



# Countertransference towards suicidal patients: a systematic review

Laurent Michaud<sup>1,2</sup> · Kyle T. Greenway<sup>1</sup> · Sylvie Corbeil<sup>1</sup> · Céline Bourquin<sup>2</sup> · Stéphane Richard-Devantoy<sup>1</sup>

Accepted: 28 January 2021

© The Author(s) 2021

## Abstract

Countertransference towards suicidal patients may blur healthcare professionals' clinical judgment and lead to suboptimal decision-making. We conducted a systematic review of the quantitative studies on this topic. Following PRISMA guidelines, various databases were searched for studies measuring countertransference in healthcare professionals treating suicidal patients. Two authors independently performed screening and the quality of included studies was formally assessed. Ten studies were identified (3/5/2 of low/intermediate/high quality, respectively). Cross-sectional studies showed evidence for specific and adverse countertransference (e.g., disinterest, anxiety, overwhelming, rejection, helplessness or distress) towards suicidal patients. Furthermore, countertransference was prospectively associated with suicidal behavior and ideation in studies that explored this issue, but the meaning of this association remains to be clarified. Healthcare professionals' characteristics (e.g. professional background, gender, personality traits) influenced countertransference. Suicidal patients elicit adverse countertransference, which should be addressed in clinical practice and through dedicated training.

**Keywords** Countertransference · Suicide · Self-harm · Mental health professionals

## Introduction

Suicidal patients are highly challenging for healthcare professionals: their wish to die strongly contrasts with the healing-perspectives of clinicians and may thus trigger strong emotional reactions (Waern, Kaiser, & Renberg, 2016). Maltsberger described these reactions as “countertransference hate” in a seminal article (Maltsberger & Buie, 1974). Countertransference was originally described by Freud as the “result of the patient’s influence on [the therapist’s] unconscious feelings” (Freud, 1957; Heiman, 1950). This definition was later broadened (Gabbard, 2001) to encompass the conscious and unconscious emotional, cognitive, and behavioral reactions by therapists towards patients.

Examining and acknowledging countertransference with suicidal patients is clinically important in at least several ways. Firstly, adverse countertransference (e.g. fear or anger) may partly explain the predominately negative attitudes of healthcare professionals towards suicidal patients (Cleaver, 2014; Rees, Rapport, Thomas, John, & Snooks, 2014; Saunders, Hawton, Fortune, & Farrell, 2012) and thus their patients’ negative experiences when receiving care (Taylor, Hawton, Fortune, & Kapur, 2009). Secondly, emotions play a large role in medical decision-making (Kozłowski, Hutchinson, Hurley, Rowley, & Sutherland, 2017) and (un)conscious aggressiveness towards suicidal patients may thus result in rejecting behaviors by healthcare professionals (Bloom, 1967) or in unnecessary compulsory hospitalizations, thus potentially affecting the prognosis of suicidal individuals. Finally, recent research shed light on countertransference towards suicidal patients as a possible predictor of suicidal outcomes (e.g. behavior or ideation) (Barzilay et al., 2018; Hawes, Yaseen, Briggs, & Galynker, 2017; Yaseen et al., 2013; Yaseen, Galynker, Cohen, & Briggs, 2017). Effectively identifying countertransference could thus improve clinical risk assessment.

To our knowledge, no systematic review has yet examined quantitative studies on countertransference with suicidal patients. This systematic review was thus designed to address three primary research questions:

---

Céline Bourquin and Stéphane Richard-Devantoy contributed equally to this work.

✉ Laurent Michaud  
laurent.michaud@chuv.ch

<sup>1</sup> Department of Psychiatry & Douglas Mental Health University Institute, McGill Group for Suicide Studies, McGill University, Montréal, Québec, Canada

<sup>2</sup> Psychiatric Liaison Service, Lausanne University Hospital, Beaumont 23, 1011 Lausanne, Switzerland

- (i) Do suicidal patients elicit specific countertransference from healthcare professionals?
- (ii) Is countertransference towards suicidal patients related to future suicidal outcomes (i.e. behaviors or ideation)?
- (iii) Which characteristics of healthcare professionals (e.g. professional background, gender, age) and settings (e.g. outpatient treatment, psychiatric hospital, emergency ward) impact countertransference towards suicidal patients?

## Methods

### Protocol and Registration

Our study followed the PRISMA statements for systematic reviews (Liberati et al., 2009; Moher, Liberati, Tetzlaff, Altman, & Group, 2009) and was registered on PROSPERO with the number CRD42017078725.

### Information Source

Medline, Pubmed, EMBASE, Web of Sciences, PsycINFO and CINAHL databases were searched from their respective first records to 30 September 2017. All the identified articles were evaluated for inclusion, as were references from five relevant PhD dissertations. The search was later updated to September 30, 2018.

### Search Strategy

The literature search was conducted for articles in English. A first search combined the largest relevant subject headings related to suicide across all the databases except for Web of sciences (Medline: medical subject heading Self-injuring-behavior; Embase Emtree: Suicidal Behavior; Psychinfo thesaurus: Suicide; CINAHL heading: Suicide) and the heading “countertransference”. A second search was performed, based on the finding that our definition of countertransference reactions did not neatly correspond with available keywords but rather encompassed a broader range of concepts. We thus combined the title/abstract [TIAB] terms Suicid\* OR self-harm OR automutilation\* with the TIAB terms countertransference OR cognitive response\* OR cognitive reaction\* OR behavioral response\* OR behavioral reaction\* OR emotional response\* OR emotional reaction\*, and with tools measuring countertransference (Feeling Word Checklist OR Checklist of feelings OR Gegenübertragungs-Rating OR Impact Message Inventory OR Rating of Emotional Attitudes to Client by Therapists OR Circle OR Psychotherapy Process Q-Set). These tools were identified on the basis of three recent systematic reviews on countertransference (Hayes, Gelso, &

Hummel, 2011; Kächele, Erhardt, Seybert, & Buchholz, 2015; Machado et al., 2014).

### Inclusion and Exclusion Criteria

Included studies had to meet all of the following criteria: (i) original research papers reporting encounters between healthcare professionals and suicidal patients; (ii) written in English; (iii) employed quantitative measures of countertransference; and (iv) published in a peer-reviewed journal. Measures of countertransference had to be based on a specific clinical encounter, or a specific set of clinical encounters, with the same patient. Studies measuring general perceptions of, or attitudes towards, self-harming or suicidal patients, or exploring reactions after suicide were excluded.

### Study Selection

After excluding duplicates, two of the authors (LM and SRD) independently screened the titles and abstract then full-texts of potential studies for inclusion, and resolved differences in opinion by a consensus process.

### Quality Assessment

As no suitable existing assessment tool was identified, we designed one based upon the work of Kirtley (Kirtley, O’Carroll, & O’Connor, 2016), and O’Connor (O’Connor, Ferguson, Green, O’Carroll, & O’Connor, 2016) (Table 1). Total scores ranged from 0 to 14 and quality was graded as low (0–4), intermediate (5–9) or high (10–14). Initial quality assessment was conducted by the first author and further validated by the last author. Disagreements were resolved by discussion until a consensus was reached.

