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COMMENTARY

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Empirical support for the use and further study of the countertransference construct in the clinical care of patients with bipolar disorder

Alberto Stefana[1] | Eric A. Youngstrom[2] | Eduard Vieta[3]

[1]Institut d'Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS), Barcelona, Spain

[2]Department of Psychology and Neuroscience, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA

[3]Department of Psychiatry and Psychology at the Hospital Clinic, University of Barcelona, Barcelona, Spain

Correspondence
Alberto Stefana, Institut d'Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS), Barcelona, Catalunya, Spain.
Email: alberto.stefana@gmail.com

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We thank Andrew Shaw and colleagues for their recent paper[1] in *Bipolar Disorders*, highlighting that the effective treatment of patients with bipolar disorder requires a good therapeutic alliance, which is related to the clinicians' countertransference reactions and their management. The authors suggest that the integration of a psychodynamic approach into the biological paradigm in psychiatry might be helpful to increase countertransference awareness in clinicians, and potentially improving dyadic communication, resolution of alliance ruptures, and treatment adherence. They also mention that although the theoretical literature on countertransference is well developed, no good empirical studies exist that investigate the countertransferential responses experienced by mental health clinicians involved in the care of individuals during acute phases of bipolar disorder. We would, however, like to add some examples of empirical evidence for the use (and further study) of the countertransference in the clinical care of these patients.

A substantial and growing body of research exists for countertransference indicating that patients with the same diagnosis tend to elicit specific and similar countertransferential responses. For example, a study[2] assessing psychiatrists and senior psychiatry residents' subjective experiences of new patients at the first clinical diagnostic interview found that clinicians experienced significantly higher levels of tension, impotence, difficulty in attunement, and disconfirmation with patients diagnosed with bipolar I disorder (n = 59 with current episode manic or mixed and with no comorbid cluster A or B personality disorder) than with patients with unipolar depressive and anxiety. Conversely, clinicians had fewer difficulties in attunement with bipolar than with schizophrenic patients, as well as greater engagement with and less feeling of being disconfirmed by patients with bipolar than cluster B personality-disordered patients. Similarly, a recent systematic review[3] on patient personality and therapist reactions in individual psychotherapy settings also found that patients who share the same personality features or disorders tend to evoke specific and similar patterns of countertransference response in their therapists. Despite the studies included in the review excluded patients with psychotic symptoms or disorder or psychopathology that could have complicated differentiation between personality traits and psychological states, the fact that persons with bipolar disorder have high rates of coexisting psychiatric conditions, including, in more than a third of cases, personality disorders, leads us to hypothesize that countertransference responses toward bipolar patients might be coherently and predictably related also to patient's personality characteristics, at least during the euthymic and depressive phases. Furthermore, it is likely that bipolar disorders, due to its core features—such as emotional dysregulation, psychotic symptoms, recurrence of illnes episodes, high rates of self-injury, and presence of negative feelings due to prior ineffective treatments for misdiagnosis, along with the above mentioned high rates of comorbidity and personality issues—might evoke even more *complex* and *intense* countertransference reactions in clinical work,

especially during episodes of mixed hypomania, mania or depression with psychotic symptoms. This would be particularly important considering that findings from a recent meta-analysis indicate that successful countertransference management is related to better psychotherapy outcomes ($r = 0.39$).[3]

Finally, it should be mentioned that also the existence of specific and mostly adverse countertransferential reactions towards suicidal patients has increasing empirical support. For example, a pilot study[4] involving adults psychiatrically hospitalized for suicide risk (including 11 subjects with diagnosis of bipolar disorder type I, II, or not otherwise specified) found that clinicians' conflicting emotional combination of distress and hopefulness (i.e., low hope but low distress or high hope but high distress) to high-risk patients predicted short-term post-discharge suicide outcomes, independent of traditional risk factors such as suicidal ideation, depression, and entrapment. Another study[5] involving patients with various diagnoses (including 47 patients with bipolar disorder) found that the relationship between clinicians' negative countertransference response at the first psychotherapeutic or psychopharmacological session and patients' suicidal ideation one month later was mediated by the patients' perception of the therapeutic alliance. These findings are particularly important in light of the high incidence of death by suicide (10–30-fold higher than in non-psychiatric population) among persons with bipolar disorder.

Overall, the existing empirical evidence concerning countertransference indicates the potential clinical value of identifying and managing such responses, and the research base, while modest, may also be larger than realized. We agree with Shaw et al. that there would be value in adding training about the concepts to the preparation for practice across settings (including emergency rooms, psychiatric wards, and outpatients facilities) where people with bipolar often get services.

Implementing evidence-based assessment and treatment is essential to reduce patients' burden at an individual, societal and public health levels. Because both diagnostic and treatment processes take place inside the patient–clinician relationship, reintroducing humanistic and emotional dynamics to them (e.g., the range of affective, cognitive, and behavioral responses the members of the care dyad have toward each other) may lead to better patients' acceptance, uptake, and adherence of the treatment, mediating processes that in turn improve outcomes.

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CONFLICT OF INTEREST

The authors have no financial interest to disclose.

ORCID

Alberto Stefana https://orcid.org/0000-0002-4807-7184
Eric A. Youngstrom https://orcid.org/0000-0003-2251-6860
Eduard Vieta https://orcid.org/0000-0002-0548-0053

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