study will help us to understand more about how best to work with clients with a personality disorder and how to support the staff working with them too. If you would like a copy of the research findings from the study please let the researcher(s) know, and we will arrange for a copy of the final written report to be sent to you once the study is complete.

**Will I experience any negative effects if I take part?**

For some, thinking about the feelings they may have about a client may be stressful, confusing or distressing. First and foremost, we would encourage participants to seek supervision from their workplace supervisor or an experienced colleague if they think these feelings might be affecting them or their work. However, it is important to consider that acknowledging and appropriately managing one's feelings towards a client(s) can

provide you with valuable insight into your patient(s) and enable you to work better with them.

**Will my taking part in this study be kept confidential?**

Information collected during the course of this research, including your answers to questionnaires, will be kept strictly confidential. At no point will you be asked to provide any personally identifiable information about yourself, where you work or the patient(s) you work with. It is up to you to decide whether to take part or not. If you decide to take part, you are still free to withdraw at any time and without giving a reason by simply closing the questionnaire window. If you decide to withdraw from the study before completing questionnaire, none of your data will be analysed and it will be disposed of securely. However, you will not be able to withdraw your data *after* you have submitted your survey responses as it will be made anonymous and we will therefore be unable to determine which data is yours.

**Who has reviewed the study?**

This study has been reviewed and given a favourable opinion by the University of Nottingham, Faculty of Medicine and Health Sciences Research Ethics Committee (ref no S200317) and is supervised by Dr Shihning Chou and Dr Thomas Schroder from the Centre for Forensic and Family Psychology, School of Medicine, University of Nottingham.

If you have any questions about this project, you may contact the Lead Researcher Laura Wright (msxlw8@nottingham.ac.uk) or if you have any concerns about any aspect of this study please contact the Research Supervisors: Dr Shihning Chou (shihning.chou@nottingham.ac.uk) or Dr Thomas Schroder (thomas.schroder@nottingham.ac.uk). If this does not achieve a satisfactory outcome please contact: fmhs-researchethics@nottingham.ac.uk

**IMPORTANT** * *Required*

☐ By ticking this box, you indicate your willingness to voluntarily take part in the study and your agreement and understanding of the statements below:

- I confirm that I have read the information sheet and I understand the nature and purpose of the research project and agree to take part.

- I confirm that I am at least 18 years of age or older.
- I understand that my participation is voluntary and I can end the study at any time and withdraw my data by exiting the survey.
- I understand that all of my responses will be anonymous and that the overall anonymised data from this study may be used in the future for research and teaching purposes.
- I understand that I may contact the researcher or supervisor if I require further information about the study.

## Page 3

First we'd like to know a few basic things about you:

Your age? * *Required*

Your gender? * *Required*

- Male
- Female
- Would Rather Not Say
- Other

If you selected Other, please specify:

What is the highest level of qualification you have obtained? * *Required*

- Undergraduate (e.g. BA, BSc)
- Postgraduate (e.g. MA, MSc, MRes, MPhil)
- Doctorate (e.g. PhD, DPhil, DClinPsy, DForenPsy, Other Professional Doctorate)
- Other

If you selected Other, please specify:

How many years have you held this qualification? * *Required*

- Less than 1 year
- 1 - 5 years
- 5 - 10 years
- 10 years or more

What is your current job title? * *Required*

What is your current employment status? * *Required*

- Full Time
- Part Time
- Fixed Term Contract
- Self-Employed
- Other

If you selected Other, please specify:

Which term best describes your main client group? * *Required*

- ○ Children and Adolescents
- ○ 'Transition' services e.g. for 18-25 year olds
- ○ Adult – Male
- ○ Adult – Female
- ○ Other

If you selected Other, please specify:

Which term best describes the type of setting in which you mainly work? * *Required*

- ☐ Inpatient - Locked Rehab
- ☐ Inpatient – Low Secure
- ☐ Inpatient – Medium Secure
- ☐ Inpatient – High Secure
- ☐ Prison – Category A
- ☐ Prison – Category B
- ☐ Prison – Category C
- ☐ Prison – Category D
- ☐ Young Offenders Institute/Secure Training Centre
- ☐ Community
- ☐ Other

If you selected Other, please specify:

## Page 4

The purpose of this questionnaire is to understand how practitioners may feel about or react to their therapeutic work with clients with a personality disorder diagnosis. According to current DSM criteria for a diagnosis of personality disorder to be applied the following criteria **must** be met:

