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BRIEF COMMUNICATION

Can countertransference at the early stage of trauma care predict patient dropout of psychiatric treatment?

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Abstract
Objectives: To investigate the association between feelings of countertransference (CT) at the early psychiatric care provided to trauma victims and treatment outcome. *Method*: The Assessment of Countertransference Scale was used to access CT after the first medical appointment. Fifty psychiatric residents cared for 131 trauma victims of whom 83% were women, aged 15 to 64 years. Patients had been consecutively selected over 4 years. Were evaluated the clinical and demographic characteristics of patients and the correlation with the therapists' CT feelings. Patients were followed-up during treatment to verify the association between initial CT and treatment outcome, defined as discharge and dropout. *Results*: The median number of appointments was 5 [4; 8], absences 1 [0; 1], and the dropout rate was 34.4%. Both groups, namely the discharge group and the dropout group, shared similar clinical and demographic characteristics. A multivariate analysis identified that patients with a reported history of childhood trauma were 61% less likely to dropout from treatment than patients with no reported history of childhood trauma (OR = 0.39, p = 0.039, CI95% 0.16-0.95). There was no association between initial CT and treatment outcome. *Conclusions*: In this sample, CT in the initial care of trauma victims was not associated with treatment outcome. Further studies should assess changes in CT during treatment, and how such changes impact treatment outcome.
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DESCRITORES
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Contratransferência no atendimento inicial de vítimas de trauma pode predizer o abandono do tratamento psiquiátrico?

Resumo
Objetivos: Investigar a associação entre contratransferência (CT) no atendimento psiquiátrico inicial de vítimas de trauma e desfechos do tratamento. *Método*: A contratransferência de 50 terapeutas foi avaliada através da Assessment of Countertransference Scale após o primeiro atendimento de 131 vítimas de trauma (83% mulheres, idade entre 15 e 64 anos) selecionadas consecutivamente durante 4 anos. Foram avaliadas características demográficas e clínicas dos pacientes, e investigaram-se seus correlatos com os sentimentos contratransferenciais dos terapeutas. Os pacientes foram acompanhados ao longo do tratamento para verificar a associação entre a CT e o desfecho do tratamento, operacionalizado como alta ou abandono. *Resultados*: A mediana de consultas realizadas foi 5 [4; 8], faltas 1 [0; 1] e taxa de abandono 34,4%. As características demográficas e clínicas dos pacientes dos grupos alta e abandono foram similares. Na análise multivariada, identificou-se que pacientes com relato de trauma na infância tiveram uma chance 61% menor de abandonar o tratamento que pacientes sem relato de trauma na infância (OR = 0,39; p = 0,039; IC 95% 0,16-0,95). Não foi detectada associação entre sentimentos contratransferenciais iniciais com os desfechos do tratamento. *Conclusões*: A CT no atendimento inicial de vítimas de trauma não esteve associada ao desfecho do tratamento. Estudos futuros devem avaliar a modificação da CT ao longo do tratamento e seu impacto sobre os desfechos.
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Introduction

In recent years, the concept of countertransference (CT) has begun to converge on the definition that it is determined by the feelings of the therapist toward patient's particular characteristics, such as the type of transference, relation with their internal objects, personality aspects, attachment pattern, and others.[1] CT is also modulated by the therapist´s own personality traits. In spite of this differentiation between transference and CT, which is necessary for the study, we cannot dissociate transference from CT as both arise in combination. It is noteworthy, however, that these feelings of the therapist that do not correlate with transference are considered to be transferences to the patient. We believe that both phenomena do integrate the dynamic field of the relationship between patient and therapist.[2] Thus, CT is a useful tool for therapists to monitor their internal world in order to improve the quality of their interpretation skills,[3] diagnostic understanding,[4] ability to establish a therapeutic alliance,[5] and to advance along the course of the psychiatric treatment. Although the literature on CT is rich from a theoretical standpoint,[1] this is not the case from an empirical point of view.[6] Certain studies correlate particular aspects of CT with types of diagnoses,[7] personality disorders,[8,9] therapeutic alliances and attachment patterns,[10] characteristics of patients and therapists,[11] establishing them as predictors of psychiatric treatment outcomes.[5]

The growing number of violent scenarios, such as sexual abuse, kidnappings, and robberies, especially in large cities, has resulted in a large demand for psychiatric care aimed at the victims of such violence.[12] Therapists have to deal with sadness, anxiety, and patient rage, which are often transferred to them, who, in turn, are unable to provide fast relief for the trauma pain.[13] In this sense, therapists need to be able to "survive" the traumatic affective experience of the patient because trauma victims are sensitive to the feelings and actions of therapists. Therefore, caring for these patients frequently arouses intense feelings of CT, including fear, anger, sadness, and impotence, which can affect the therapeutic relationship if not properly contained and understood, thus favoring an impasse and treatment discontinuation.[14] Moreover, negative CT patterns in therapists and a poor therapeutic alliance are frequently mentioned as reasons for treatment discontinuation.[10] Despite the fact that this association has been extensively described, the evidence of the role played by CT in this mechanism is still rather scarce.[3,15] The aim of the present study was to investigate whether CT at the early stages of treatment of trauma victims can be used to predict dropout of psychiatric treatment.

