**Student: Bagambhrini Gerace, MSIII | The University of Arizona College of Medicine – Tucson**

# SUBJECTIVE TOOLS IN DIAGNOSIS: A CASE FOR COUNTERTRANSFERENCE

***Gerace, B.***




## ABSTRACT

Psychiatric diagnosis and treatment depends on the therapist's ability to accurately observe and analyze the patient's emotional, mental, and behavioral state. During this process, the variety of unconscious responses arising in the therapist is termed *countertransference*—which describes the predictable patterns of emotional and behavioral changes that occur in response to the patient's personality. In the case of a personality disorder, this phenomenon is amplified. With understanding and non-judgmental recognition of these responses, therapists can use countertransference to inform their diagnosis and approach to treatment. An informal study of these responses, elicited in both experienced clinicians and medical student trainees, was conducted to elucidate the phenomenon of countertransference in the context of a case presentation.


## BACKGROUND

As physicians and scientists, it is the nature of our field to drive toward impartiality and objectivity in the practice of medicine. We often identify our emotional response subjectivity as obstacles to treatment, especially with the increasing importance of evidenced-based decision-making. Here, I will propose how subjective emotionality and evidenced-based decision-making are not mutually exclusive in the psychiatric milieu. A physician's subjectivity may help inform their diagnosis and treatment plan in predictable ways that ultimately serve the patient.

Countertransference is the analyst's emotional response to the state of the patient during treatment sessions.[1] Although the phenomenon is necessarily dependent on the therapist's history, expectations, and emotional availability, countertransference response shows remarkable inter-analyst reliability that persists when controlled for the therapist's experience, expectation, and therapeutic modality showing it is a reliable measure of patient personality.[1]

Personality is the set of stable, predictable, emotional and behavioral traits that arise in childhood or early adolescence and persist for the lifetime of the individual.[2] There is no clear cut point between a personality disorder and a normal personality. There may be a continuum among individual personalities who could be described from clingy to dependent, proud to narcissistic, or suspicious to paranoid[2]. In the case of personality disorders, these patterns are inflexible and produce significant impairment in social or occupational functioning.[2,3] Patients with personality disorders rarely seek treatment voluntarily, as their beliefs and behaviors are not distressing—the disorder is ego-syntonic.[2] Though countertransference occurs to some degree within every patient interaction, patients with personality disorders illicit inflated emotional responses in their therapists.[3] This is because of the inflexible and exaggerated expression of maladaptive personality traits and inherent instability, both emotional and psychological, that occur in personality disorders. In this case report, I hypothesize that identification and analysis of countertransference responses during therapy sessions for patients with personality disorders may provide a robust tool for generating a differential diagnosis in addition to assessing a patient's progress and/or regression over time.

## CASE PRESENTATION

Clinical information was acquired via a search of the patient's Southern Arizona Veterans Affairs Health Care System medical records, over an 11 month period, with specific attention to psychiatric admission history and physical examinations.

The patient is a 67-year-old obese Caucasian woman with history of mixed personality disorder with borderline, histrionic, and dependent traits; somatization disorder; Post-Traumatic Stress Disorder (PTSD); hysterectomy and oophorectomy on estrogen replacement therapy; and multiple cardiovascular disease diagnoses. Over the year of charts reviewed, the patient was admitted to the inpatient psychiatric ward four times. In the first two admissions, which occurred in the first and third month of the period reviewed, she was primarily concerned with exacerbations of her PTSD symptoms and inability to cope under stress. She reported symptoms of PTSD originating from repeated sexual trauma and physical abuse committed against her as a young child by family members. In interview she reported that the flashbacks trigger desire to hurt herself and "wish that God would take me home." She reported that she had not followed up with previous medical and psychiatric outpatient appointments because "the nurse was mean and not compassionate" and that another nurse was rude with her "with her body language."

Her second admission was significant for that she recently lost consistency with some of her health care providers; her primary care provider retired and her previous social worker switched departments. She reported, "I have no one to go to for help." Additionally, her computer had recently broken, leaving her unable to play games or listen to her favorite Christian music, and she felt "frightened and angry" that she was unable to cope under this stress. At that time she submitted a 2-page written list of ongoing medical problems including "thyroid not right," "B-vitamins aren't working," and concern that she was developing Alzheimer's dementia.

In the first of these visits, she reported that her medication regimen of fluoxetine and diazepam was "helping," but in the following admission she reported "fluoxetine was making me worse" so she discontinued taking the medication.

She reported no alcohol or other substance use and her urine screen is negative on all admissions.

The second two inpatient psychiatric admissions occurred in the 9th and 11th month of the period reviewed. During these admissions, the patient presented in extreme distress which she was was caused by on her medical team's decision to discontinue her estrogen replacement therapy due to cardiovascular concerns. She reported, "I need extra high estrogen" levels, without which she complains of severe psychological distress and extreme physical symptoms of menopause. She reported:

"What they are doing is going to make me crazy and make me want to commit suicide."