- The essential feature of a personality disorder is **an enduring pattern of inner experience and behaviour** that deviates markedly from the expectations of the individual's culture and **is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control (Criterion A)**
- This enduring pattern **is inflexible and pervasive across a broad range of personal and social situations (Criterion B)**
- It leads to **clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C)**
- The pattern is **stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood (Criterion D)**
- The pattern is **not better explained as a manifestation or consequence of another mental disorder (Criterion E)**
- It is also **not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, exposure to a toxin) or another medical condition (e.g., head trauma) (Criterion F)**

Please click NEXT to continue.

## Page 5

We'd like to ask you to think about the most recent client you've seen who meets the criteria for a 'personality disorder' outlined on the previous page. In addition to the DSM criteria this client should also:

- Be aged 18 or over.
- Not have been experiencing any psychotic symptoms when you last met with them.

With this client in mind, please answer the following questions:

**IMPORTANT** Please remember that any information you provide about yourself or your clients will remain strictly confidential. Data provided in response to these questions will only be used for the purposes of data categorisation.

What is this clients' current diagnosis? * *Required*

How old are they? * *Required*

What is their gender? * *Required*

If you selected Other, please specify:

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What do you feel are the most pronounced symptoms of this clients' presentation? *Please list a few in the categories below.*

| | * Required |
|---|---|
| Behavioural e.g. Impulsivity, aggression, self-harm, suspicious of others. | |
| Social e.g. Difficulty maintaining relationships, over-reliance on others, wanting to be the centre of attention. | |
| Cognitive e.g. Paranoia, lack of emotion, hearing voices. | |

In what kind of setting are you currently working with this client? * *Required*

- ○ Inpatient - Locked Rehab
- ○ Inpatient – Low Secure
- ○ Inpatient – Medium Secure
- ○ Inpatient – High Secure
- ○ Prison – Category A
- ○ Prison – Category B
- ○ Prison – Category C
- ○ Prison – Category D
- ○ Young Offenders Institute/Secure Training Centre
- ○ Community
- ○ Other

If you selected Other, please specify:

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Do you feel there are any organisational stressors that are impacting on your work in this setting/with this client? *E.g. organisational structure, restrictions within your job role, pressure for treatment results.*
*Optional*

What is the nature of the treatment you are currently doing with this client? *E.g. CBT, DBT etc.*
* *Required*

Does this person have a history of offending? If yes, what is their index offence? * *Required*

- Yes
- No

Without providing any information which may identify your client, please give a brief description of their index offence here:

Approximately how many sessions have you had with this client? * *Required*

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Please enter a whole number (integer).

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## Page 6

Now, with the same client in mind as before, please read the following items and rate the extent to which they are true of you in your work with them. Where 1=not true at all, 3=somewhat true, and 5=very true. It can be hard to generalise across a treatment of many weeks or months, but try to describe the way you have felt with your client over the course of their entire treatment. Do not worry if your responses appear inconsistent since clinicians often have multiple responses to the same patient. * *Required*

Please don't select more than 1 answer(s) per row.

Please select at least 79 answer(s).

