Title: Differences and similarities in instant countertransference towards patients with suicidal ideation and personality disorders.

Authors: Michaud L, Ligier F, Bourquin C, Corbeil S, Saraga M, Stiefel F, Séguin M, Turecki G, Richard-Devantoy S

Journal: Journal of affective disorders

Year: 2020 Mar 15

Issue: 265

Pages: 669-678

DOI: 10.1016/j.jad.2019.11.115

Differences and similarities in instant countertransference towards patients with suicidal ideation and personality disorders

1. Introduction

Countertransference was originally theorized by Freud as the "result of the patient's influence on [the therapist's] unconscious feelings" (Freud, 1957; Heiman, 1950). Although its definition remains controversial (Hayes, Gelso, & Hummel, 2011), it is considered by many authors as a joint creation involving contributions from both clinicians and patients and including both conscious and unconscious aspects (Gabbard, 2001). While Freud first presented countertransference as an obstacle to the therapeutic process, further developments of the concept, including those from Freud himself, underlined its high clinical value (Holmes, 2014). Empirical research later confirmed that its proper identification and management can facilitate diagnosis and treatment (Machado Dde et al., 2014). However, if unrecognized, countertransference may lead to suboptimal clinical decisions (da Silva & Carvalho, 2016; Hendin, Haas, Maltsberger, Koestner, & Szanto, 2006; Jobes & Linehan, 2016). Although countertransference has been conceptualized in relation to the specific setting of psychotherapy, already in 1955 Balint used the concept for the doctor-patient relationship noticing that clinicians showed reactions towards the patient from the very first consultation (Balint, 1955) These reactions are also observed among nurses and other health professionals (O'Kelly, 1998). In the emergency setting, they have been called *instant countertransference (iCT)*, 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). These reactions are based on the caregiver's "preconceived notions and prior experiences ", may be conscious or unconscious and positive or negative (Moukaddam et al., 2019; Moukaddam et al., 2016). For a caregiver, dealing with such iCT is of

utmost importance, especially in an emergency setting, where major decisions are made (such as discharge or hospital admission).

Suicidal patients are among the most challenging patients with regard to countertransference. Seminal theoretical work described the risk of "hate in the countertransference" (Maltsberger & Buie, 1974) with this population. Empirical studies later identified negative countertransference towards suicidal patients associated with adverse reactions such as high levels of distress, hopelessness, feelings of inadequacy, and apprehension (Barzilay et al., 2018; Soulié, Bell, Jenkin, Sim, & Collings, 2018; Yaseen et al., 2013). However, research on countertransference towards suicidal patients has mainly focused on clinicians in long-term working relationships with outpatients (Soulié et al., 2018; Yaseen et al., 2013) or inpatients (Rossberg & Friis, 2003). One team studied countertransference towards suicidal patients after a single encounter in a psychiatric hospital (Hawes, Yaseen, Briggs, & Galynker, 2017; Yaseen, Galynker, Cohen, & Briggs, 2017) or in an outpatient center (Barzilay et al., 2018; Barzilay et al., 2019) but, to our knowledge, no study exists in an emergency setting. Furthermore, research on countertransference or iCT towards suicidal patients rarely take into account the presence or absence of a personality disorder (PD). One study on countertransference in psychotherapy (Soulié et al., 2018) showed that, among suicidal patients, a concurrent PD exacerbated feelings of inadequacy, hopelessness and entrapment in psychotherapists. Such a gap in research is noticeable as PDs are highly prevalent among suicidal patients and also known to elicit challenging countertransference (Betan, Heim, Zittel Conklin, & Westen, 2005; Colli & Ferri, 2015)., Finally, the role of the components of suicidality - i.e. current suicidal ideations (SI), versus recent or past self-harm (SH)- in CTR remains unclear (Barzilay et al., 2018; Soulié et al., 2018; Yaseen et al., 2013; Yaseen et al., 2017). Improving our knowledge on iCT towards difficult patients is a way to address specific adverse

reactions by targeted training intervention, and thus a first step towards a better care for suicidal patients and those suffering from PDs. In this study, we aimed to evaluate the impact of SI, SH and the presence of personality disorders (PDs) on iCT by identifying among them possible predictors of iCT (primary objective) and to analyze how identified predictors were associated with specific patterns of iCT (secondary objective). We hypothesized that SI, SH and PDs would elicit different and "negative" iCT (e.g. angriness, fear, anxiety, hopelessness), without hypotheses on their specific patterns.

2. Methods

2.1. Procedure

During a six-month period, caregivers (nurses, social workers, psychologists, and physicians) working in the emergency ward and in a specialized depressive disorders outpatient clinic at the Douglas Mental Health University Institute in Montreal rated their iCT to a number of patients they met for the very first time. To ensure a balanced sample of suicidal and non-suicidal patients, caregivers were asked to rate iCT after every single consultation with patients presenting SI and/or SH in the previous 48 hours, as well as the next non-suicidal patient they saw immediately afterward. The only exclusion criteria was a current or recent episode of hetero-aggressiveness, since we considered that such behavior would significantly influence iCT.

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human subjects/patients were approved by the local research ethics committee (Douglas Hospital, Montreal, Canada). Participants were informed of the study purpose and signed a consent form.

2.2. Patients-related measures

Caregivers reported patients' sociodemographic and clinical characteristics (e.g., age, gender, nationality, socioeconomic situation, migration in the past 10 years, civil status, substance use) and information on suicidality (suicidal ideation (SI) and recent (less than 48 hours)/lifetime episodes of self-harm (SH)). They reported this information based on their own clinical judgment and following precise guidelines enclosed in every questionnaire: SI was rated on a three-point scale: no SI (e.g no desire to die); low (presence of a desire to die and/or suicidal ideation); high (presence of intrusive suicidal ideation, including a plan about specific method and, or, a specific place and, or, a specific date). Self-harm was defined inclusively as any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. Caregivers also reported psychiatric diagnoses, using both existing medical records (for patients already known) and discussion with the on-duty psychiatrist who saw every patient. Diagnoses were recorded as binary variables (presence/absence of Depressive disorders, Bipolar disorder, Anxiety disorder, Personality disorder, Psychotic disorder, Substance related disorder).

2.3. Caregivers-related measures

Participants provided basic personal information (age, sex, profession, and years of experience). To explore the role of potential confounders, we also gathered information on recent/past experience with suicide or serious suicide attempts of patients.

2.4. Instant countertransference (outcome measure)

As we aimed to capture iCT towards suicidal patients and towards patients suffering from PDs, we wanted to use tools designed for these populations. We identified the Therapist Response Questionnaire-Suicide Form (TRQ-SF), specifically developed to assess clinicians' responses towards suicidal patients. This tool was actually developed from the Therapist Response

Questionnaire (TRQ; originally called the Countertransference Questionnaire (Betan et al., 2005)), a questionnaire developed and later used to study patients suffering from PDs. TRQ was however designed to study psychotherapeutic setting and therefore not suitable to measure iCT. As we did not identify any other specific tool on iCT towards patients with a PD, , we decided to use (i) the TRQ-SF and (ii) the Feeling-Word-Checklist 30 (FWC), which is a non-specific instrument assessing countertransference.