## Results

A total of 1171 references were retrieved (excluding duplicates). Selection based on titles and abstracts led to the exclusion of 993 articles, and full-text examination resulted in the exclusion of an additional 167 (see Flowchart in Fig. 1). Data were extracted from ten studies (3/5/2 of low/intermediate/high quality, respectively) and details of each study (Barzilay et al., 2018; Colson et al., 1986; Dressler, Prusoff, Mark, & Shapiro, 1975; Gillig, Hillard, Deddens, Bell, & Combs, 1990; Hawes et al., 2017; Perry, Bond, & Presniak, 2013; Rossberg & Friis, 2003; Soulié, Bell, Jenkin, Sim, & Collings, 2018; Yaseen et al., 2013; Yaseen et al., 2017) are available in Table 2.

**Table 1** Quality assessment criteria

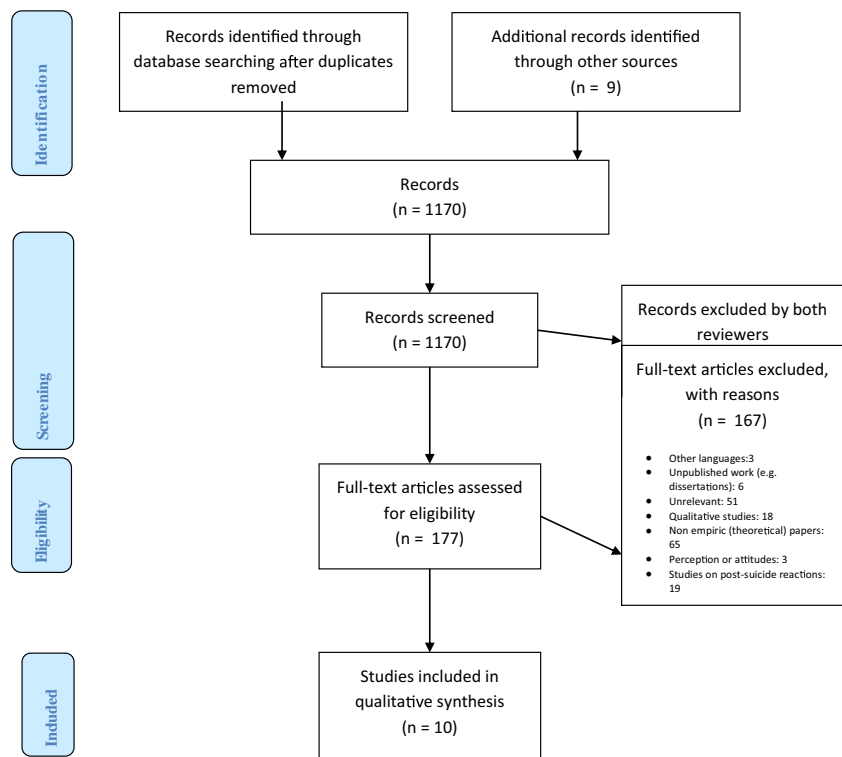
Criteria	0	1	2
Power and sample recruitment	No mention of a power calculation; major recruitment biases	Power calculation reported, but sufficient power not achieved and/or minor recruitment biases	Power achieved and no recruitment biases
Consideration of HP's variables	None	Only limited information	Detailed information
Measures of patient variables (sociodemographi, suicidal ideation/behaviour)	Non-validated scale; single question; no external judge	Validated questionnaire; impartial external judge	Validated questionnaire through independent raters
Type of countertransference reactions assessment	New ad hoc tool, non-validated	Previously used tool	Validated tool
Comparison group	No control group	Control group	
Confounding variables (double rated)	No attempt to control for confounding factors in recruitment or analyses	Accounting for basic confounding variables either during recruitment or analysis	Accounting for basic and additional confounding variables either during recruitment or analysis
Other biases	Other significant biases	Other minor biases	No other biases

**General Description of Studies**

Around 700 health professionals participated in the ten studies and their countertransference was measured from clinical encounters with 2247 patients. Patients came from outpatient/psychotherapeutic clinics (Barzilay et al., 2018; Perry et al., 2013; Soulié et al., 2018; Yaseen et al., 2013), psychiatric hospitals (Colson et al., 1986; Rossberg & Friis, 2003; Yaseen et al., 2013; Yaseen et al., 2017) and emergency wards (Dressler et al., 1975; Gillig et al., 1990). Countertransference was measured based on a mid- or long-term therapeutic relationship (Colson et al., 1986;

Perry et al., 2013; Rossberg & Friis, 2003; Soulié et al., 2018; Yaseen et al., 2013; Yaseen et al., 2017) or on a single consultation (Barzilay et al., 2018; Dressler et al., 1975; Gillig et al., 1990; Hawes et al., 2017). Five studies (Colson et al., 1986; Dressler et al., 1975; Gillig et al., 1990; Rossberg & Friis, 2003; Soulié et al., 2018) studied mainly cross-sectional associations between countertransference and suicidality and five studies (Barzilay et al., 2018; Hawes et al., 2017; Perry et al., 2013; Yaseen et al., 2013; Yaseen et al., 2017) examined countertransference as possibly related to future suicidal outcomes (Table 3).

**Fig. 1** PRISMA Flow Diagram



**Table 2** Included studies

Reference and design	Main aim Design Quality scores (score/14)	HP's variables			Patients and setting Diagnosis	Measure of suicidal behaviour and groups comparisons	Tools measuring countertransference and way of administration	Key results concerning countertransference towards suicidal patients
		Profession T=total n	Sex M/W	Mean age				
Dressler et al., (1975)	To identify clinical variables evoking strong emotions toward SA. Cross-sectional; no-control group Low quality (2)	20 PR	Unknown	24 M	248 PSH (in the last 3 days) in ED. No diagnosis available	Non formalized measures of SI, intent to die, suicidal risk, past suicidal history Recorded by PR	Dedicated checklist including 23 items mood adjectives (Tomkins & Izard, 1965), scored on a 4 points scale. Rating just after meeting patient	Three factors identified: warm and understanding (8 items), anxious and confused (8 items) and disinterest and annoyed (7 items) • Past SH history, intent to die and suicide risk were positively associated with confusion and anxiety and negatively associated with disinterest and annoyed • Past SH history and suicide risk were negatively associated with warmth and understanding
Colson et al., (1986)	To identify specific profession-relative affective responses to four patient behavior dimensions. Cross-sectional Low quality (2)	11 N 11 P 11 SW 11 O T 44	Sex: 21/23 Mean age and experience unknown		127 Psychiatric long-term inpatients PD: 56, SOPD: 75 AD: 19	Not precisely known but related to suicidal behavior.	Dedicated tool including 16 emotional reactions scored on a 5-point scale Global rating of patient	Five factors identified: angry-provoked, positive engagement, fearful, helpless-confused and protective • Suicidal-depressed behavior was not associated consistently with any affective responses for psychiatrists and activity therapists • Suicidal-depressed trendly associated with feelings in social workers (angriness, positive, helpless) and nurses (positive, fearful, protective).
Gillig, 1990 (Gillig et al., 1990)	To determine association between countertransference and decision of admission. Cross-sectional Low quality (3)		Master level social workers (n unknown, estimation 50–100), mostly female and with one to two years if experience		783 patients in ED No further information	Past suicidal behavior and ideation	Dedicated tool including 5 items scored on a 5-point scale Filling just after meeting patient	• Suicidal ideation was not associated with specific feelings on the part of therapists.
Rosberg & Friis, (2003)	To explore association between violent		Physicians, psychologists, nurses (n, sex, age and experience unknown). N estimation 20–30.		207 inpatients 165 SOPD; 42 AD/PD	Social Dysfunction and Aggression Scale: 11 items of which two measured suicidal	FWC-58 Global rating of patient: several	Two positive (important and confident) and five negative (rejected, on guard, bored,