| | Not true at all 1 | 2 | Somewhat true 3 | 4 | Very true 5 |
|---|---|---|---|---|---|
| 1. I am very hopeful about the gains s/he is making or will likely make in treatment. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. At times I dislike him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. I find it exciting working with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. I feel compassion for him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. I wish I had never taken him/her on as a patient. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. I feel dismissed or devalued. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. If s/he were not my patient, I could imagine being friends with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| 8. I feel annoyed in sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. I don't feel fully engaged in sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. I feel confused in sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. I don't trust what s/he's telling me. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. I feel criticised by him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. I dread sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. I feel angry at people in his/her life. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. I feel angry at him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. I feel bored in sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. I feel sexually attracted to him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. I feel depressed in sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19. I look forward to sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| 20. I feel envious of, or competitive with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21. I wish I could give him/her what others never could. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22. I feel frustrated in sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 23. S/he makes me feel good about myself. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24. I feel guilty about my feelings toward him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 25. My mind often wanders to things other than what s/he is talking about. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 26. I feel overwhelmed by his/her strong emotions. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 27. I get enraged at him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 28. I feel guilty when s/he is distressed or deteriorates, as if I must be somehow responsible. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 29. S/he tends to stir up strong feelings in me. | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| 30. I feel anxious working with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 31. I feel I am failing to help him/her or I worry that I won't be able to help him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 32. His/her sexual feelings toward me make me anxious or uncomfortable. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 33. I feel used or manipulated by him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 34. I feel I am "walking on eggshells" around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 35. S/he frightens me. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 36. I feel incompetent or inadequate working with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 37. I find myself being controlling with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 38. I feel interchangeable—that I could be anyone to him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| 39. I have to stop myself from saying or doing something aggressive or critical. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 40. I feel like I understand him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 41. I tell him/her I'm angry at him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 42. I feel like I want to protect him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 43. I regret things I have said to him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 44. I feel like I'm being mean or cruel to him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 45. I have trouble relating to the feelings s/he expresses. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 46. I feel mistreated or abused by him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 47. I feel nurturant toward him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 48. I lose my temper with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 49. I feel sad in sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 50. I tell him/her I love him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| 51. I feel overwhelmed by his/her needs. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 52. I feel hopeless working with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 53. I feel pleased or satisfied after sessions with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 54. I think s/he might do better with another therapist or in a different kind of therapy. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 55. I feel pushed to set very firm limits with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 56. I find myself being flirtatious with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 57. I feel resentful working with him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 58. I think or fantasise about ending the treatment. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 59. I feel like my hands have been tied or that I have been put in an impossible bind. | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| 60. When checking my phone messages, I feel anxiety or dread that there will be one from him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 61. I feel sexual tension in the room. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 62. I feel repulsed by him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 63. I feel unappreciated by him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 64. I have warm, almost parental feelings toward him/her. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 65. I like him/her very much. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 66. I worry about him/her after sessions more than other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 67. I end sessions overtime with him/her more than with my other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 68. I feel less successful helping him/her than other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| 69. I do things for him/her, or go the extra mile for him/her, in ways that I don't do for other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 70. I return his/her phone calls less promptly than I do with my other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 71. I disclose my feelings with him/her more than with other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 72. I call him/her between sessions more than my other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 73. I find myself discussing him/her more with colleagues or supervisors than my other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74. S/he is one of my favourite patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 75. I watch the clock with him/her more than with my other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 76. I self-disclose more about my personal life with him/her than with my other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| 77. More than with most patients, I feel like I've been pulled into things that I didn't realise until after the session was over. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 78. I begin sessions late with him/her more than with my other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 79. I talk about him/her with my spouse or significant other more than my other patients. | ☐ | ☐ | ☐ | ☐ | ☐ |

## Page 7: Thank you

Thank you for taking the time to complete this survey. Please click the **finish** button below to end the survey and **save** your responses.

If taking part in this study has affected you in any way, or you wish to be informed of the results of this research at a later date please contact either the lead researcher Laura Wright (msxlw8@nottingham.ac.uk) or the research supervisors Dr Shihning Chou (shihning.chou@nottingham.ac.uk) and Dr Thomas Schroder (thomas.schroder@nottingham.ac.uk).

If you have found thinking about the thoughts and feelings you have about a client confusing or distressing, in the first instance we would encourage you to seek supervision from a workplace supervisor or an experienced colleague. However, it is important to consider that acknowledging and appropriately managing feelings towards a client can also provide you with valuable insight into your patients and enable you to work better with them.

## Executive Summary

*The intended target audience of this research includes therapeutic practitioners and their supervisors, those who work with clients with personality disorders and anyone who may be interested in understanding more about therapist-client working relationships.*

The aim of this research report was to investigate the relationship between the countertransference (CT) reactions of therapeutic practitioners and the nature of the clients they work with, particularly in relation to them having a diagnosis of personality disorder (PD) and working in a forensic setting. Previous research has highlighted the complexities of working with this client group and how this can influence the course of therapy.

It is estimated that between 4 and 12% of the general UK population have a diagnosis of personality disorder (Yang, Coid, & Tyrer, 2010). Those with a PD diagnosis account for a large proportion of the offending population and the population of secure inpatient services (Coid, Kahtan, Gault, & Jarman, 1999; Registrar, Fox, & Coxell, 2006; Willmot & Gordon, 2010). Those with the diagnosis often engage in maladaptive thoughts and behaviour and have great difficulty in managing emotions. This can lead to problems maintaining positive relationships with others around them.