The FWC is a checklist of 30 words recording feelings possibly present in the caregiver. It was originally developed to investigate countertransference in psychiatric nurses (Whyte, Constantopoulos, & Bevans, 1982). Holqvist et al. further adapted and validated the tool (Holmqvist & Armelius, 1994), and used it in studies in different settings (psychiatric hospitals, outpatient clinic, psychotherapy) (Holmqvist, 2000; Holmqvist & Armelius, 1996; Holmqvist & Jeanneau, 2006). We chose to use the shorter 30-item version to enhance participation in the emergency ward, as in other recent studies (de Vogel & Louppen, 2016), with a 4 points scale to rate every item (0: not at all, 1:little, 2:much, 3:very much).The TRQ-SF was specifically developed to assess clinicians 'responses towards suicidal patients after a single encounter, thus corresponding to iCT. It includes five items derived from the Therapist Response Questionnaire (Betan et al., 2005), two items from the therapist form of the Working Alliance Inventory (Horvath & Greenberg, 1989) and three items developed de novo (Yaseen et al., 2017). It is a Likert-type scale with 10 items rated by the caregiver. Items include "negative" (e.g. *I felt dismissed or devalued; I thought life really might not be worth living for him/her; I felt guilty about my feelings towards him/her*) and "positive" (e.g. *the patient made me feel good about myself; I liked him/her very much; I feel confident in my ability to help him/her)* iCT. Items range from 0 (not at all) to 4 (extremely), with positive emotional responses reversely scored; the total score ranges from 0 to

40. Previous studies identified and validated (Barzilay et al., 2018) three sub-scores of affiliation (5 items; 0–20), distress (3 items; 0–12) and hopefulness (2 items; 0–8,). The total score and sub-scores thus constitute a quantitative measures of iCT. TRQ-SF previously demonstrated a construct validity and a good internal reliability; it has been used in several studies including, psychiatrists (Barzilay et al., 2018; Barzilay et al., 2019; Hawes et al., 2017; Yaseen et al., 2017) psychologists (Barzilay et al., 2018; Barzilay et al., 2019) and social workers (Barzilay et al., 2018; Barzilay et al., 2019)) meeting suicidal inpatients (Hawes et al., 2017; Yaseen et al., 2017) and outpatients (Barzilay et al., 2018; Barzilay et al., 2019).

2.5. Statistical analysis

We conducted the analysis in two subsequent steps. To identify predictors of iCT (primary objective), we first searched for univariate associations between (i) level of SI, (ii) past and recent SH history, and (iii) presence of PD diagnosis and iCT measured by means of the TRQ-SF total and subscales scores. All variables with a <0.2 p value were integrated in a stepwise linear regression model and associations were tested with TRQ-SF scores as the dependent variable and (i), (ii), (iii) as the predictors. Patient socio-demographics and other clinical information (e.g diagnoses and substance use) were included in the model as confounding variables. As we discuss in the results section, the predictors identified were SI and presence of PDs. We then divided patients in groups (no/low/high SI and presence/absence of PDs) and compared them with regard to total TQR-SF score and sub-scores. In the second step, we analyzed how SI and presence of PDs were associated with specific patterns of iCT (secondary objective), using a stepwise linear regression model predicting the individual items of both tests (TQR-SF and FWC). Interactions between independent predictors were also tested.

Comparisons across groups were performed with SPSS 23 software, with independent t-tests for continuous variables, Mann-Whitney's U test for ordinal variables and Pearson's chi-square test (or Fisher's exact test) for categorical variables.

The vast majority of previous studies on countertransference shared the limitation of not taking into account the interdependency of data of the same caregiver (Lindqvist et al., 2017). Each caregiver may indeed have a specific pattern of countertransference, independently of the patient's characteristics, which may influence their countertransference with different patients. As other authors (Barzilay et al., 2018), we thus used the Intra-class Correlation (ICCs) for TRQ-SF and FWC scores and subscales to estimate the CTR attributable to the caregiver. Most ICCs for total score of TRQ-SF were between 0.3 and 0.6, indicating that 30% to 60% of the variance could be attributed to the caregiver's own characteristics. A multilevel analysis was therefore indicated for linear regressions. As our sample had a significant proportion of small groups (i.e. caregivers having rated less than 10 patients), a multilevel analysis had statistical weakness (Bressoux, 2010). We therefore performed both a classical and a multilevel analysis for our primary objective, which showed similar results regarding the research question. We therefore present the results on a multilevel analysis, correcting for the specific influence of each caregiver (results with classical methods are available from the authors on request). Multilevel analysis was performed with R software, using the lme4 package. All statistical tests were two-tailed, and significance was determined at the 0.05 level. We did not use Bonferroni adjustment on the multiple items of TRQ-SF and FWC, because we were testing individually different components of CTR and thus not repeating the test of the same hypothesis and since using Bonferroni corrections may increase type II error and lead to miss important findings (Moran, 2003).

3. Results

Thirty caregivers were included. Their characteristics are detailed in Table II. Caregivers rated their iCT with 321 patients (264 patients of the emergency ward and 57 outpatients from the specialized depression program). Characteristics of the patients are presented in table II.

Table III shows the multivariate analysis to identify predictors of iCT as measured by TRQ-SF scores. Regarding primary objective to identify predictors of iCT, levels of SI and presence of PDs were identified as independent predictors of total score and of several sub-scores. They were therefore tested for each item of TRQ-SF (Table IV) and FWC (Table V) (secondary objective). Contrary to SI and PDs, recent or past history of SH did not predict any TRQ-SF score, thus suggesting that the clinician's iCT was not impacted by history of self-harm. Level of patient education predicted *hopelessness* score and occupation predicted *distress* score. We compared clinical encounter grouped according to level of SI (absent, low, high) and on presence/absence of PDs and found few significant differences (table VI), thus minimizing the risk of confounding variables regarding measures of iCT. Total TRQ-SF scores and all sub-scores were significantly higher for clinical encounters with patients with PDs (figure 1); total TRQ-SF, *distress* and *hopelessness*, but not *affiliation*, were significantly higher when patients exhibited high SI (figure 2).

Figure 3 summarizes all the results. Presence of PDs independently predicted TRQ-SF *affiliation* sub-score, indicating that caregivers had a lower affinity to this population. Moreover, with these patients, individual items showed caregivers to be **more** *dismissed or devalued, guilty, manipulated, disliked, disappointed, indifferent, bored, frustrated, aloof with these patients,* and **less** *liking the patient, receptive, interested, affectionate, objective, motherly, trustful and helpful.* Level of SI independently predicted *hopelessness* and *distress TQR-SF* sub-scores, which means

that caregivers reported significantly higher level of distress and hopelessness when meeting patients with SI. In addition, caregivers *thought life really might not be worth living* for these patients, they *gave them chills* and were **more**, *suspicious, anxious, surprised*, **less** *happy* and *enthusiastic*. Finally, PDs and level of SI both predicted *total TRQ-SF score*, the fact of *feeling like having hands* **more** *tied or being put in an impossible bind*, **less** *confident in ability to help the patient and* **less** *relaxed.*

4. Discussion

Our aim was to understand the contributions of suicidality and presence of PDs on the caregivers' iCT in a first encounter with a patient. We found that level of SI and PDs elicited common adverse iCT (e.g. lacking self-confidence, being tied, feeling tensed); presence of PDs was specifically associated with iCT such as frustration, disaffiliation, guilt and SI with iCT such as distress, lack of hope, fear and sense that the patient's life had little worth. In contrast, lifetime and recent episodes of SH were not associated with a specific iCT.