Method

Setting

The sample was comprised of therapists and patients who were consecutively included, over 4 years, in the study conducted at the Center for Study and Treatment of Traumatic Stress (NET-TRAUMA), Hospital de Clínicas de Porto Alegre, Brazil.

Sample

The therapists were residents of Psychiatry in rotation at NET-TRAUMA for a period of six months. All residents (n = 50) were invited to participate after the first visit with a new patient. Patients treated at NET-TRAUMA came from urban areas and had been referred from primary, secondary, and tertiary care facilities. The study sample comprised 131 patients, including 60 victims of sexual violence (incest, rape, and attempted rape), 46 victims of urban violence (robberies, kidnapping, attempted homicide, beating, torture, and being run over by vehicles), 18 victims of vicarious trauma (traumatic and/or violent loss of a close relative), and 7 victims of multiple trauma. Patients were selected after screening, which assessed clinical variables and established diagnoses according to DSM-IV-TR criteria. Patients with severe suicidal ideation, psychotic symptoms and/or referral for psychiatric hospitalization were excluded, considering these situations potentially not specific for CT toward trauma victims. Most patients were women (83.2%), whose mean age was m = 36 (SD = 13) years, 48.9% lived with a partner, 55.7% had finished elementary school, and 60.5% were employed. The median time between the appointment and the trauma event was 11 [1; 146] months. Therapists' mean age was m = 27 (SD = 3) years, 67.9% were women, and 50.4% had previous experience in caring for victims of trauma.

Ethical aspects

All participants gave their written informed consent before entering the study, which was approved by the local ethics committee.

Measures

After the first appointment with every new patient, residents completed the standard protocol and the Assessment of Countertransference Scale (ACS). Patients were followed-up during psychiatric treatment, and, regardless of the use of psychotropic medications, a brief psychodynamic psychotherapy session was conducted to determine outcome measurements, which included the number of appointments and number of absences, and the type of outcome, i.e., discharge (patients that attended at least 6 sessions, number of sessions regarded by the therapists as the minimum number needed to consider the treatment accomplished) or dropout. The psychiatric treatment offered at weekly sessions and conducted over an average of 2 months has focused on psychoeducation and the relationship between the current trauma (fears, fantasies, and symptoms) and childhood issues, such as primary conflicts, object-relation patterns, and defense mechanism styles. Before therapists started seeing patients, they received training on brief psychodynamic psychotherapy for trauma victims from an expert team during 4 weeks, and were under individual and joint supervision for all cases treated over the 6-month rotation.

The ACS was developed based on a qualitative study on CT, which listed the feelings found in six cases treated with brief dynamic psychotherapy.[16] This list had been compiled based on an analysis of the therapist's CT report and a retrospective analysis of the sessions, which were audiotaped by a group of experts during treatment. From this list, a theoretical review of CT was performed, and each feeling was standardized and conceptualized. This version was considered to have face validity by experienced psychoanalysts and psychoanalytic psychotherapists.[17] ACS is a self-applied scale composed of 23 items (feelings) measured at three different times of the session, namely at the start, at midpoint, and at the end. A Likert-type scale was used (0 = absence to 3 = very) to produce a mean score distributed into three domains: closeness (10 items), distance (10 items), and indifference (3 items).[17] In trauma victims, it presented consistent psychometric properties: rejection (9 items: irritation, rejection, hostility, disinterest, mistrust, accusation, reproach, boredom, and distance; $\alpha = 0.88$); closeness (7 items: interest, affection, curiosity, solidarity, wish to help, sympathy, and attraction; $\alpha = 0.82$); and a third factor, which was different from the original, namely sadness (6 items: sadness, pity, despair, immobility, discomfort, and fear; $\alpha = 0.72$).[18] The scores for each of the subscales were standardized in Z scores.