Countertransference refers to the emotional reaction of a therapist to their client. CT reactions can be both positive and negative and can have a significant effect on the outcomes of therapy. Managing the conscious and unconscious effects of CT is important for both practitioners and their supervisors to consider in order to facilitate positive therapeutic relationships and successful outcomes for clients. Poor management of CT can lead to a breakdown in the therapeutic alliance and boundary violations such as a therapist becoming over-protective of the client or even engaging in romantic relationships.

The study looked to answer the following questions:

1. Is there any association between a client's PD diagnosis and the countertransference (CT) reactions of the clinicians working with them?

If the data collected would allow for it, we also wanted to look to answer the following:

2. What patterns of CT are prevalent in those working with clients with particular PD diagnoses (or clusters)? (e.g. Borderline)
3. Is there any association between the setting in which a clinician is working in and their CT reactions? (e.g. prison vs. secure hospital)
4. Is there any association between the clients' offence history and the practitioners' CT response?

As part of the current study an online survey was set up which asked for those who carried out 1:1 therapeutic work with clients with PD to complete some questions about themselves, their client and their therapeutic relationship. The items ask about the feelings, thoughts and behaviours of the clinician towards their client. E.g. 'I feel annoyed in sessions with him/her', 'I look forward to sessions with him/her' and 'I find myself discussing him/her more with colleagues or supervisors than my other patients'. The results of the questionnaire will then place participants into one of eight countertransference domains covering aspects such as feeling overwhelmed by a client, feeling overly protective towards a client or feeling disengaged from working with a client, amongst others.

Analysing the data from the survey did not produce any statistically significant results for any of the four hypotheses above. It is likely that these results were down to a small sample size with excessive variance between individual participants. On the other hand, as far as the researchers could ascertain this study was the first to expand upon previous understanding of CT reactions to clients with PD to determine how this

might unfold in forensic settings. Therefore, the non-significant results still raise a number of points of interest that warrant further study.

- Could it be the case that, whilst forensic clients may present with more risk than those in non-forensic services, maybe those with the same PD diagnoses present psychologically as very similar regardless of forensic background?
- Perhaps, due to the arguably greater complexity of the clients they meet with, forensic practitioners are more aware of and better at managing their CT reactions than their non-forensic counterparts? Those in forensic services often have access to more specialised training and more in-depth supervision than those in non-forensic services (Maden, 2006; Moore, 2012).
- Do the attitudes of forensic practitioners to clients with PD differ from those practitioners in non-forensic settings? More positive attitudes to those with PD could make forensic practitioners less susceptible to negative CT reactions.

As arguably the first of their nature, these findings indicate that further comparison between forensic and non-forensic practitioners is warranted. Further research into the nature of training, supervision and staff attitudes across different disciplines could elicit important information on how services across the board could be improved – leading to a better work environment and outcomes for both staff and service users.

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## PowerPoint Slides

Understanding countertransference reactions to forensic clients with a personality disorder diagnosis: an empirical study using the Countertransference Questionnaire.

Final Research Project for MSc Forensic and Criminological Psychology

Laura Wright (mxdlw8@nottingham.ac.uk)
Division of Psychiatry & Applied Psychology,
School of Medicine
University of Nottingham

### Aims and Rationale

We hoped to find out:

- If there was any association between a client's PD diagnosis and the countertransference (CT) reactions of the clinicians working with them.

There is little empirical research at present regarding the countertransference reactions of practitioners working in forensic settings with clients with a PD diagnosis so this is an area to expand upon.

Also, most of the existing research centred on Cluster B diagnoses.

If the data collected allowed for it, we also would look to answer the following:

- What patterns of CT are prevalent in those working with clients with particular PD diagnoses (or clusters)? (e.g. Borderline)
- Is there any association between the setting in which a clinician is working in and their CT reactions? (e.g. prison vs. secure hospital)
- Is there any association between the clients' index offence and the practitioners' CT reactions?

### Method

*Participants*

N = 17. One pt. then excluded as they did not work with PD.

Pts. worked 1:1 with clients with PD in a forensic setting.

Pts. provided some information about themselves and their client (all anonymous).

*Procedure*

Pts. recruited via online advert through LinkedIn, Twitter, Facebook and other professional sites and forums.

Survey hosted through Bristol Online Surveys.

Survey took around 20 mins to complete.