Patients with SI and PDs similarly challenge caregivers' self-confidence, generating an uncomfortable feeling of being tied. However, they also present different and specific challenges. To our knowledge, our study is the first on iCT towards patients suffering from PDs; it suggested a tension in the therapeutic relationship, as it was observed in a previous research involving all-coming patients in a psychotherapeutic setting (Betan et al., 2005). Indeed, our findings showed that these patients generated reactions of *being manipulated* and *disliked*; moreover we also identified a specific *low affiliation*, which may reflect the difficulty for the caregiver to connect with these patients. In a vicious circle, other reactions such as *anger*, *frustration*, *indifference*, and *guilt* may be the result from, or result in, that lack of affiliation. More specifically, this is in line with Soulié et al.'s study (Soulié et al., 2018), which showed more inadequacy, hopelessness and

entrapment in psychotherapists towards suicidal patients suffering from PDs. On the other hand, suicidal patients elicited specific reactions evocative of pain and despair, such as *helplessness, distress* and *anxiety*. Previous studies already identified these reactions in countertransference towards inpatients (Hawes et al., 2017; Rossberg & Friis, 2003; Yaseen et al., 2017), outpatients (Barzilay et al., 2018; Barzilay et al., 2019) and psychotherapy patients (Soulié et al., 2018); however, they also observed disinterest, anger and inadequacy in reaction to suicidal patients. Our findings suggest that the latter iCT results may rather be related to the presence of PDs or personality traits. Similarly, "hate in the countertransference" towards suicidal patients, as described in the early clinical literature on countertransference (Maltsberger & Buie, 1974), may also be understood as a reaction towards aspects of the patient's personality rather than to suicidal condition per se. Finally, the *lack of enthusiasm* and *lack of happiness* that we observed in iCT to suicidal patients may reflect an (unconscious) identification of the caregiver with the suicidal patient. These results illustrate the relevance of investigating generic and specific iCT: both may have a possible negative impact on the patient (e.g. perception of hostile feelings towards him), the therapeutic alliance (which may be weakened), and the clinician (e.g. exhaustion by identification, feelings of guilt and shame). It should be noted that our results have to be considered in light of the fact that iCT and countertransference in psychotherapy are two narrow but different concepts: for instance, strong emotional reactions in the caregiver may be favored by the fact of not knowing the patient, and eventually being aware of a PD diagnosis especially in an emergency setting (Chartonas, Kyratsous, Dracass, Lee, & Bhui, 2017). We also showed unexpected results: although these are preliminary findings and further research is warranted, it seems that the caregiver's iCT is impacted by the level of patient education (independently predicting hopelessness score) and by occupation (independently predicting distress score). This association

is open to interpretation. For instance, we could speculate that caregivers may carry less hope when seeing patients with a lower education level, being less confident in their ability to recover; in addition unemployed patients may elicit distress in caregivers as unemployment is associated with an impaired mental health (Paul & Moser, 2009).

We hypothesized that clinicians meeting a patient shortly after he/she self-harmed would experience strong iCT. This was not confirmed, since neither recent nor lifetime history of SH were predictive of iCT. The result may be explained by time elapsed between their acting-out and the investigated consultation, since they were met after an initial evaluation by somatic and psychiatric staff in a general hospital, from which they had been transferred. For instance, a study considering iCT in a general hospital emergency ward where caregivers see patients minutes or a few hours after they self-harmed themselves, may have raised other results. In addition, the fact that self-harm was recorded by caregivers themselves may have introduced measure biases. Furthermore, we had an inclusive definition of self-harm (rather than, for example, considering suicide attempts with a clear intent to die), which may have diluted the iCT. With this in mind, this finding may however suggest that the "historical" (recent or lifetime SH) - while being clinically relevant with regard to risks of future self-harm - is less important than the "hic et nunc" (current suicidal ideation) in eliciting iCT in the caregiver. Previous research found that both, behaviors (e.g. outward and inward aggressions) (Colson et al., 1986) and mental states (e.g. having suicidal ideation) (Soulié et al., 2018), may elicit specific countertransference. In addition, studies on association between psychiatric diagnoses and specific countertransference showed mixed results, with several studies showing no (Colson et al., 1986; Rossberg & Friis, 2003) or weak (Holmqvist, 2000) association, but others, as stated above, associating personality traits with specific countertransference (Colli & Ferri, 2015). In our study, different personality traits probably

accounted for the specific iCT related to the diagnosis of PDs and a specific mental state of being suicidal accounted for suicidal-related iCT.

Limitations

Several limitations of our study must be considered. First, regarding statistical aspects, high ICC showed that variables related to caregivers played an important role in iCT. In order to account for this, we performed a multilevel analysis which, however, suffers from the heterogeneity of group's size. This may have an influence on our results. In addition, due to this high difference in group's size and a lack of power, we were not able to introduce caregivers' variables (e.g. socio-demographics, experience with suicides or attempts from patients, empathy and self-esteem) in our multivariate regression model. One study on countertransference among suicidal patients showed that caregivers with more anxiety and anger state and traits tended to have more negative countertransference (Barzilay et al., 2018), and another found differences in countertransference related to profession and gender (Mackay & Barrowclough, 2005). Furthermore, our patient sample was based on two settings (i.e. emergency ward (264 ratings out of 321) and outpatient specialized depressive and suicide disorders) and iCT were mostly recorded by nurses (225 ratings out of 321). In order to evaluate the possible impact of these two facts, we performed a separate analysis of the sample - (i) without physician and (ii) without patients from the outpatient program, which did not change the results. Contribution of caregivers' characteristics have nevertheless to be further explored. Second, regarding data recording, unmeasured patient's variables may have had an influence on CTR. The most important one is patient's violent behaviors, which we thus considered an exclusion criteria. In addition, our measures of psychiatric diagnosis and suicidality also lacked accuracy, since they were clinical and not formalized, and assessed by caregivers and not externally. We therefore cannot exclude that the very CTR we were assessing could have some

influence (e.g. by enactment of anger) on diagnosis of PDs by on-duty psychiatrists and/or on reporting on PDs, SH and SI by caregivers. In addition, we did not specify the type of PDs. Most of our patients consulted an emergency setting, based on epidemiological studies, we can assume a high proportion of PDs from cluster B (Soulié et al., 2018). Third, although participants were repeatedly told not to "choose" the patients they evaluated, they may have tended to pick patients either whom they identified as evoking "difficult" or "positive" iCT.This should however not have affected comparisons between groups. In addition, the fact that caregivers rated their iCT towards non-suicidal patients immediately after a suicidal patient may have influenced their iCT. Hypotheses on such an influence could tend to be "positive" (caregiver rating the afterward patient better in comparison to a possibly difficult suicidal patient) or "negative" (caregiver being emotionally negatively affected by a suicidal patient, which would color his/her iCT towards afterward patient). Fourth, even if the questionnaires were anonymous, caregivers may have been reluctant to disclose "undesirable" feelings towards patients, which could have mitigated the importance of "negative" iCT. In this regard, another study on countertransference in psychotherapy setting interestingly showed that clinicians reported that countertransference dimensions tended to not apply to them, except for the positively connoted factor (Soulié et al., 2018). As stated in the introduction, (instant) countertransference includes both conscious and unconscious phenomena. To address, at least in part, this limitation, we could have used a video documentation of the consultation and an external independent rating of countertransference, although this would have implied very complex design issues (video and informed consent of acute suicidal patients in an emergency setting). Fifth, as above mentioned, caregivers were mostly nurses, which limits the generalization of our findings to other professional categories.