Statistical analysis

A frequency table and histogram were used to analyze the scoring of items. The items were compared across the 3 moments using the Friedman rank test. Pearson and Spearman´s rho correlation coefficient determined the relationship between the three domains of ACS. Wilcoxon´s signed rank test (Z), ANOVA, and Chi-squared test were used to compare styles of CT according to the characteristics of the sample, and these characteristics according to the outcome. The overall scores of the three ACS domains, weighted for the number of items within each domain, were compared using the Friedman rank test. All variables associated with the outcome with a p-value lower than 0.2 were included in a multivariable logistic regression model in order to control for confounders using a forward stepwise method (Likelihood) for selection of variables to maximize prediction. Because the effect of covariates as confounding factors was controlled, a statistical analysis was performed separately for the following covariates: the rejection and closeness domains, as they showed moderated correlation ($r = -0.61$; $p < 0.001$); and the different types of trauma. Spearman´s rho was used to investigate the correlation between the number of appointments with each one of the ACS factors. All tests were two-tailed and performed using the Statistical Package for the Social Sciences (SPSS) v. 16.0 (SPSS, Chicago, IL, USA). The level of significance adopted was $\alpha = 0.05$ and CI 95%.

Results

There were significant differences between the overall scores of ACS domains, with a predominance of closeness (Rank 2.82, m = 2.05, SD = 0.45) in relation to sadness (Rank 2.03, m = 1.20, SD = 0.52) and rejection (Rank 1.15, m = 0.45, SD = 0.45); (chi-square = 186.3, $p < 0.001$).The scores of items in the closeness domain of ACS increased throughout the session, except for the item "attraction" , whose scores increased from the start to the midpoint, after which it decreased. The factor sadness presented a distinct pattern: only the item "pity" presented increased scores throughout the session, while the other 5 items presented an increase followed by a decrease to middle scores. Moreover, the rejection factor presented more variation in the pattern of

item scores: the items "mistrust", "rejection", "despair", and "reproach" presented increased scores from start to midpoint, followed by a decrease to higher levels compared to the first scores; the scores for "distance" and "disinterest" fell throughout the session; and the score for the item "boredom" increased throughout the session. Considering the average score at the three times of ACS, the item "wish to help" achieved the highest average (m = 2.51; SD = 0.57), while the item "hostility" achieved the lowest (m = 0.19; SD = 0.42). There were significant differences among scores at the three times of ACS for 8 of the 23 items, namely affection, sadness, pity, discomfort, mistrust, despair, accusation, hostility, and immobility. The correlation between the rejection and closeness factors was r = -0.61 (p < 0.001), and between sadness and rejection was r = 0.36 (p < 0.001). Nevertheless, closeness and sadness did not present significant correlation (r = -0.05, p = 0.59).

Residents aged 27 years or under scored higher in rejection than the older therapists (m = 0.14; SD = 1 *vs*. m = -0.21; SD = 0.9, Z = -2.35, p = 0.019), who scored higher in closeness than younger therapists, although the difference was not significant (m = 0.21; SD = 0.9 *vs*. m = -0.13; SD = 1.04). We found a low inverse correlation between the age of the therapists and rejection scores (r = -0.21; p < 0.05). Married patients imposed more feelings of rejection on the therapists (m = 0.20; SD =1 *vs*. m = -0.19;SD = 0.9, Z = -2.41, p = 0.016) and sadness (m = 0.18; SD = 1 *vs*. m = -0.17; SD = 1, t = -1.99, p = 0.049) on therapists than single patients. Regarding clinical variables, victims of vicarious trauma and multiple traumas aroused more sadness (m = 0.38; SD = 1 and m = 0.76; SD = 0.4, respectively) compared to sexual violence (m = 0.03; SD = 0.9) and urban trauma victims (m = -0.3; SD = 1) (F = 3.83, p = 0.039).

The median number of appointments was 5 [4-8] and of absences was 1 [0-1]. The overall rate of dropout was 34.4%. The dropout rate for each of the violence situations was as follows: sexual violence 31.7%; urban trauma 43.5%; vicarious trauma 27.8%; and multiple trauma 14.3%. There were no correlations between ACS factors and the number of appointments and absences. According to a multivariate analysis, patients who reported a history of childhood trauma are less likely to dropout (OR = 0.39, p = 0.039, CI95% 0.16 to 0.95). There were no associations between countertransference feelings and treatment outcomes (Table 1).