**Table 2** (continued)

Reference and design	Main aim Design Quality scores (score/14)	HP's variables			Patients and setting Diagnosis	Measure of suicidal behaviour and groups comparisons	Tools measuring countertransference and way of administration	Key results concerning countertransference towards suicidal patients
		Profession T = total n	Sex M/W	Mean age				
Perry et al., (2013)	To study therapeutic processes and alliance associated with improvement in suicidality in long-term dynamic psychotherapy. Longitudinal High quality (10)	22 PT	Sex and age unknown	13 Y	2473 ratings of countertransference behavior and nine measured outward directed aggression.	MHs rated each patients.	overwhelmed, and inadequate) dimensions were examined: <ul style="list-style-type: none"> <li>• Suicidal behaviors were strongly related to the degree of the five components of negative feelings.</li> <li>• Patient characteristics explained much more of the variance in negative feelings than in positive</li> </ul> Diagnostic gathered only information about the presence/absence of psychosis <ul style="list-style-type: none"> <li>• Alliance moderated the relationship between negative reaction to treatment and improvement in suicidal ideation and the relationship between quality of patient-therapist interaction and improvement</li> <li>• Avoiding therapist errors emanating from negative countertransference improved the therapeutic interaction, which is followed by faster rate of improvement in suicidality</li> </ul>	
Yaseen et al., (2013)	To quantify differences in the patterns of clinician response to patients with differing levels or	MD 20 Psy 7 SW 9 O 2 T 40	19/21	Age unknown 0-5 y: 11 5-10 y: 7 10-15y: 6 15-20y: 4 >20 y: 12	82 patients 13 SOPD 43 AD 15 PD OD 11	Comparisons of clinicians countertransference with groups of patients died unexpectedly (n=16), died by suicide (n=12) or having attempted suicide with a low (n=26) or high (n=28) lethality.	Therapist Response/Countertransference Questionnaire (79 items) (Betan et al., 2005) Retrospectively rated on the last	Therapist Response Countertransference Questionnaire have eight defined subscales: overwhelmed/disorganized; helpless-inadequate; positive; special-overinvolved;

**Table 2** (continued)

Reference and design	Main aim Design Quality scores (score/14)	HPs variables			Patients and setting Diagnosis	Measure of suicidal behaviour and groups comparisons	Tools measuring countertransference and way of administration	Key results concerning countertransference towards suicidal patients
		Profession	Sex M/W	Mean age				
Hawes et al., (2017)	To establish the predictive validity of the MARIS in measuring short-term suicide risk following hospital discharge. Longitudinal Intermediate quality (9)	12 PR			59 Psychiatric inpatients admitted for SI or SA 6 SOPD 37 AD 16 OD	Cross-sectional associations between SI at time of initial assessment assessed through the Beck Scale for Suicidal Ideation (Beck et al., 1979) and MARIS. Comparison between 2 groups for prospective analysis: 53 patients without SA and 6 with SA, as determined by administration of CSSI-S.	One subscale of MARIS was TRQ-SF (see Table 4) Rated just after meeting patient	TRQ-SF is a likert-type scale score on a 4 point scale with 10 items. Specifically designed to record countertransference with suicidal patients and based on five items of countertransference questionnaire (Betan et al., 2005), two of Working Alliance Inventory (Horvath & Greenberg, 1989) and three developed de novo by researchers; see Table 4 for further details.
	types of suicidality. Retrospective and longitudinal Intermediate quality (7)						meeting before death/SA	sexualized; disengaged; parental-protective and criticized-mistreated: <ul style="list-style-type: none"> <li>Patients subsequently died by suicide generated more negative feelings (overwhelming, distress, and avoidance) but higher hope in treatment than those subsequently dying from another cause</li> <li>Items related to hope, distress, overwhelming and avoidance classified the best between patients subsequently died by suicide versus from another cause</li> </ul>
								<ul style="list-style-type: none"> <li>In cross-sectional analyzes, MARIS total score correlated with lifetime SA and SI and SI in past month but specific correlations between countertransference measured by TRQ-SF and SI/SA past history was not detailed.</li> <li>In prospective analysis, countertransference measured by the TRQ-SF independently captured differences between attempters and non-attempters.</li> </ul>



**Table 2** (continued)

Reference and design	Main aim Design Quality scores (score/14)	HP's variables			Patients and setting Diagnosis	Measure of suicidal behaviour and groups comparisons	Tools measuring countertransference and way of administration	Key results concerning countertransference towards suicidal patients
		Profession T = total n	Sex M/W	Mean age				
Yaseen et al., 2017 (2017)	To study the prospective relation between TRQ-SF and short-term suicide outcomes after hospital discharge. Longitudinal Intermediate quality (9)	12 PR	6/6	30 1 y	75 discharged psychiatric inpatients 6 SOPD 52 AD 16 OD	SI and SB were measured with CSSR (Posner et al., 2011) at admission for cross-sectional analyzes and 4–8 weeks following discharge for prospective associations. Comparison between 2 groups for prospective analysis: 68 patients without SB and 7 with SB.	TRQ-SF (see above) Filled within 24 to 48 h of patient discharge and globally rated	<ul style="list-style-type: none"> <li>In cross-sectional analyzes level of suicidal ideation at admission, lifetime history of SA, and SA leading to admission were not correlated with countertransference after discharge.</li> <li>A specific combination of Distress and Hopefulness significantly predicted post-discharge suicide outcomes after covarying for depression, entrapment, and suicidal ideation severity</li> </ul>
Barzilay et al., 2018 (2018)	To validate the TRQ-SF in a general outpatient clinic. Longitudinal High quality (12)	38 PR 2 P 2 PL 2 SW	26/22	Age unknown 4 y mean experience	346 adult outpatients included at their first visit 26 SOPD 200 AD 101 OD	At baseline for cross-sectional analyzes, past SB was measured with the CSSR (Posner et al., 2011) and SI with Beck scale for Suicide Ideation (Beck et al., 1979; Beck & Steer, 1991) For prospective analyzes at one month follow-up, SI was measured by both CSSRS and BDSI and SA were measured by CSSRS, For both cross-sectional and prospective analyzes, clinician risk assessment was measured through the Clinician Prediction Scale (Nock et al., 2010)	TRQ-SF Rating just after meeting at baseline	<p>Cross-sectional analyzes,</p> <ul style="list-style-type: none"> <li>Total TRQ-SF, subscales and all items of TRQ-SF were correlated with risk assessment by the clinician. Total TRQ-SF, affiliation subscale and items 1,2,6, and 10 were correlated with lifetime and recent SB and distress and hope subscales as well as items 5 and 8 only with lifetime SB.</li> <li>Total TRQ-SF, affiliation subscale and items 1,2,7 and 10 were correlated with SI.</li> </ul> <p>Prospective analyzes</p> <ul style="list-style-type: none"> <li>Total TRQ-SF, the three subscales and items 3, 7, 8, and 9 were associated with SI at 1-month follow-up. Total TRQ-SF, hope subscale and item 6 were associated with STB at 1-month follow-up.</li> <li>Clinician contribution</li> <li>Clinician state anxiety and clinician report of therapeutic alliance were independently associated with negative</li> </ul>