Implications for clinical practice and future research

As implications in clinical practice, we can underline that adverse reactions towards suicidal and/or patients suffering from PDs may weaken the therapeutic alliance and negatively impact clinical decision-making. For example, enacting a countertransference reaction of anger, a caregiver may decide to inappropriately discharge a patient needing hospitalization, or order an abusive compulsory admission. Instant countertransference thus deserves to be better recognized and considered. Ways of working on it must be developed. While psychodynamic-oriented training promotes personal psychotherapy or psychoanalysis as a tool to enable caregivers to identify their own countertransference, this appears difficult to implement at a large scale in the real-world setting, in which persons from various professional and disciplinary backgrounds are working. Possible options include case-based learning with simulated patients (McLean, 2016), clinical supervision in small-group settings, such as the Balint groups used in general medicine(Balint, 1955; Player et al., 2018), or individual supervisions specifically addressing these situations, which have been shown effective even with a small number of sessions in other fields of medicine (Berney et al., 2017). Such interventions should be implemented both in under- and postgraduate mental health training and in clinical settings such as psychiatric emergency departments. Considering the fact that caregivers rely on different conceptual frameworks, they should be trans-theoretical, as proposed by Cartwright for example (Cartwright, Barber, Cowie, & Thompson, 2018). Adequate interventions targeting iCT may also have an effect on negative attitudes and therefore the stigmatization observed towards suicidal patients and those suffering from PDs (Chartonas et al., 2017).

Regarding research implications, a main finding of our study is that iCT, namely caregiver's immediate responses towards patients, is elicited even during a single meeting (e.g. in emergency

ward) and thus must also be taken into account. This adds to previous research, mostly conducted in psychotherapeutic or hospital settings (Barzilay et al., 2018; Rossberg & Friis, 2003; Soulié et al., 2018; Yaseen et al., 2013), reporting on interactions with the patients over a longer period. In other words: the chapter on countertransference is not closed yet, and we consider that our results, challenging some of the existing literature, illustrate the need to further investigate countertransference. Specific (instant) countertransference should be studied not only with regard to clinical situations or psychiatric diagnoses, but also with regard to how psychopathology manifests itself, be it as a verbal expression, a relational stance or as enactment with different degrees of hostility and violent behavior.

Conclusions

Our study corroborated the hypothesis that the presence of PDs and SI in the patient generates significant iCT in the caregiver after a single patient encounter. According to our findings, both patients with SI and those suffering from PDs challenge the caregivers' self-confidence. Specifically, PDs alter affiliation and suicidality diminishes hope and increases anxiety. These adverse iCT may have harmful consequences on the patient and the clinician. We believe that mental health institutions have the duty to promote specific strategies to address them.

References

Balint, M. (1955). The doctor, his patient, and the illness. *The Lancet, 265*(6866), 683-688.

Barzilay, S., Yaseen, Z. S., Hawes, M., Gorman, B., Altman, R., Foster, A., . . . Galynker, I. (2018). Emotional Responses to Suicidal Patients: Factor Structure, Construct, and Predictive Validity of the Therapist Response Questionnaire-Suicide Form. *Front Psychiatry, 9*(104). doi:10.3389/fpsyt.2018.00104

Barzilay, S., Yaseen, Z. S., Hawes, M., Kopeykina, I., Ardalan, F., Rosenfield, P., . . . Galynker, I. (2019). Determinants and Predictive Value of Clinician Assessment of Short‐Term Suicide Risk. *Suicide and Life‐Threatening Behavior, 49*(2), 614-626.

Berney, A., Carrard, V., Schmid Mast, M., Bonvin, R., Stiefel, F., & Bourquin, C. (2017). Individual training at the undergraduate level to promote competence in breaking bad news in oncology. *Psycho‐oncology, 26*(12), 2232-2237.

Betan, E., Heim, A. K., Zittel Conklin, C., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. *Am J Psychiatry, 162*(5), 890-898. doi:10.1176/appi.ajp.162.5.890

Bressoux, P. (2010). *Modélisation statistique appliquée aux sciences sociales*: De boeck Brussels.

Cartwright, C., Barber, C., Cowie, S., & Thompson, N. (2018). A trans-theoretical training designed to promote understanding and management of countertransference for trainee therapists. *Psychotherapy Research, 28*(4), 517-531. doi:10.1080/10503307.2016.1252071

Chartonas, D., Kyratsous, M., Dracass, S., Lee, T., & Bhui, K. (2017). Personality disorder: still the patients psychiatrists dislike? *BJPsych Bulletin, 41*(1), 12-17.

Colli, A., & Ferri, M. (2015). Patient personality and therapist countertransference. *Current Opinion in Psychiatry, 28*(1), 46-56.

Colson, D. B., Allen, J. G., Coyne, L., Dexter, N., Jehl, N., Mayer, C. A., & Spohn, H. (1986). An anatomy of countertransference: staff reactions to difficult psychiatric hospital patients. *Hosp Community Psychiatry, 37*(9), 923-928.

da Silva, J. V., & Carvalho, I. (2016). Physicians Experiencing Intense Emotions While Seeing Their Patients: What Happens? *The Permanente journal, 20*(3), 31.

de Vogel, V., & Louppen, M. (2016). Measuring feelings of staff members towards their most complex female and male forensic psychiatric patients: a pilot study into gender differences. *International Journal of Forensic Mental Health, 15*(2), 174-185.

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. *J Clin Psychol, 57*(8), 983-991.

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. doi:10.1016/j.comppsych.2016.10.002

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy (Chic), 48*(1), 88-97. doi:10.1037/a0022182

Heiman, P. (1950). *On countertransference Journal of Psycho-Analysis, 31, 81-84 experiences of dissertation, San Francisco, 1.6., 3607-B*.