"My doctors don't understand PTSD and they are horrible to me."

"My gynecologist turned on me…and I feel like I've been attacked by 5 people."

In the group milieu, she started conversations with students and nurses as they were treating other patients. She was very difficult to interrupt or redirect, and continues speaking for 10-15 minutes without recognition of attempts to end the conversation. In clinical rounds, the patient was very cordial and complimentary of medical students and residents: "You are all such beautiful people." She was very comfortable with the group watching her interview and continued sharing

despite multiple attempts on the attending clinician's part to wrap up the interview.

## DIFFERENTIAL DIAGNOSES

1. Mixed personality disorder:
   Patient shows cluster B and C traits:
   - Cluster B: Borderline: desperate efforts to avoid real/imagined abandonment, unstable mood/affect, transient stress related paranoia/dissociation, history of childhood sexual trauma.
   - Cluster B: Histrionic: uncomfortable when not center of attention, theatrical/exaggerated expression of emotion, easily influenced by situation, perceives relationship as more intimate than it actually is.
   - Cluster C: Dependent: needs others to assume responsibility for most areas of life, goes to excessive lengths to obtain support from others, feels helpless when alone.
2. Somatization Disorder:
   Given the patient's history, it's important to consider this as a contributory factor in her current presentation. Though general medical conditions are present, her physical complaints are in excess of what would be expected. Patients with somatization disorder express a great deal of concern over their condition, chronically perseverate over the issue, and often complain that their doctors are unable to help—all evident in this patient's current presentation.
3. Severe menopause syndrome:
   More likely if she also reported severe premenstrual dysphoric disorder before hysterectomy and onset of menopause.

## CLINICAL EXPERIMENT

The question arises: is this a trained response that occurs as a result of years of tuning of the analytical instrument through residency and practice? Or is there an extent to which countertransference is a universal and human response to interpersonal interaction that therapists may become more sensitive to with exposure? It stands to reason that previous experience, both personal and professional, would shape the therapist's emotional responses at least to some extent. However, the research on countertransference alludes to a more universal and predictable response pattern.[1,3,5] Gazzillo states "Interpersonal actions evoke 'restricted classes' of reactions from persons with whom we interact",[5] suggesting that countertransference occurs even in novice psychiatrists (i.e. medical students) and is not directly subject to the analyst's personal history or level of training.

## METHODS

In order to study the countertransference response to the presented patient, I conducted an informal study of four attending physicians and eight third year medical students using the questions from the Therapist Response Questionnaire and 1-to-5 rating scale, described above, and stratifying the answers according to the nine dimensions of countertransference as elucidated by Tanzilli et al.[3]

## RESULTS

The attending physicians all reported primarily hostile/angry response patterns, and secondarily disinterested responses. Helpless/inadequate and overwhelmed/disorganized patterns were also reported, but to a lesser extent. The medical students, when given the same questionnaire, reported less distinct patterns of responses in general with more categories of just one or two questions mildly endorsed. The majority of the students reported feeling overwhelmed/disorganized and helpless/inadequate to the greatest extent, with lesser degrees of positive and disinterested patterns.

## DISCUSSION

The concept of countertransferance was originally introduced in the early 1900s by Sigmund Freud, who defined it as the result of the patient's influence on the analyst's unconscious feelings.[3,4] In the classical view, countertransference was considered a hindrance to the patient's treatment because it created blind spots or distortions of the clinician's perspective of the patient.[1,2] Theories began to emerge in the midcentury on the utility of countertransference to inform a psychiatric differential diagnosis.[3] Clinicians have since begun to appreciate the diagnostic power of countertransference in using the analyst's own thoughts, feelings, attitudes, and behaviors during treatment to gain valuable information and insight into the patient's psychiatric state.[1]

Countertransference has also been studied in the context of therapeutic alliance—the capacity to develop a working relationship between therapist and client.[4] Therapeutic alliance in early psychotherapy was found to correlate negatively with negative countertransference responses, but no significant correlation or trend was found with positive and indifferent countertransference responses.[4] In the same study, researchers reported secondary findings correlating therapists' emotional response to patients' defense mechanisms.[4] These findings suggest a reactive nature of the clinician's emotional response to all their patients, not just to personality disorders, regardless of the therapist's ability to recognize the behavior as a defense mechanism.