**Table 2** (continued)

Reference	Main aim and design	HP's variables			Patients and setting	Measure of suicidal behaviour and groups comparisons	Tools measuring countertransference and way of administration	Key results concerning countertransference towards suicidal patients
		Quality scores (score/14)	Profession	Sex M/W				
Soulié et al., 2018 (2018)	To provide a systematic description of countertransference to patients at risk for suicide.	46 P 147 PL 74 PT T 267	73%/26%	Age unknown 70% >11y	Outpatients treatment (psychiatric and/or psycho-therapeutic) 48% PD (86% cluster B)	“suicidal patient” as: “a person who shows or has shown suicidal behaviours (including suicidal ideation); or who has attempted suicide before AND who seems [to the clinician] to be at risk of suicide	Therapist Response/Countertransference Questionnaire (79 items) (Betan et al., 2005)	countertransference measured by the TRQ-SF total score. Seven factors identified 1) entrapped/rejecting, 2) fulfilled/engaging, 3) aroused/reacting, 4) informal/boundary crossing, 5) protective/overinvolvement, 6) ambivalent/inconsistent, and 7) mistreated/controlling. On average, clinicians reported that CT dimensions tended to not apply to them, except for the positively connoted factor.

AD Affective Disorders, CSSR Columbia Suicide Severity Rating, ED Emergency Department, HLSA High Lethality Suicide Attempts, LLSA Low Lethality Suicide Attempts, N Nurses, O Others, OD Other or unknown Diagnosis, P Psychiatrists, PD Personality Disorders, PL PsychoLogists, PR, Psychiatric Residents PT PsychoTherapists, PSH Patient who Self-Harmed, Psy Psychologists SA Suicide Attempter, SB Suicidal Behaviour (actual, interrupted, and aborted suicide attempts), SOPD Schizophrenia and Other Psychotic Disorders, SW Social Workers, TRQ-SF, Therapist Response Questionnaire-Suicide Form, U Unknown;



**Table 3** Quality ratings

Reference and design	Power and sample recruitment	Consideration of HP variables	Measures of patient variables (sociodemographic, suicidal ideation/behaviour)	Type of countertransference reactions assessment	Comparison group (presence of non-suicidal patients)	Confounding variables (PD, hetero-aggressivity, age, gender)	Total
Dressler et al., (1975)	0	0	1	1	0	0	2
Colson et al., (1986)	0	1	0	0	1	0	2
Gillig et al., (1990)	0	0	1	0	1	2	4
Rosberg & Friis, (2003)	0	0	1	2	1	2	6
Mackay & Barrowclough, (2005)	0	1	1	1	0	2	5
Wheatley & Austin-Payne, (2009)	1	1	1	1	1	2	7
Perry et al., (2013)	1	1	2	2	2	2	10
Yaseen et al., (2013)	1	0	1	2	1	2	7
Hawes et al., (2017)	1	0	2	2	2	2	9
Yaseen et al., (2017)	1	0	2	2	2	2	9
Barzilay et al., (Barzilay et al., 2018)	2	2	2	2	2	2	12
Soulié et al., (2018)	2	2	1	2	0	1	8

### Measures of Suicidality

Suicidality was most often measured in a non-formalized way through suicidal ideation, intent to die, past history, or a combination of these factors. However, three recent studies (Barzilay et al., 2018; Hawes et al., 2017; Yaseen et al., 2017) used standardized scales: the Beck Scale for Suicidal

Ideation (Beck, Kovacs, & Weissman, 1979) and the Columbia Suicide Severity Rating (Posner et al., 2011).

### Measures of Countertransference

Three studies used non-validated tools consisting of items rated on unipolar or bipolar Likert scales that ranged from 2

**Table 4** Therapist Response Questionnaire-Suicide Form

*Rate how much each of the following is true regarding how you felt with/about this patient by writing the appropriate number on the line following each item. Follow the scale below:*

- 0 – Not at all
- 1 – A little
- 2 – Somewhat
- 3 – Quite a bit
- 4 – Extremely

1. S/he made me feel good about myself. \_\_\_\_\_
2. I liked him/her very much. \_\_\_\_\_
3. I felt like my hands were tied or that I was put in an impossible bind. \_\_\_\_\_
4. I felt dismissed or devalued. \_\_\_\_\_
5. I felt guilty about my feelings toward him/her. \_\_\_\_\_
6. I thought life really might not be worth living for him/her. \_\_\_\_\_
7. This patient gave me chills. \_\_\_\_\_
8. I had to force myself to connect with him/her. \_\_\_\_\_
9. I feel confident in my ability to help him/her. \_\_\_\_\_
10. We trust one another. \_\_\_\_\_

<b>Subscales (Items 1-2-9-10 reversely scored)</b>
Affiliation (Sum of items 1-2-4-8-10)
Distress (Sum of items 3-5-7)
Hope (Sum of items 6-9)

to 7 points (Colson et al., 1986; Dressler et al., 1975; Gillig et al., 1990). Four studies used validated tools: the Feeling Word Checklist-58 (Rossberg & Friis, 2003), the Therapeutic Alliance Analogue Scales (Perry et al., 2013) and the Countertransference Questionnaire (Soulié et al., 2018; Yaseen et al., 2013). One team developed and validated a tool for measuring countertransference towards suicidal patients (Therapist Response Questionnaire-Suicide Form (TRQ-SF) (Yaseen et al., 2017): see Table 4) and used it in three studies (Barzilay et al., 2018; Hawes et al., 2017; Yaseen et al., 2017).

## Results of the Three Main Questions

### Do Suicidal Patients Elicit Specific Countertransference?

Four studies (1/2/1 of low/intermediate/high quality; 1/2/1 inpatients/outpatients/emergency patients) found significant cross-sectional associations between suicidality and countertransference (Barzilay et al., 2018; Dressler et al., 1975; Rossberg & Friis, 2003; Soulié et al., 2018), one study obtained mixed results depending on the healthcare professionals' profession (Colson et al., 1986), and one study showed no association (Gillig et al., 1990). Suicidality was associated with more anxiety, confusion, and anger among psychiatric residents assessing suicide attempters (Dressler et al., 1975). Among psychiatric nurses treating suicidal inpatients, it was associated with feelings of being rejected, on guard, bored, overwhelmed, and inadequate (Rossberg & Friis, 2003), and in therapists treating suicidal outpatients, with an "ambivalent combination" of entrapment/rejection and fulfillment/engagement (Soulié et al., 2018). In addition, a study employing the TRQ-SF found that lifetime suicidal behavior of outpatients was associated with low scores on affiliation and hope subscales and a high score on the distress subscale, whereas recent suicidal behavior/ideation was only associated with the affiliation subscale (Barzilay et al., 2018).