Hendin, H., Haas, A. P., Maltsberger, J. T., Koestner, B., & Szanto, K. (2006). Problems in psychotherapy with suicidal patients. *Am J Psychiatry, 163*(1), 67-72. doi:10.1176/appi.ajp.163.1.67

Holmes, J. (2014). Countertransference before Heimann: An historical exploration. *Journal of the American Psychoanalytic Association, 62*(4), 603-629.
Holmqvist, R. (2000). Staff feelings and patient diagnosis. *The Canadian Journal of Psychiatry, 45*(4), 349-356.
Holmqvist, R., & Armelius, B.-Å. (1996). Sources of therapists' countertransference feelings. *Psychotherapy Research, 6*(1), 70-78.
Holmqvist, R., & Armelius, B. Å. (1994). Emotional reactions to psychiatric patients: Analysis of a feeling checklist. *Acta Psychiatr Scand, 90*(3), 204-209.
Holmqvist, R., & Jeanneau, M. (2006). Burnout and psychiatric staff's feelings towards patients. *Psychiatry research, 145*(2), 207-213.
Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223.
Jobes, D. A., & Linehan, M. M. (2016). *Managing Suicidal Risk, Second Edition: A Collaborative Approach*: Guilford Publications.
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.
Machado Dde, 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. doi: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. *Br J Clin Psychol, 44*(Pt 2), 255-267. doi:10.1348/014466505x29620
Maltsberger, J. T., & Buie, D. H. (1974). Countertransference hate in the treatment of suicidal patients. *Arch Gen 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.
Moran, M. D. (2003). Arguments for rejecting the sequential Bonferroni in ecological studies. *Oikos, 100*(2), 403-405. doi:doi:10.1034/j.1600-0706.2003.12010.x
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.
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'Kelly, G. (1998). Countertransference in the nurse-patient relationship: a review of the literature. *J Adv Nurs, 28*(2), 391-397.
Paul, K. I., & Moser, K. (2009). Unemployment impairs mental health: Meta-analyses. *Journal of Vocational behavior, 74*(3), 264-282.
Player, M., Freedy, J. R., Diaz, V., Brock, C., Chessman, A., Thiedke, C., & Johnson, A. (2018). The role of Balint group training in the professional and personal development of family medicine residents. *The International Journal of Psychiatry in Medicine, 53*(1-2), 24-38.
Rossberg, J. I., & Friis, S. (2003). Staff members' emotional reactions to aggressive and suicidal behavior of inpatients. *Psychiatr Serv, 54*(10), 1388-1394. doi:10.1176/appi.ps.54.10.1388
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*, 1-47. doi:10.1080/13811118.2018.1506844

Whyte, C. R., Constantopoulos, C., & Bevans, H. G. (1982). Types of countertransference identified by Q-analysis. *Br J Med Psychol, 55*(Pt 2), 187-201.

Yaseen, Z. S., Briggs, J., Kopeykina, I., Orchard, K. M., Silberlicht, J., Bhingradia, H., & Galynker, II. (2013). Distinctive emotional responses of clinicians to suicide-attempting patients--a comparative study. *BMC Psychiatry, 13*, 230. doi:10.1186/1471-244X-13-230

Yaseen, Z. S., Galynker, II, 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. *Compr Psychiatry, 76*, 69-78. doi:10.1016/j.comppsych.2017.03.013

Figure 1 : TRQ-SF scores with and without personality disorders (PD)

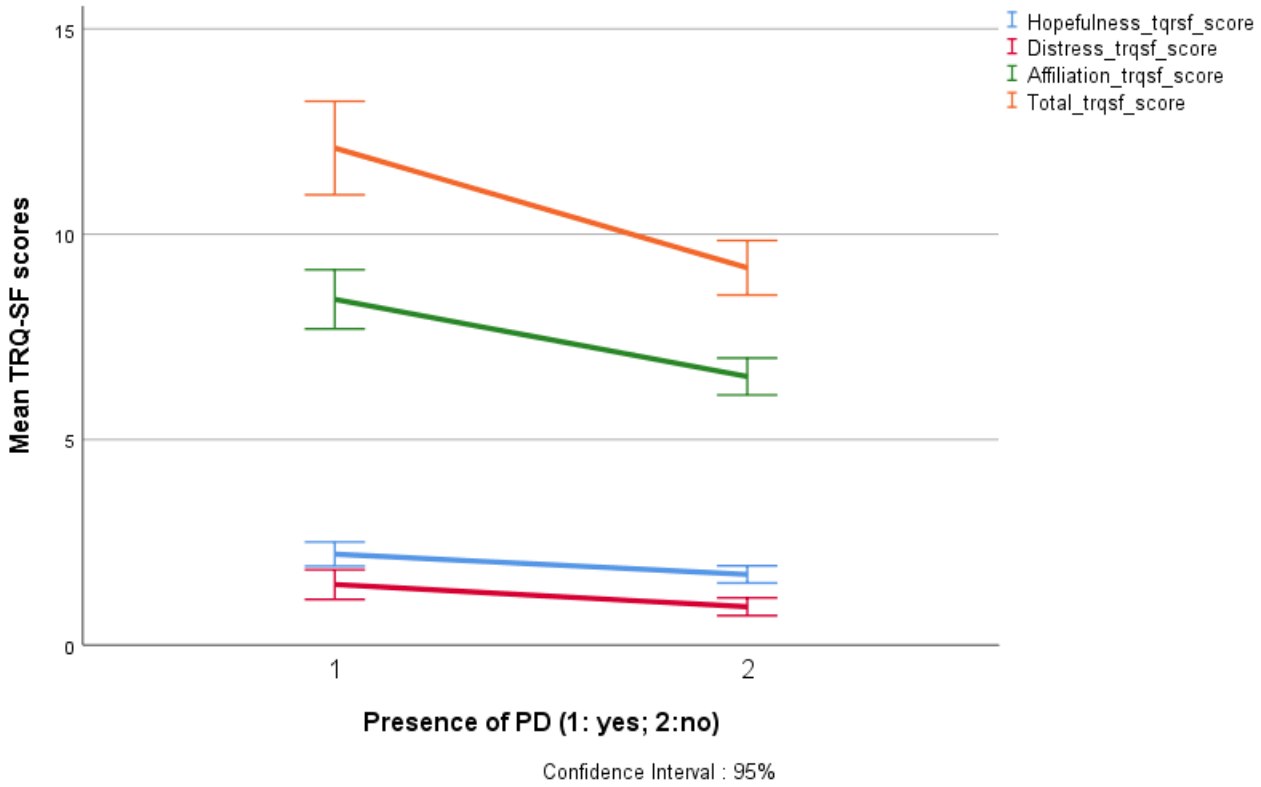

Figure 2 : TRQ-SF scores with different levels of suicidal ideation (SI)

