An empirical study of countertransference reactions toward patients with personality disorders

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Abstract

Objective: The study examined to what extent patients with cluster A + B personality disorders (PDs) evoked other countertransference reactions among psychotherapists compared with patients with cluster C PDs as well as the relationship between the different countertransference reactions and outcome.

Methods: A total of 11 therapists at the Department for Personality Psychiatry, Ullevaal University Hospital, Oslo, Norway, filled out the Feeling Word Checklist-58 (FWC-58), 2 weeks after admission and 2 weeks before discharge, for 71 patients admitted to the day treatment program. The patients were diagnosed with the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II).

Results: The study revealed that patients with cluster A + B PDs evoked more negative and less positive countertransference reactions than those with cluster C PDs. The psychotherapists varied significantly more in their reported countertransference reactions toward patients with cluster A + B PDs than toward those with cluster C PDs. Patients who dropped out of treatment evoked significantly more negative countertransference reactions after 2 weeks than patients who completed the treatment. In addition, the study revealed strong correlations between countertransference feelings and change during the treatment.

Conclusions: This empirical study confirms clinical narratives on specified relationships between countertransference reactions, different PDs, and treatment course.

1. Introduction

Countertransference reactions play an important role in psychotherapy. Although there are numerous definitions of countertransference, all emphasize the emotions evoked in therapists when they are working with patients. Freud introduced the concept and viewed it as therapists' unconscious reactions toward patients, triggered by the therapists' own neurotic conflicts [1]. With this narrow view, countertransference reactions were considered a hindrance to treatment. However, a different view, including all the emotional reactions therapists have toward their patients, was introduced in the 1950s [2], and it is today the most frequently used definition of the concept [3]. With this "totalistic" view, many theorists have described the relevance and importance of countertransference reactions in the therapist-patient relationship [4-6]. First, it may give therapists important information about patients and be helpful in understanding the problems patients are struggling with [7-11]. Second, it may affect the outcome directly through the presence, or lack of, empathic attunement. This means that disengagement may strengthen a feeling of worthlessness in the patient, whereas interest, on the other hand, may increase patients' sense of self-cohesion [12].

The literature on countertransference reactions evoked by patients with personality disorders (PDs) is mainly anecdotal. Moreover, the main focus has, to a large extent, been limited to countertransference reactions evoked by patients with borderline PDs (BPD). It is claimed that patients with BPD elicit more troublesome and problematic countertransference reactions than other patients, and these, in particular, are feelings of anger, fear, and hatred to the therapists [13,14]. Furthermore, BPD patients are said to split their therapists in "all good" or "all bad" and evoke feelings in the
therapists of being either omnipotent or helpless, exhausted, and rejected [15,16].

There are few empirical studies that have examined countertransference reactions toward patients with different PDs. Two studies have used clinical vignettes to describe patients with BPD and examine the extent to which these patients elicit different countertransference reactions than other groups of patients. Brody and Farber [17] found that vignettes of patients with BPD evoked more negative countertransference reactions than vignettes of patients with depression or schizophrenia. Comparing vignettes of patients with major depression and BPD, McIntyre and Schwartz [18] showed that vignettes of BPD evoked more extreme reactions of hostility and dominance. To our knowledge, only 3 studies have examined therapists’ countertransference reactions with regard to different PDs in a clinical setting. Holmqvist [19] studied staff members’ countertransference reactions toward severely disturbed psychiatric patients in 17 different treatment homes. Holmqvist found no significant differences in countertransference reactions toward patients with different axis I and axis II diagnoses. Moreover, Holmqvist found that the patient’s self-image was more important than their diagnosis in influencing staff members’ countertransference reactions. This is in line with a study by Colson et al [20] who found that patients’ diagnosis influenced staff members’ countertransference reactions to only a small degree. On the other hand, patient behavior, such as suicidality, and character pathology lead to specific countertransference reactions among the staff members. However, Betan et al [21] found that different clusters of PDs were associated with different countertransference reactions. Furthermore, the study revealed that countertransference patterns were systematically related to patients’ personality pathology across therapeutic approaches, suggesting that clinicians, regardless of therapeutic orientation, can make diagnostic and therapeutic use of their own responses to the patient. Thus, there are divergent data on whether different PDs elicit different countertransference reactions among therapists, and further empirical studies are needed.

In this study, we examined the therapists’ countertransference reactions in a specialized day treatment program for patients with PDs. Our main aims were to examine whether patients with cluster A + B PDs (mainly BPD) would elicit different countertransference reactions than patients with cluster C PDs (mainly avoidant PD), and whether the staff varied more in their reported countertransference reactions toward patients diagnosed with cluster A + B PDs than toward patients diagnosed with cluster C PDs. We also wanted to explore whether patients who dropped out of treatment (noncompleters) evoked different countertransference reactions 2 weeks after the start of treatment than patients who completed treatment (completers), and explore the relationship between different countertransference feelings and improvement during treatment.

2. Material and methods

2.1. Setting

Patients were recruited from the day treatment program of the Department for Personality Psychiatry, Ullevaal University Hospital, Oslo, Norway. The treatment program consisted of a combination of analytical and cognitive behavioral-oriented group therapies. The program lasted for 18 weeks (4 days a week) and comprised 24 patients [22]. The program involved a large group meeting for all patients and staff. Thus, all therapists had some knowledge based upon clinical encounter with every patient. No individual psychotherapy was offered during the treatment period.

All groups were led by 2 therapists. All 11 therapists (2 men and 9 women; mean age, 41 years) completed the countertransference form. Their professions were the following: 1 psychiatrist, 1 resident, 1 psychologist, 1 art therapist, 1 physiotherapist, 1 social worker, and 5 psychiatric nurses. The study lasted for 16 months, and all patients who stayed longer than 2 weeks were included.

2.2. Participants

A total of 71 patients were included. Eleven patients dropped out of treatment, and 6 patients had missing data at the end of treatment. The total number of patients included in the data analyses at discharge was 54. To calculate differences in countertransference reactions toward patients who completed the treatment and patients who dropped out of treatment, we included all the 71 patients. The other statistical analyses included only patients with cluster A, B, or C diagnoses. Patients diagnosed with PD not otherwise specified were excluded because they did not belong to a specific cluster. A total of 42 patients at admittance and 30 patients at discharge had a diagnosis within cluster A, B, or C.

Most of the patients were women (79%). The mean age was 34 years (SD, 8.1 years).

2.3. Instruments

Two weeks after admission and 2 weeks before discharge, all therapists completed the Feeling Word Checklist-58 (FWC-58). The therapists were asked to indicate on a 5-point rating scale, ranging from 0 (not at all) to 4 (very much), if he or she had feelings (eg, helpful, anxious, sad, happy) during their last conversation with the patient. The checklist contains 58 feeling words. The psychometric properties of the FWC-58 have been found satisfactory in a previous study [23]. The instrument measures 7 clinically meaningful dimensions. There are 2 positive subscales named important (empathic, caring, and enthusiastic) and confident (relaxed, objective, and calm), and 5 negative subscales named rejected (disliked, disparaged, and stupid), on guard (anxious, cautious, and threatened), bored (aloof, indifferent, and empty), overwhelmed (surprised, confused, and invaded), and inade-
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