Two studies (one with inpatients, one with ward emergency patients) of low quality found mixed or negative results. Colson et al. (Colson et al., 1986) found associations between suicidality of inpatients and countertransference only for nurses and social workers but not psychiatrists. In terms of negative studies, Gillig and al aimed to identify specific patient characteristics or emergency ward clinicians' countertransference as predictors of psychiatric hospitalizations (Gillig et al., 1990). In this study, suicidal ideation did not generate a specific countertransference.

### Is Countertransference towards Suicidal Patients Related to Future Suicidal Outcomes?

Five high quality studies (Barzilay et al., 2018; Hawes et al., 2017; Perry et al., 2013; Yaseen et al., 2013; Yaseen et al.,

2017) examined potential associations between countertransference towards suicidal patients and future suicidal outcomes, all indeed finding associations (four with outpatients, one with inpatients). The same research team in New-York conducted four of these studies (Barzilay et al., 2018; Hawes et al., 2017; Yaseen et al., 2013; Yaseen et al., 2017). In their first (retrospective) study on psychotherapists, patients who subsequently died by suicide generated more overwhelming and disorganized countertransference, as well as a so-called paradoxical combination of high hope in the treatment with "negative" feelings (avoidance of the patient and discomfort in the treatment), as compared to those subsequently dying from another cause (Yaseen et al., 2013). Following these results, this team developed the previously mentioned tool designed specifically to study countertransference towards suicidal patients (TRQ-SF (Yaseen et al., 2017) see Table 4). This tool includes three subscales: hope, distress and affiliation. Lower hope, higher distress and lower affiliation generate higher subscores, and these last are summed for a total score. In two subsequent studies on psychiatric inpatients, the total TRQ-SF score has been shown to distinguish between future attempters and non-attempters (Hawes et al., 2017), and a specific combination of distress and hopefulness subscores predicted post-discharge suicide behaviors and ideation (Yaseen et al., 2017). In their most recent study, total score and hope subscores were associated with suicidal ideation and behavior in the month following discharge, while distress and affiliation subscores only predicted suicidal ideation (Barzilay et al., 2018). Finally, another team made a longitudinal study (Perry et al., 2013) on long-term psychodynamic psychotherapists and showed that suicidal patients elicited a "negative" countertransference (externally judged and expressed through dogmatic attitudes, rationalizations, inadequate confrontations), which was predictive of worsening suicidality (measured through the level of suicidal ideation and frequency of suicide attempts).

### Which Characteristics of Healthcare Professionals and Setting Impact Countertransference towards Suicidal Patients?

**Characteristics of Healthcare Professionals** Although characteristics of healthcare professionals were rarely taken into account in the examined studies, some associations have been identified. One high quality study found that amongst professionals treating outpatients, psychiatrists experienced a less fulfilled/engaging countertransference than psychotherapists (Soulié et al., 2018). A low quality study showed that suicidal behaviors of inpatients elicited specific countertransference in social workers (e.g. angeriness, helplessness) and in nurses (e.g. positive and protective but fearful), but not in psychiatrists (Colson et al., 1986). In the same study, female clinicians were found to be more fulfilled/engaged and less aroused/reactive than male counterparts (Colson et al., 1986). Finally, one study showed the state anxiety of psychiatry

residents to be associated with negative countertransference towards their suicidal outpatients (Barzilay et al., 2018).

**Setting** Of the two studies where healthcare professionals evaluated suicide attempters on emergency wards, both of low quality, one found psychiatric residents to be anxious, confused, and angry (Dressler et al., 1975), whereas the other showed no influence of suicidality on social workers' countertransference (Gillig et al., 1990). Regarding studies on hospital staff, three (1/2 of intermediate/high quality) had positive results, either on cross-sectional associations (Rossberg & Friis, 2003) or on countertransference as predictors of suicidal outcomes (Yaseen et al., 2013; Yaseen et al., 2017), and one low quality study found results depending on the health professionals' profession (Colson et al., 1986). The four studies, all of high quality, on therapists conducting outpatient treatments had positive results, either on cross-sectional associations (Barzilay et al., 2018; Soulié et al., 2018) or on countertransference as predictor of suicidal outcomes (Barzilay et al., 2018; Perry et al., 2013; Yaseen et al., 2013).

## Discussion

The following discussion addresses the available evidence on countertransference of healthcare professionals encountering suicidal patients based on the systematic review of ten studies. Despite important limitations, moderate and high-quality data demonstrates (i) the existence of specific and mostly adverse countertransference towards suicidal patients which depends on the level of current or recent suicidal ideation and suicidal behaviors, and (ii) associations between this countertransference and suicidal outcomes, with the caveat that causality requires further exploration. Such associations were (iii) identified across various settings, and (iv) were influenced by characteristics of the healthcare professionals (e.g. profession, gender), though evidence remains scarce on this last point.

### Specific Countertransference towards Suicidal Patients

Our results show that suicidal patients elicit disinterest, anger, anxiety, confusion, overwhelming, entrapment, rejection, inadequacy, helplessness or distress - but also engagement and fulfillment - among healthcare professionals, which suggests a specific and mostly adverse suicidal-related countertransference. Furthermore, current suicidal ideation appears to be involved in eliciting such a countertransference (Barzilay et al., 2018; Dressler et al., 1975), while the evidence is inconclusive on recent or past suicidal behavior (Barzilay et al., 2018; Colson et al., 1986; Gillig et al., 1990; Yaseen et al., 2017). This may reflect the clinical observation that current suicidality has a stronger dynamic influence on

countertransference than past suicidality. Moreover, acutely suicidal patients experience very strong emotions (e.g. hopelessness, self-hate, irritation, entrapment) (Joiner, Simpson, Rogers, Stanley, & Galynker, 2018; Rogers, Galynker, Yaseen, DeFazio, & Joiner, 2017) and countertransference may represent an "emotional contagion" of the healthcare professionals by the negative emotions of the patients, which can be understood from biological (Joiner & Stanley, 2016) and psychodynamic (Richards, 2000) perspectives. This result emphasizes that the "here and now" state of suicidal patients is crucial in suicide risk assessment. Clinicians should take care to avoid overestimating the importance of self-harm history in short-term risk assessment (Carter & Spittal, 2018), and researchers should continue to study acute suicidal states (Joiner et al., 2018; Rogers et al., 2017).