It has been well established, by empirical investigation, that countertransference is increased in personality disorders relative to other DSM diagnoses.[1,5] In an interview-based study comparing patients with borderline personality disorder (BPD) to patients with major depressive disorder (MDD), the valence of the therapists' responses was significantly more negative toward the patients with BPD. Additionally, BPD patients were perceived as withdrawing, rather than attending within their sessions.[1] Therapists reported feeling more anger and irritation, and perceived the patient as being more dominant and aggressive than patients with MDD.[5]

There are many accepted tools for measuring countertransference, both qualitative and quantitative, including subjective inventories, critical observation of transcripts or notes, or supervision during the therapeutic session. Among these options, the Therapist Response Questionnaire has been rigorously verified, shows strong association between distinct countertransference responses and Axis II personality clusters, and demonstrates validity regardless of the therapist's orientation or expectation.[3] This questionnaire uses subjective scaling—from 1 (not true) to 5 (very true)—of clinically relevant questions like "When checking my phone messages, I feel anxiety or dread that there will be one from him/her" or "I self-disclose more about my personal life with him/her than with my other patients." The Therapist Response Questionnaire was found to stratify countertransference responses into eight distinct dimensions:

(a) overwhelmed/disorganized: desire to avoid the patient and strong negative feelings of dread, repulsion, or resentment;

(b) helpless/inadequate: feelings of incompetence, hopelessness about treatment outcome and anxiety;

(c) positive/satisfying: feelings of positive working alliance and close connection;

(d) special/overinvolved: feeling the patient is 'special' relative to other patients and signs of difficulty maintaining boundaries;

(e) sexualized: feelings of sexual tension;

(f) disengaged: feeling distracted, annoyed, or bored in sessions;

(g) paternal/protective: nurturing feeling toward the patient; and

(h) criticized/mistreated: feeling unappreciated and devalued by the patient.

In a validation study performed by Tanzilli et al in 2016, these dimensions were confirmed almost exactly, with the criticized/mistreated category further characterized into (h1) criticized/devalued: feeling dismissed, or that they are 'walking on eggshells;' and (h2) hostile/angry: feeling angry or critical of the patient.[3] Using these dimensions of countertransference, researchers verified previously identified associations between countertransference reactions and patients Axis II diagnoses. Cluster A diagnoses correlated with the hostile/angry and criticized/devalued patterns. Cluster B diagnoses correlated with the most heterogeneous reactions, primarily overwhelmed/disorganized, but also disengaged, helpless/inadequate, and sexualized. Finally, cluster C diagnoses correlated with the paternal/protective pattern[1]. Borderline patients tended to evoke the most variability and intensity in countertransference reactions, which may mirror the patient's instability in their emotional regulation and splitting defense mechanism1. Antisocial patients typically aroused overwhelmed/disorganized, disengaged, and angry/hostile patterns, which mirror their own lack of empathy and disrespect of others rights.[1] On the other hand, schizoid patients evoked disengaged but also helpless/inadequate patterns which may be a reaction to their difficulty building intimate connections.[1] Like schizoid patients, dependant patients evoke feelings of helplessness/inadequacy in the analyst, but also evoke the protective, parental desire to provide the emotional support that is lacking in the patient's relationships with parents or significant others.[3] The disengaged pattern is also a characteristic response to patients with somatization personality disorder, which is characterized by alexithymia, the embodiment of psychological problems as physical symptoms.[1,5]

A review of the countertransference phenomenon reveals significant relationship between the severity of the patients psychological distress and the intensity of the countertransference response.[1] This is a clinically useful finding as the exacerbated countertransference response may be a sensitive indicator of acute psychological decompensation in a previously stable patient. Recognizing this phenomenon may help the therapist stay attuned to the changing needs of the patient and escalate therapy preemptively when it is appropriate.

## CONCLUSION

Findings of the countertransference responses endorsed by trained attending physicians supports the external validity of the Tanzilli study and is clinically consistent with the countertransference patterns that would be expected from this patient's history. Comparison of data collected from the attendings to those collected from the medical students on service suggests that the countertransference is, at least in part, a normal human response as it is still observable in the psychiatrist in training; however, sensitivity to and identification of countertransference is most certainly honed by training and practice.

Due to the personal and subjective nature of the data, the study of countertransference is rife with potential bias. Evaluations furnished by the clinicians or a single observer may be suspect to social desirability bias: response bias toward a favorable or expected answer.[1] An additional confounding factor in the elucidation of therapist countertransference in personality disorders is the relatively high prevalence of mixed disorders and low prevalence of "pure" types. Researchers attempt to control for this confounding factor by broadening the analysis to cluster type (A, B, and C), rather than restricting the analysis to specific personality disorder subtypes. This fails to account for personality disorders with traits from multiple clusters, as in the case of our patient.

Personality disorders are dysfunctional schemas of the self, others and relational interactions.[1] Identification of the therapist's emotional response to personality disorder patients can provide insight into the type and severity of pathopsychology present. Evidence shows the study of countertransference responses to be valid and useful in clinical decision-making[1]. Therapists may be able to understand and treat their patients more effectively if they are aware and thoughtful of countertransference, rather than attempting to disavow their emotions in therapy sessions.



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