*Measures*

Countertransference Questionnaire (Betan, Heim, Zittel Conklin, & Westen, 2005).

79 item questionnaire – pts. categorised into one of eight CT domains (criticised/mistreated, helpless/inadequate, positive/satisfying, parental/protective, overwhelmed/disorganised, special/overinvolved, sexualised and disengaged).

### Results

- Chi-square tests across all four hypotheses failed to produce any statistically significant results.
- It is likely that such results were down to a small sample size with excessive variance between individual participants.
- On the other hand, to our knowledge this study was the first to expand to looking at CT reactions to clients with PD in forensic services specifically.
- Therefore, the non-significant results still raise a number of points of interest...

### Implications

'Uniqueness' of forensic sample – It is possible that the non-significant results have arisen because there is little noticeable difference between forensic clients and non-forensic clients who share the same personality disorder diagnosis.

Not all of the sample had committed an index offence (or even the same offence) – how different are the forensic clients from non-forensic clients? Same behaviours? Etc.

Nature of the client work – DBT and CBT not uniquely forensic. One participant doing forensic schema therapy.

Validity of PD diagnosis – some of the clients described were 18 – 20, validity of PD diagnosis in this age group?

Maybe forensic practitioners have different/better training/supervision and are more adept at understanding and managing countertransference reactions?

### Suggestions for future studies

- Analysis of the training and supervision given to forensic staff vs. non-forensic staff – how do they differ? Are forensic staff more equipped to handle CT?
- Attitudes to PD – how does this effect the therapeutic relationship and does this impact upon the experience of positive/negative CT reactions?
- Larger study of CT in forensic PD population – lots of variance within small sample e.g. participants working in lots of different settings and using different therapies – if there had been less variance might we have found significant results?

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## Reflective Report

This is a brief reflection on my final year research project for the MSc Forensic and Criminological Psychology qualification. The project was about countertransference reactions in those carrying out therapeutic work within a forensic setting – previous research had mostly concentrated on clinical populations and was mostly only with qualified practitioners, so we sought to expand into forensic services with any practitioners who carry out psychologically informed work, which could include trainees and assistants. Following data collection, the total sample size was insufficient and analysis failed to reach statistical significance. This paper presents the research process from a personal perspective. The structure of this report has been based around Gibbs (1988) reflective cycle.

My initial project ideas were focused on the links between institutional violence and staff burnout in forensic settings. At the time I had recently been assaulted by a patient myself, at the medium secure unit I had worked in. I was reflecting back on how that experience had made me feel and how, although initially I was anxious about returning to work and having to work therapeutically with that patient again after the assault, in practice the experience wasn't as bad as I imagined. In the past I had struggled with social anxiety and was worried I would come to be afraid of the patients I worked with but I felt okay and was 'back to my old self' sooner than I'd imagined. In my mind this was down to my experience of previous assaults and the strong staff team I was a part of. Even though the ward in which I was based was known for having some of the most complex patients and highest incident rates I had

never really felt unsafe there – my experience meant I felt confident in my abilities and our staff team were incredibly supportive and much more capable of handling incidents effectively than other teams I'd worked with. I wondered if this feeling was common amongst other forensic staff – if a worker's perceived control of violence and aggression, rather than the level of violence itself, influenced their feelings of stress and burnout when working difficult clients? This lead to the conception of my first project idea: to compare staff groups e.g. qualified vs. non-qualified, male ward vs. female ward, new staff vs. experienced staff etc. on a measure of burnout to see whether there was any relationship between their perceptions of violence and aggression in their workplace and the level of stress they subsequently experience.

I approached Dr Shihning Chou with this project idea as she had expressed interest in researching the possible association between staff burnout and coping styles among frontline forensic staff. We met and during this Shihning brought up the concept of countertransference. Admittedly it was not a term I fully understood but Shihning explained the concept and we had soon decided on researching the experience of countertransference amongst forensic staff who worked with clients with a personality disorder (PD) diagnosis using a questionnaire tool that Shihning already had available.

I was on the MSc course part-time, and worked concurrently as a healthcare assistant – doing bank work when at home in Essex and working at a unit in Nottingham also. I was to do the bulk of the course in my first year so although I had an already conceived research project, this was then put to one side for the rest of the academic year to allow me to concentrate on the other

assignments and my professional work. Looking back now, this was possibly my first mistake. I was trying to juggle too much work and put myself under a lot of stress. I lost two close family members as well during the course of the year and found myself feeling physically unwell a lot of the time because of stress.