Aggressive behaviors of patients (Lion & Pasternak, 1973; Maier & Van Rybroek, 1995) and the presence of a personality disorder (Betan, Heim, Zittel Conklin, & Westen, 2005; Antonello Colli & Ferri, 2015; A. Colli, Tanzilli, Dimaggio, & Lingiardi, 2014) may also influence countertransference and have to be considered when examining our results. Two of the reviewed studies (Gillig et al., 1990; Rossberg & Friis, 2003) accounted for countertransference related to aggressive behaviors and one (Soulié et al., 2018) for personality disorder, and they confirmed that both are associated with adverse countertransference. These factors were not considered explicitly in the other studies, and their respective influence remains unclear. Future research is warranted: one study recently found that personality disorders play a role in explaining countertransference towards suicidal patients (Michaud et al., 2020) and another article showed that negative affects impact suicidal patients more when they suffer from a personality disorder (Mou et al., 2018), and such an interaction is probable regarding countertransference.

### Countertransference Related Suicidal Outcomes

Results consistent across five high quality studies show that specific patterns of countertransference may be associated with future suicidal behaviors (Barzilay et al., 2018; Hawes et al., 2017; Perry et al., 2013; Yaseen et al., 2013; Yaseen et al., 2017) and ideation (Barzilay et al., 2018; Perry et al., 2013; Yaseen et al., 2017). This relationship could be understood in several manners. As the team conducting these studies has argued, countertransference might be a marker of patients' states, in that those who have a higher future suicidal risk elicit specific countertransference reactions. Alternatively, this association may be related to the cross-sectional link discussed above between countertransference and concurrent suicidal variables (e.g. suicidal ideation or behaviors). In other words, if (i) highly suicidal patients elicit adverse countertransference and (ii) a high suicidality is a marker in terms of future suicidal behaviors and ideation, then

adverse countertransference is likely to be associated with a worse prognosis. Indeed, the core components of countertransference identified in these studies share some similarities with those observed in cross-sectional studies: mostly adverse reactions but sometimes paradoxically combined with “positive” reactions (fulfillment/engagement or higher hope). Finally, this prospective association may be due to the influence of healthcare professionals’ countertransference on future outcomes, as was acknowledged in several clinical studies decades ago (Bloom, 1967; Modestin, 1987). While these alternative explanations were briefly evoked in the studies (Barzilay et al., 2018; Hawes et al., 2017; Yaseen et al., 2013; Yaseen et al., 2017), many questions remain. Countertransference may be a consequence of a patient’s suicidality, thereby serving as an indicator of suicidal risk, but it may also have – depending on how it is managed or acted out by clinicians – a positive or negative impact on outcomes. To explore these questions, future research should aim to make longitudinal, prospective measurements of countertransference such that their predictive power can be clarified. Quality of care measures, or qualitative methods that include patient perspectives could better characterize how countertransference can influence health outcomes and affect both healthcare providers and patients. Lastly, results of these studies call for replication as the samples, especially regarding the “positive” suicidal outcomes (e.g. suicidal ideation and behaviors) are small.

### Impact on Countertransference of the Health professional’s Characteristics and of the Setting

Our results also shed light on the importance of healthcare professionals’ characteristics. Firstly, professional background seems to have an importance but results were contradictory at times (Colson et al., 1986; Soulié et al., 2018) and inconclusive overall. Further research on this topic is warranted. On the one hand, health professional’s training may have an influence on the way they moderate their reactions, e.g. psychotherapists or psychiatrists experiencing psychotherapy as a patient gaining insight on their own countertransference. On the other hand, compared to other mental health professionals, physicians usually take more responsibility for legal (e.g. compulsory admission) and therapeutic (e.g. discharge from hospital, choice of an appropriate treatment) decisions, and have to fulfill multiple tasks (e.g. psychiatric assessment and building therapeutic alliance (K. Michel et al., 2002)). Qualitative research shows that it represents a significant burden (Waern et al., 2016), and thus may engender a specific countertransference. Secondly, differences regarding gender of the health professional (Colson et al., 1986) also require confirmation. Thirdly, the only study measuring variables of the healthcare professionals’ personality showed that both state and trait anxiety of healthcare professionals may be

associated with negative countertransference (Barzilay et al., 2018). This is in line with theoretical work on countertransference with suicidal patients (Maltzberger & Buie, 1974). Altogether, our review revealed a lack of research regarding the influence of healthcare professional’s characteristics on countertransference towards suicidal patients. Indeed, studies on this question show that an important part of the countertransference variance is attributable to the healthcare professionals, though exactly how and in what way is not known (Barzilay et al., 2018; Lindqvist et al., 2017).

Regarding setting, our results were strong for psychiatric hospitals and outpatient clinics, but scarce for emergency wards. Studies on other types of patients in emergency wards found an *instant countertransference*, defined as an “instant, spontaneous set of feelings that form towards patients, even in the shortest of clinical interactions” (Moukaddam et al., 2019; Moukaddam, Tucci, Galwankar, & Shah, 2016). Further research on such countertransference towards suicidal patients would be of utmost value. On the one hand, “positive” or “negative” countertransference could influence major decisions such as discharge or hospital admission. On the other hand, the presence of adverse countertransference may trigger negative attitudes towards suicidal patients in emergency wards in a variety of hospital staff (Saunders et al., 2012). As part of a recent study in an emergency ward setting (not included in this review), we found evidence of such an instant countertransference towards suicidal patients (Michaud et al., 2020).

Of note, the two identified studies also measuring countertransference after a single clinical encounter (Barzilay et al., 2018; Hawes et al., 2017) towards outpatients outside of an emergency context found it to be predictive of suicidal outcomes. In summary, our results on this point are aligned with theoretical (Jacoby, 2004; Maltzberger & Buie, 1974) and empirical (Richards, 2000) work that focused on countertransference in psychotherapeutic settings, but confirmed that countertransference is also an actual and important consideration in every clinical encounter with patients, even if it is a once-off meeting.

### Implications for Practice

Altogether, our results raise the question of how to best manage and make use of countertransference towards suicidal patients. Psychodynamic-oriented training emphasizes the value of personal psychotherapy and individual supervision, and this would ideally be promoted for all mental health professionals, albeit at significant cost. Alternatively, specific trainings on countertransference, for example through case-based learning with simulated patients (McLean, 2016), can be implemented in undergraduate and postgraduate mental health training, in clinical settings such as psychiatric emergency departments, and in training programs on suicide risk

assessment. Such trainings should help healthcare professionals increase their capacity to recognize and manage their countertransference (Linn-Walton & Pardasani, 2014) and allow better management of suicidal patients. In addition, we believe that an approach to suicidal patients that is more patient-experience-based, collaborative, and compassionate, with less emphasis on clinician experience-based risk assessment (Hawgood & De Leo, 2016; Konrad Michel, Valach, & Gysin-Maillart, 2017) may reduce the development of adverse countertransference by promoting a more horizontal relationship between healthcare professionals and patients (Konrad Michel et al., 2017). In a recent qualitative study (Petrik, Gutierrez, Berlin, & Saunders, 2015), suicidal risk assessment was indeed shown to greatly depend on the quality of healthcare professionals' communication with patients.

## Limitations

Our conclusions must be considered with several limitations. First, study designs, settings, and measurement methods of countertransference and suicidality greatly varied across included studies, hampering any quantitative synthesis of results. Secondly, as no existing tool to assess quality was well-suited to our sample of studies, we developed our own. We, however, formalized this tool based on existing ones (Kirtley et al., 2016; O'Connor et al., 2016). Third, our literature search, although as inclusive as possible, excluded publications not available in English, as well as dissertational theses.