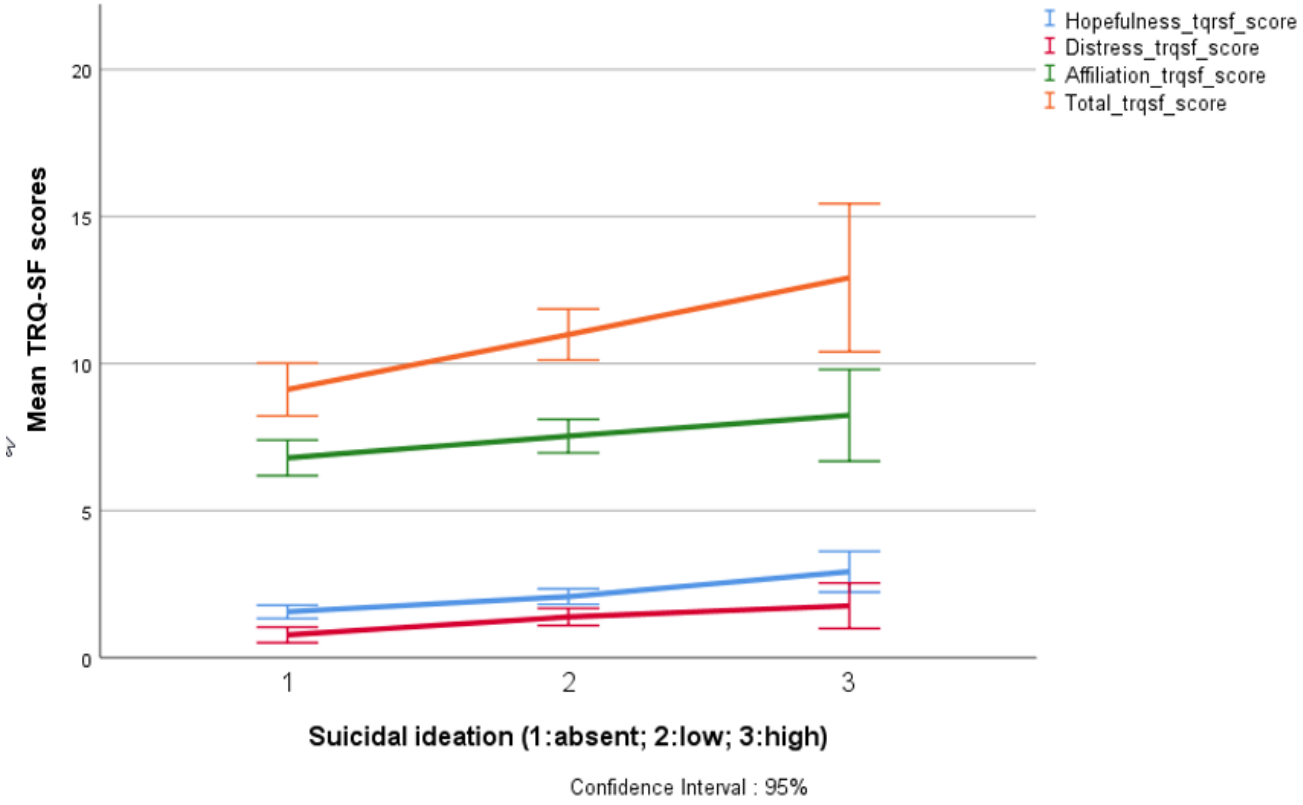

Figure 3 Specificity of PD-related and suicidal related-CTR

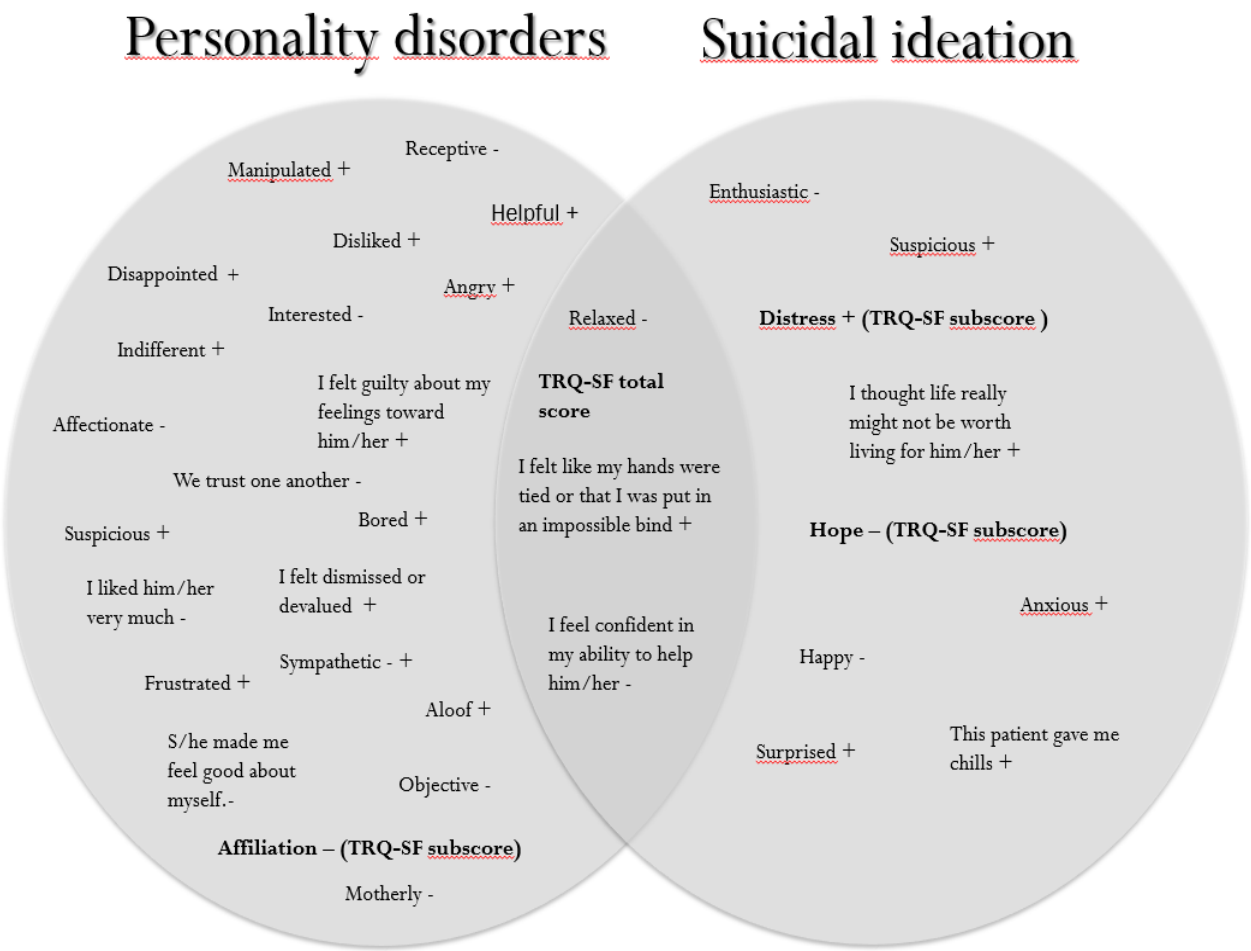

Table I: Caregivers characteristics (n=30)

Female gender, N (%)	18 (60)	
Age, mean (range)	40 (26-60)	
Profession	N (%)	patients rated N (%)
Nurse	23 (74)	225 (70)
Psychologists	4 (13)	32 (10)
Social workers	2 (6)	26 (8)
Psychiatrist	1 (3)	38 (12)
Experience with a patient died by suicide, N (%)		
Less than one year ago	5 (17)	
Between 1 and 3 years ago	4 (13)	
More than 3 years ago	6 (20)	
Never	14 (47)	
No information	1 (3)	
Experience with a patient doing a severe suicide attempt, N (%)		
Less than one year ago	14 (47)	
Between 1 and 3 years ago	5 (17)	
More than 3 years ago	3 (10)	
Never	7 (23)	
No information	1 (3)	
Years of working in mental health	0	
0-1 year	2 (7)	
1-3 years	4 (13)	
3-5 years	8 (27)	
5-10 years	11 (37)	
10-20 years	2 (7)	
20-30 years	2 (7)	
More than 30 years	1 (3)	
No information		