I recommenced work on the research project the following October as I entered the second part of the course. I only had to be in lectures one day a week and had started a new job with reduced working hours to try and ease some of my stress. I put together my formal research proposal and set up my survey online. I then submitted my application for ethical clearance on 4th March and at this point I was on target with all suggested deadlines – which I had had to juggle alongside completing the final assignment for the F03 module. There were a lot of delays to gaining ethics approval, due to sickness within the ethics team. This was frustrating as I couldn't progress further with the project during this time and despite emails to the ethics admin team by myself and my supervisor there wasn't much improvement. I felt like I was wasting time when I could be collecting data – especially as it was Easter and due to formal teaching having finished I had the spare time to be doing so.

Ethical approval was eventually granted on 2nd June. Although I was given an extension on the dissertation deadline it was still irritating that it had taken almost three months to approve what was a very simple study. My online survey went live on 6th June. I got a few of my colleagues and friends to take part to check that everything was readable and working correctly. I then had some annual leave to spend time with my family at home for my birthday so I formally started advertising the survey to participants on my return. The first

participant came in on the 22nd June. I used LinkedIn, Twitter, Facebook and other social media and professional forums to advertise the study. In retrospect I wish I had added a question into the survey that asked participants where they had found the study link – to find out which method was most successful at gaining participants. However, Twitter analytics enabled me to see how many had clicked on my link and other practitioners who I engaged with on social media could share my survey link too. At one point even the chair of the British Psychological Society (BPS) Forensic Division had shared my call for participants as had other clinicians whose names I recognised or whose work I had read previously – this is certainly something positive that I will take away from the project, that I have been able to build some online links and professional relationships with other clinicians and researchers.

Despite my persistence the survey responses came in quite slowly. I was sharing my advert daily to push it to the top of forum results and expand my receiving audience as much as possible. Nearly 3000 users had viewed my survey tweets on Twitter and through other professionals sharing I theoretically had an audience of tens of thousands of potential participants (The BPS Division of Clinical Psychology twitter has 10,000 followers, the Clinpsy.org twitter page has almost 6000). Yet still, come the 22nd August over 1200 people had accessed my survey but only 17 had completed. The lack of participation really affected my motivation for the project. The responses I did have were good – they varied from trainee psychologists to psychotherapists to clinical leads all of whom had provided really detailed responses and early analysis showed the

data to be heading in the expected direction. However there just wasn't enough of it to reach statistical significance.

I had encountered a similar situation during my undergraduate research. Despite all my best efforts - which had even included standing on campus handing out leaflets to potential participants, I still failed to achieve an adequate sample and significant results. I think I really took this to heart and felt as though I was sure to fail. I believe it was at this point I started to fall behind on the project, I had never been very adept at using SPSS and my supervisor was away so I didn't know where to look for advice. I struggled to make any progress and wasted hours on SPSS trying to make sense of the data and still not getting any further. The lack of progress in my analysis meant I couldn't advance with my discussion as I didn't know in which direction to frame it. Whilst I waited for assistance from one of the statistics tutors I assumed my results would be non-significant and decided to write my discussion to this angle so I didn't fall further behind. I tried to maintain an optimistic outlook and think of ways in which I could positively frame my non-significant results – such as considering the validity of the personality disorder construct as a whole and how maybe my forensic sample was actually no different to the non-forensic samples used in the previous research. For such a small sample, there was a lot of variance between participants in terms of the services in which they worked, their clients and the type of treatment which they were carrying out – potentially if I had been able to acquire a larger sample I might have seen some really interesting and unique results.

Surprisingly, my failures in this project have really made me reflect upon what my choices should be next in my career as a whole. I've realised I'm not very academic and as I have started in a new job towards the end of this project I realise I much prefer the practical aspects of forensic psychology instead. I now know I need to consider if I am even suitable for further doctoral study and how this affects my choices. I dread the thought of working towards another research project to end with poor results and I also recognise a need to address my own stress levels and time-management when stressed. I have struggled to address the setbacks throughout this project which has ultimately led to me feeling demotivated and avoiding work in order to avoid stress. In hindsight, my own avoidance has probably contributed to its shortcomings just as much as the external factors that have affected this project.

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