## Conclusions

While a recent meta-synthesis attested to the complexity of encountering patients with suicidal ideation or behavior (O'Connor & Glover, 2017), our review demonstrates that suicidal patients may elicit significantly adverse countertransference in healthcare professionals working in various settings, and that this countertransference may be related to suicidal outcomes – potentially in a causally bidirectional manner. Clinicians should be aware of the risks related to such adverse reactions, and aim to identify and manage their own countertransference in order to offer the best care possible to suicidal patients.

**Sponsor's Role** None.

**Funding** Open Access funding provided by Université de Lausanne.

**Data Availability** Data available on request from the authors.

## Declarations

**Ethical Approval Statement** All procedures performed in reviewed studies involving human participants were in accordance with the ethical standards of specific Ethics Committees mentioned in each study, and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

**Informed Consent** Informed consent was obtained from all individual participants included in the reviewed studies.

**Conflict of Interest** All authors have no conflict of interest with this text.

**Open Access** This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit <http://creativecommons.org/licenses/by/4.0/>.

## References

- Barzilay, S., Yaseen, Z. S., Hawes, M., Gorman, B., Altman, R., Foster, A., Apter, A., Rosenfield, P., & Galynker, I. (2018). Emotional responses to suicidal patients: Factor structure, construct, and predictive validity of the therapist response questionnaire-suicide form. *Frontiers in Psychiatry, 9*(104). <https://doi.org/10.3389/fpsy.2018.00104>.
- Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The scale for suicide ideation. *Journal of Consulting and Clinical Psychology, 47*(2), 343–352.
- Betan, E., Heim, A. K., Zittel Conklin, C., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *The American Journal of Psychiatry, 162*(5), 890–898. <https://doi.org/10.1176/appi.ajp.162.5.890>.
- Bloom, V. (1967). An analysis of suicide at a training center. *The American Journal of Psychiatry, 123*(8), 918–925. <https://doi.org/10.1176/ajp.123.8.918>.
- Carter, G., & Spittal, M. J. (2018). Suicide risk assessment: Risk stratification is not accurate enough to be clinically useful and alternative approaches are needed. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 39*(4), 229–234.
- Cleaver, K. (2014). Attitudes of emergency care staff towards young people who self-harm: A scoping review. *International Emergency Nursing, 22*(1), 52–61. <https://doi.org/10.1016/j.ienj.2013.04.001>.
- Colli, A., & Ferri, M. (2015). Patient personality and therapist countertransference. *Current Opinion in Psychiatry, 28*(1), 46–56.
- Colli, A., Tanzilli, A., Dimaggio, G., & Lingiardi, V. (2014). Patient personality and therapist response: An empirical investigation. *The American Journal of Psychiatry, 171*(1), 102–108. <https://doi.org/10.1176/appi.ajp.2013.13020224>.



- Colson, D. B., Allen, J. G., Coyne, L., Dexter, N., Jehl, N., Mayer, C. A., et al. (1986). An anatomy of countertransference: staff reactions to difficult psychiatric hospital patients. *Hospital & Community Psychiatry, 37*(9), 923–928.
- Dressler, D. M., Prusoff, B., Mark, H., & Shapiro, D. (1975). Clinician attitudes toward the suicide attempter. *The Journal of Nervous and Mental Disease, 160*(2–1), 146–155.
- Freud, S. (1957). The future prospects of psycho-analytic therapy. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XI (1910): Five Lectures on Psycho-Analysis, Leonardo da Vinci and Other Works* (pp. 139–152).
- Gabbard, G. O. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology, 57*(8), 983–991.
- Gillig, P. M., Hillard, J. R., Deddens, J. A., Bell, J., & Combs, H. E. (1990). Clinicians' self-reported reactions to psychiatric emergency patients: Effect on treatment decisions. *The Psychiatric Quarterly, 61*(2), 155–162.
- Hawes, M., Yaseen, Z., Briggs, J., & Galynker, I. (2017). The modular assessment of risk for imminent suicide (MARIS): A proof of concept for a multi-informant tool for evaluation of short-term. *Comprehensive Psychiatry, 72*, 88–96. <https://doi.org/10.1016/j.comppsy.2016.10.002>.
- Hawgood, J., & De Leo, D. (2016). *Suicide prediction—a shift in paradigm is needed*. Hogrefe Publishing.
- Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy (Chicago, Ill.), 48*(1), 88–97. <https://doi.org/10.1037/a0022182>.
- Heiman, P. (1950). *On countertransference Journal of Psycho-Analysis, 31, 81–84 experiences of dissertation, San Francisco, 1.6., 3607-B*.
- Jacoby, A. M. (2004). Negative countertransference in psychotherapy with suicidal patients. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 64*(11-B), 5786.
- Joiner, T. e., Simpson, S., Rogers, M. I., Stanley, I. h., & Galynker, I. i. (2018). Whether called acute suicidal affective disturbance or suicide crisis syndrome, a suicide-specific diagnosis would enhance clinical care, increase patient safety, and mitigate clinician liability. *Journal of Psychiatric Practice®, 24*(4), 274–278.
- Joiner, T. E., & Stanley, I. H. (2016). Can the phenomenology of a suicidal crisis be usefully understood as a suite of antipredator defensive reactions? *Psychiatry, 79*(2), 107–119.
- Kächele, H., Erhardt, I., Seybert, C., & Buchholz, M. B. (2015). Countertransference as object of empirical research? Paper presented at the International Forum of Psychoanalysis.
- Kirtley, O. J., O'Carroll, R. E., & O'Connor, R. C. (2016). Pain and self-harm: A systematic review. *Journal of Affective Disorders, 203*, 347–363. <https://doi.org/10.1016/j.jad.2016.05.068>.
- Kozlowski, D., Hutchinson, M., Hurley, J., Rowley, J., & Sutherland, J. (2017). The role of emotion in clinical decision making: An integrative literature review. *BMC Medical Education, 17*(1), 255.
- Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gotzsche, P. C., Ioannidis, J. P., et al. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: Explanation and elaboration. *PLoS Medicine, 6*(7), e1000100. <https://doi.org/10.1371/journal.pmed.1000100>.
- Lindqvist, K., Falkenström, F., Sandell, R., Holmqvist, R., Ekeblad, A., & Thorén, A. (2017). Multilevel exploratory factor analysis of the feeling word checklist–24. *Assessment, 24*(7), 907–918.
- Linn-Walton, R., & Pardasani, M. (2014). Dislikable clients or countertransference: A clinician's perspective. *The Clinical Supervisor, 33*(1), 100–121.
- Lion, J. R., & Pasternak, S. A. (1973). Countertransference reactions to violent patients. *American Journal of Psychiatry, 130*(2), 207–210. <https://doi.org/10.1176/ajp.130.2.207>.
- Machado, B., Coelho, F. M., Giacomelli, A. D., Donassolo, M. A., Abitante, M. S., Dall'Agnol, T., & Eizirik, C. L. (2014). Systematic review of studies about countertransference in adult psychotherapy. *Trends Psychiatry Psychother, 36*(4), 173–185. <https://doi.org/10.1590/2237-6089-2014-1004>.
- Mackay, N., & Barrowclough, C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: attributions, emotions and willingness to help. *The British Journal of Clinical Psychology, 44*(Pt 2), 255–267.
- Maier, G. J., & Van Rybroek, G. J. (1995). Managing countertransference reactions to aggressive patients.
- Maltsberger, J. T., & Buie, D. H. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry, 30*(5), 625–633.
- McLean, S. F. (2016). Case-based learning and its application in medical and health-care fields: A review of worldwide literature. *Journal of Medical Education and Curricular Development, 3*, JMECD.S20377.
- Michaud, L., Ligier, F., Bourquin, C., Corbeil, S., Saraga, M., Stiefel, F., Séguin, M., Turecki, G., & Richard-Devantoy, S. (2020). Differences and similarities in instant countertransference towards patients with suicidal ideation and personality disorders. *Journal of Affective Disorders, 265*, 669–678. <https://doi.org/10.1016/j.jad.2019.11.115>.
- Michel, K., Maltsberger, J. T., Jobes, D. A., Leenaars, A. A., Orbach, I., Stadler, K., Dey, P., Young, R. A., & Valach, L. (2002). Discovering the truth in attempted suicide. *American Journal of Psychotherapy, 56*(3), 424–437.
- Michel, K., Valach, L., & Gysin-Maillart, A. (2017). A novel therapy for people who attempt suicide and why we need new models of suicide. *International Journal of Environmental Research and Public Health, 14*(3), 243.
- Modestin, J. (1987). Counter-transference reactions contributing to completed suicide. *The British Journal of Medical Psychology, 60*(Pt 4), 379–385.
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Group, P. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine, 6*(7), e1000097. <https://doi.org/10.1371/journal.pmed.1000097>.
- Mou, D., Kleiman, E. M., Fedor, S., Beck, S., Huffman, J. C., & Nock, M. K. (2018). Negative affect is more strongly associated with suicidal thinking among suicidal patients with borderline personality disorder than those without. *Journal of Psychiatric Research, 104*, 198–201.
- Moukaddam, N., Andry, T., Cao, J., Moon, Y. M., Tucci, V., Shah, A., & Lomax, J. W. (2019). Instant countertransference affects assessment and treatment recommendations for depression in patients openly professing religious faith. *Spirituality in Clinical Practice, 6*(2), 100–109.
- Moukaddam, N., Tucci, V., Galwankar, S., & Shah, A. (2016). In the blink of an eye: Instant countertransference and its application in modern healthcare. *Journal of emergencies, trauma, and shock, 9*(3), 95.
- O'Connor, S., & Glover, L. (2017). Hospital staff experiences of their relationships with adults who self-harm: A meta-synthesis. *Psychology and Psychotherapy, 90*(3), 480–501. <https://doi.org/10.1111/papt.12113>.
- O'Connor, D. B., Ferguson, E., Green, J. A., O'Carroll, R. E., & O'Connor, R. C. (2016). Cortisol levels and suicidal behavior: A meta-analysis. *Psychoneuroendocrinology, 63*, 370–379. <https://doi.org/10.1016/j.psyneuen.2015.10.011>.
- Perry, J. C., Bond, M., & Presniak, M. D. (2013). Alliance, reactions to treatment, and counter-transference in the process of recovery from suicidal phenomena in long-term dynamic psychotherapy. *Psychotherapy Research, 23*(5), 592–605. <https://doi.org/10.1080/10503307.2013.809560>.
- Petrik, M. L., Gutierrez, P. M., Berlin, J. S., & Saunders, S. M. (2015). Barriers and facilitators of suicide risk assessment in emergency departments: A qualitative study of provider perspectives. *General*