Table II: Patient characteristics (n=321)

Gender (Female), N (%)	175 (54.5)
Age, mean (SD)	36.7 (14.3)
Civil status	
Single, N (%)	198 (62.5)
Level of education, N (%)	
Primary school	9 (3.7)
Secondary school	102 (42.0)
High school	74 (30.5)
University	58 (23.9)
Occupation, N (%)	
Work/study/stay-at-home work)	171 (57.4)
Other (retired, invalidity, unemployment)	127 (39.6)
Having child, N (%)	107 (35.0)
Suicidal ideation, N (%)	
No	144 (44.9)
Low	152 (47.4)
High	25 (7.8)
Diagnosis, N (%)	
Depressive disorders	171 (53.6)
Bipolar disorder	23 (7.2)
Anxiety disorder	52 (16.2)
Personality disorder	123 (38.3)
Psychotic disorder	55 (17.1)
Substance related disorder	51 (15.9)
Other	41 (12.8)
Past history of self-harm, N (%)	
Lifetime	145 (46.0)
Last 24h	61 (19.0)
Substance related problems past 3 months, N (%)	
Alcohol	71 (24.4)
Cannabis	60 (20.5)
Psychostimulants	44 (15.3)
Opiates	12 (4.3)

Table III: Multivariate linear regression between patients' variables and TQR-SF

	TQR-SF total score				Affiliation subscale				Distress				Hopefulness			
	Univariate		Multivariate		Univariate		Multivariate		Univariate		Multivariate		Univariate		Multivariate	
	Estimate (std error)	p	Estimate (std error)	p	Estimate (std error)	p	Estimate (std error)	p	Estimate (std error)	p	Estimate (std error)	p	Estimate (std error)	p	Estimate (std error)	p
Personality disorder	-2.89 (0.60)	2.93e-06 ***	-2.49 (0.64)	0.0001 ***	-2.03 (0.39)	4.85e-07 ***	-1.90 (0.42)	8.5e-06 ***	-0.41 (0.19)	0.027*	Ns	Ns	-0.38 (0.16)	0.017*	Ns	Ns
Suicidal ideation	1.66 (0.47)	0.0005 ***	1.22 (0.47)	0.010 *	0.65 (0.31)	0.038 *	0.38 (0.30)	0.219	0.50 (0.14)	0.0004 ***	0.41 (0.14)	0.0044 **	0.46 (0.12)	0.00015 ***	0.38 (0.12)	0.0022 **
Life history of SH	1.85 (0.56)	0.0014 **	Ns	Ns	0.98 (0.36)	0.01**	Ns	Ns	0.46 (0.17)	0.0066 **	Ns	Ns	.40 (0.14)	0.00674 **	Ns	Ns
Recent history of SH	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns
Presence of children	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	-0.06 (0.03)	0.0534	Ns	Ns
Alcohol	-0.28 (0.10)	0.003**	Ns	Ns	-.19 (0.06)	0.002 **	Ns	Ns	-.06 (0.03)	0.026 *	Ns	Ns	Ns	Ns	Ns	Ns
Level of education	Ns	Ns	Ns	Ns	-0.08 (0.04)	0.09	Ns	Ns	Ns	Ns	Ns	Ns	-.04 (0.02)	0.028*	-0.04 0.02	0.028*
Opiates	-.21 (0.08)	0.011 *	Ns	Ns	-.15 (0.05)	0.005**	Ns	Ns	-.04 (0.02)	0.097 .	Ns	Ns	Ns	Ns	Ns	Ns
Cannabis use	-0.18 (0.10)	0.070	Ns	Ns	-0.13 (0.07)	0.044 *	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns
Occupation	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	-.08 (0.035)	0.022 *	-.08 (0.04)	0.027 *	Ns	Ns	Ns	Ns
Psychostimulants use	-0.21 (0.09)	0.021 *	Ns	Ns	-0.15 (0.06)	0.007 **	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns	Ns
Signif. codes: 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1																

Table IV: Level of SI and presence of PD as predictors of TRQ-SF individual items (linear regression)

	Presence of PD		Suicidal ideation	
	Estimate (std error)	p	Estimate (std error)	p
S/he made me feel good about myself.	-0.39 (0.12)	0.0011 **	0.17 (0.090)	0.059
I liked him/her very much.	-0.27 (0.12)	0.025 *	0.16 (0.094)	0.094
I felt like my hands were tied or that I was put in an impossible bind.	-0.34 (0.11)	0.0025 **	0.25 (0.09)	0.0047 **
I felt dismissed or devalued.	-0.27 (0.072)	0.00020 ***	-0.032 (0.055)	0.56
I felt guilty about my feelings toward him/her.	-0.14 (0.069)	0.042 *	0.089 (0.053)	0.095
I thought life really might not be worth living for him /her.	-0.0069 (0.092)	0.94	0.24 (0.071)	0.00081 ***
This patient gave me chills.	0.15 (0.079)	0.0649	0.13 (0.06)	0.027 *
I had to force myself to connect with him/her.	-0.50 (0.12)	3.0e-05 ***	0.11 (0.091)	0.22
I feel confident in my ability to help him/her.	-0.30 (0.11)	0.0066 **	0.21 (0.085)	0.016 *
We trust one another.	-0.50 (0.11)	1.5e-05 ***	0.051 (0.086)	0.55
Signif. codes: 0 ‘***’ 0.001 ‘**’ 0.01 ‘*’ 0.05 ‘.’ 0.1 ‘ ’ 1				

Table V: Level of SI and presence of PD as predictors of FWC individual items (linear regression)

When I am in conversations with this patient, I feel …	Presence of PD		Suicidal ideation	
	Estimate (std error)	p[&]	Estimate (std error)	p[&&]
Helpful	0.26 (0.092)	0.0044 **	-0.12 (0.070)	0.092
Happy	0.15 (0.10)	0.12	-0.18 (0.077)	0.024 *
Angry	-0.17 (0.074)	0.023 *	0.094 (0.057)	0.10
Enthusiastic	0.19 (0.10)	0.064	-0.24 (0.078)	0.0024 **
Anxious	-0.0016 (0.080)	0.98	0.16 (0.061)	0.012 *
Strong	0.14 (0.087)	0.10	0.12 (0.067)	0.070
Manipulated	-0.44 (0.091)	1.8e-06 ***	0.11 (0.070)	0.12
Relaxed	0.23 (0.093)	0.014 *	-0.15 (0.071)	0.035 *
Cautious	-0.12 (0.10)	0.24	0.15 (0.077)	0.057 .
Disappointed	-0.16 (0.070)	0.026 *	0.065 (0.054)	0.23
Indifferent	-0.14 (0.071)	0.046 *	0.021 (0.054)	0.70
Affectionate	0.26 (0.089)	0.0037 **	-0.019 (0.068)	0.78
Suspicious	-0.27 (0.088)	0.0019 **	0.14 (0.067)	0.037 *
Sympathetic	0.22 (0.097)	0.024 *	-0.059 (0.074)	0.42
Disliked	-0.26 (0.075)	0.00066 ***	-0.028 (0.057)	0.63
Surprised	0.037 (0.076)	0.62	0.13 (0.058)	0.02 *
Tired	-0.021 (0.085)	0.80	0.036 (0.065)	0.58
Threatened	-0.041 (0.060)	0.50	0.025 (0.046)	0.58
Receptive	0.20 (0.074)	0.0066 **	0.011 (0.056)	0.84
Objective	0.15 (0.070)	0.038 *	0.039 (0.053)	0.47
Overwhelmed	0.018 (0.073)	0.80	0.075 (0.056)	0.19
Bored	-0.32 (0.076)	4.5e-05 ***	0.080 (0.058)	0.17
Motherly	0.21 (0.094)	0.027 *	-0.023 (0.072)	0.75
Confused	-0.019 (0.057)	0.75	0.079 (0.044)	0.071 .
Embarassed	-0.097 (0.060)	0.11	0.027 (0.046)	0.56
Interested	0.28 (0.081)	0.00051 ***	-0.090 (0.062)	0.15
Aloof	-2.6e-01 (7.4e-02)	0.00046 ***	7.5e-04 (5.6e-02)	0.99
Sad	0.060 (0.072)	0.41	0.073 (0.055)	0.18
Inadequate	-0.11 (0.060)	0.062	0.069 (0.046)	0.13
Frustrated	-0.20 (0.083)	0.014 *	0.10 (0.063)	0.12
Signif. codes: 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1; [&]**Levene test;** [&&] **ANOVA**				

Table VI: Groups of patients

	Total	Highly suicidal	Suicidal	Non suicidal	*p*-value	PD	No PD	*p*-value #
Sample, N (%)	321 (100)	25 (7.8)	152 (47.4)	144 (44.9)		123 (38.3)	198 (61.7)	
Female gender, n (%)	175 (54.5)	17 (68)	87 (57.2)	71 (49.3)	Ns	79 (64.2)	96 (48.5)	0.006
Age, mean (SD)	36.7 (14.3)	40.1 (15.8)	34.4 (12.9)	38.4 (15.0)	Ns	34.1 (13.1)	38.2 (14.8)	Ns
Single, n (%)	198 (62.5)	14 (58.3)	97 (63.8)	87 (61.7)	Ns	93 (75.6)	105 (54.1)	0.027
Level of education, n (%)								
Primary school	9 (3.7)	0	2 (1.7)	7 (6.5)	Ns	3 (3.0)	6 (4.2)	Ns
Secondary school	102 (42.0)	7 (35)	50 (43.1)	45 (42.1)		37 (36.6)	65 (45.8)	
High school	74 (30.5)	8 (40)	39 (33.6)	27 (25.2)		37 (36.6)	37 (26.1)	
University	58 (23.9)	5 (25)	25 (21.6)	28 (26.2)		24 (23.8)	34 (23.9)	
Occupation, n (%)								
Work/study/stay-at-home work	171 (57.4)	11 (50)	87 (60.4)	73 (55.3)	Ns	69 (61.1)	102 (55.1)	Ns
Other (retired, invalidity, unemployment)	127 (39.6)	11 (50)	57 (39.6)	59 (44.7)		44 (38.9)	83 (44.9)	
Childs, n (%)	107 (35.0)	10 (45.5)	49 (34.0)	48 (34.3)	Ns	30 (24.4)	77 (41.2)	0.004
Suicidal ideation, n (%)								
No	144 (44.9)					40 (32.5)	104 (52.5)	<0.001
Low	152 (47.4)					77 (62.6)	75 (37.9)	
High	25 (7.8)					6 (4.9)	19 (9.6)	
Diagnosis, n (%)								
Depressive disorders	171 (53.6)	16 (64.0)	86 (57.0)	69 (48.3)	Ns	55 (44.7)	116 (58.6)	Ns
Bipolar disorder	23 (7.2)	0	12 (7.9)	11 (7.6)	Ns	9 (7.3)	14 (7.1)	Ns
Anxiety disorder	52 (16.2)	4 (16.0)	24 (15.8)	24 (16.7)	Ns	10 (8.1)	42 (21.2)	0.002
Personality disorder	123 (38.3)	6 (24.0)	77 (50.7)	40 (27.8)	< 0.01			
Psychotic disorder	55 (17.1)	3 (12.0)	14 (9.2)	38 (26.4)	< 0.01	10 (8.1)	45 (22.7)	0.001
Substance related disorder	51 (15.9)	2 (8.0)	27 (17.8)	22 (15.3)	Ns	10 (8.1)	41 (20.7)	0.003
Other	41 (12.8)	6 (28.6)	17 (11.2)	15 (10.4)	< 0.01	11 (8.9)	30 (15.2)	ns
Past history of self-harm (self-reported), n (%)								
Lifetime	145 (46.0)	18 (72.0)	90 (59.2)	62 (43.1)	< 0.01	83 (67.5)	87 (43.9)	<0.001
Last 48h	61 (19.0)	5 (20.0)	40 (26.3)	16 (11.1)	< 0.01	37 (30.1)	24 (12.1)	<0.001
Substance related problems past 3 months, n (%)								
Alcohol	71 (24.4)	4 (19.0)	39 (28.5)	28 (21.1)	Ns	26 (23.4)	45 (25.0)	Ns
Cannabis	60 (20.5)	3 (13.0)	34 (24.8)	23 (17.3)	Ns	21 (21.4)	36 (19.9)	Ns
Psychostimulants	44 (15.3)	1 (4.5)	24 (17.9)	19 (14.5)	Ns	15 (14.0)	29 (16.1)	Ns
Opiates	12 (4.3)	0	9 (6.9)	3 (2.4)	Ns	3 (2.8)	9 (5.2)	Ns

Score TRQ-SF, mean (SD)								
Total score	10.30 (5.60)	12.92 (6.10)	10.99 (5.43)	9.12 (5.45)	< 0.01	12.10 (6.38)	9.18 (4.74)	0.000
Affiliation	7.26 (3.66)	8.24 (3.78)	7.53 (3.57)	6.79 (3.69)	0.08	8.41 (4.04)	6.54 (3.21)	0.000
Distress	1.14 (1.76)	1.76 (1.88)	1.38 (1.81)	0.77 (1.61)	< 0.01	1.47 (2.03)	0.93 (1.54)	0.007
Hope	1.91 (1.57)	2.92 (1.68)	2.07 (1.63)	1.56 (1.37)	< 0.01	2.21 (1.64)	1.72 (1.49)	0.000

Signif. codes: 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1 ; # : chi-2, Pearson and Anova; PD : Personality Disorders ; SD : Standard Deviation ; TRQ-SF: Therapist Response Questionnaire-Suicide Form :