- Hospital Psychiatry*, 37(6), 581–586. <https://doi.org/10.1016/j.genhosppsy.2015.06.018>.
- Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., et al. (2011). The Columbia–suicide severity rating scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, 168(12), 1266–1277.
- Rees, N., Rapport, F., Thomas, G., John, A., & Snooks, H. (2014). Perceptions of paramedic and emergency care workers of those who self-harm: A systematic review of the quantitative literature. *Journal of Psychosomatic Research*, 77(6), 449–456. <https://doi.org/10.1016/j.jpsychores.2014.09.006>.
- Richards, B. M. (2000). Impact upon therapy and the therapist when working with suicidal patients: Some transference and countertransference aspects. *British Journal of Guidance & Counselling*, 28(3), 325–337. <https://doi.org/10.1080/03069880050118975>.
- Rogers, M. L., Galynker, I., Yaseen, Z., DeFazio, K., & Joiner, T. E. (2017). An overview and comparison of two proposed suicide-specific diagnoses: Acute suicidal affective disturbance and suicide crisis syndrome. *Psychiatric Annals*, 47(8), 416–420.
- Rossberg, J. I., & Friis, S. (2003). Staff members' emotional reactions to aggressive and suicidal behavior of inpatients. *Psychiatric Services*, 54(10), 1388–1394. <https://doi.org/10.1176/appi.ps.54.10.1388>.
- Saunders, K. E., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders*, 139(3), 205–216. <https://doi.org/10.1016/j.jad.2011.08.024>.
- Soulié, T., Bell, E., Jenkin, G., Sim, D., & Collings, S. (2018). Systematic exploration of countertransference phenomena in the treatment of patients at risk for suicide. *Archives of Suicide Research*, 24, 1–47. <https://doi.org/10.1080/13811118.2018.1506844>.
- Taylor, T. L., Hawton, K., Fortune, S., & Kapur, N. (2009). Attitudes towards clinical services among people who self-harm: Systematic review. *The British Journal of Psychiatry*, 194(2), 104–110.
- Tomkins, S. S., & Izard, C. E. (1965). *Affect, cognition, and personality: empirical studies*. New York: Springer.
- Waern, M., Kaiser, N., & Renberg, E. S. (2016). Psychiatrists' experiences of suicide assessment. *BMC Psychiatry*, 16(1), 440. <https://doi.org/10.1186/s12888-016-1147-4>.
- Wheatley, M., & Austin-Payne, H. (2009). Nursing staff knowledge and attitudes towards deliberate self-harm in adults and adolescents in an inpatient setting. *Behavioural and Cognitive Psychotherapy*, 37(3), 293–309.
- Yaseen, Z. S., Briggs, J., Kopeykina, I., Orchard, K. M., Silberlicht, J., Bhingradia, H., & Galynker, I. I. (2013). Distinctive emotional responses of clinicians to suicide-attempting patients—a comparative study. *BMC Psychiatry*, 13, 230. <https://doi.org/10.1186/1471-244X-13-230>.
- Yaseen, Z. S., Galynker, I. I., Cohen, L. J., & Briggs, J. (2017). Clinicians' conflicting emotional responses to high suicide-risk patients association with short-term suicide behaviors: A prospective pilot study. *Comprehensive Psychiatry*, 76, 69–78. <https://doi.org/10.1016/j.comppsy.2017.03.013>.

**Publisher's Note** Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.