Table 1 Demographic and clinical characteristics of the study sample between the two outcome groups

	Dropout (n = 45)	Discharge (n = 86)	p
Therapists			
Female, N (%)	33 (73)	56 (65)	0.43††
Previous experience with trauma, N (%)	20 (44)	46 (54)	0.36††
Years of age, mean (SD), years	27 (2)	27 (4)	0.30‡
ACS, median (IQR), z score			
Closeness	0.32 (-0.42; 0.85)	-0.05 (-0.52; 0.66)	0.57‡
Rejection	-0.50 (-0.78; 0.18)	-0.26 (-0.74; 0.49)	0.28†
Sadness	-0.18 (-1.15; 0.68)	0.14 (-0.61; 0.63)	0.25‡
Patients			
Female, N (%)	38 (84)	71 (83)	0.99††
Years of age, mean (SD), years	34 (13)	38 (13)	0.12‡
Years of study, mean (SD), years	9 (3)	9 (4)	0.48‡
Marriage/live with partner, N (%)	20 (44)	44 (51)	0.58††
Reported history of previous psychiatry disorder, N (%)*	11 (30)	32 (41)	0.31††
Reported history of childhood trauma, N (%)	9 (20)	30 (35)	0.11††
Clinical diagnosis, N (%)			0.62‡
Post Traumatic Stress Disorder	33 (73)	49 (57)	
Acute Stress Disorder	4 (9)	19 (22)	
Mood Disorder	5 (11)	15 (17)	
AnxiolyticDependence Disorder	1 (2)	0	
Somatization Disorder	0	1 (1)	
None	2 (4)	2 (2)	
Presence of Axis II, N (%)			0.45‡
Cluster A Personality Disorders	1 (2)	0	
Cluster B Personality Disorders	4 (9)	13 (15)	
Mental Retardation	0	2 (2)	
None	40 (89)	71 (83)	
Presence of Comorbidities in Axis I and/or II, N(%)	10 (22)	30 (35)	0.16††
Type of trauma, N (%)			0.32‡
Sexual	19 (42)	41 (48)	
Urban	20 (45)	26 (30)	
Vicarious	5 (11)	13 (15)	
Multiple	1 (2)	6 (7)	
Months since episode of trauma, median (IQR), months	9 (2; 44)	17 (1; 211)	0.35†
Single episode of trauma, N (%)	29 (64)	45 (52)	0.19††

ACS: Assessment of Countertransference Scale; SD: standard deviation, IQR: interquartile range; *N = 116; †† Chi-squared test, ‡ ANOVA, †Wilcoxon´s signed rank test (Z).

Discussion

In this study, we have documented a predominance of CT feelings of closeness compared to rejection and sadness, regardless of the socio-demographic and clinical data of patients and therapists. The mean scores of the ACS items varied during the appointment: 8 items were significantly different between the 3 moments of the ACS. In general, CT feelings increased during the session, except for distance and disinterest, which, as expected, fell due to the trauma-related context. The feelings of sadness presented increasing scores from the start to the midpoint of the session, reaching mean scores from the first two moments of the session at its end. Feelings of rejection presented more variation. The rather complex structure of the items' arrangement, probably responsible for establishing a set of non-linear correlations, seems to indicate that, over the session, there

was a formulation of the CT. However, there was absence of a specific pattern of CT feelings associated with dropout. The present research pioneered the investigation on the relationship between CT and the outcome of psychiatric treatment offered to trauma victims. There is initial evidence that found an association between the therapeutic ability to notice positive and negative CT feelings in the beginning of treatment of borderline patients, and better clinical outcomes,[19] although no comparison can be drawn based on the present data. Another study indicated an association between positive treatment outcomes of psychotic patients and fewer CT feelings of distance.[5]

We have found data of little resonance in the literature. Therapists younger than 27 years of age presented more feelings of rejection than older therapists. We emphasize that the measured portion of CT is indeed conscious, that all therapists had similar professional experience in terms of years of study, and that they had undergone the same training program on applied therapy at the research center. We hypothesize that this result can be explained by the fact that the difference in the rejection scores was influenced by the life cycle experience. Supporting this hypothesis, a previous study found no difference between CT behavior pattern in therapists with fewer or more than 3 years of clinical experience.[3] Another result that caught our attention concluded that married patients aroused more feelings of sadness and rejection in therapists. Other studies should further explore this finding.

Certain methodological aspects of this study need to be contemplated. First of all, CT was assessed at the beginning of treatment. Empirical evidence indicates that the therapeutic alliance is a variable that may determine treatment outcome, and that treatment alliance evolves over the sessions.[10] Because subsequent CT changes were not found in our study, new research projects are needed to evaluate CT during treatment, as well as its correlation with therapeutic alliance and treatment outcomes. Second, the outcome measures were the number of appointments and absences, discharge or dropout, and there were no clinical measurements of the improvement achieved. In this sense, CT may be related to qualitative treatment outcomes. Third, all therapists are residents in Psychiatry, a fact that increases the internal validity of the data, but restricts the generalization of results. Fourth, the group of residents and patients were formed basically by women, which also prevents us from generalizing results. However, in a recent study conducted in our area of study, the difference in CT pattern according to therapist´s gender was not detected.[15] Fifth, the feelings of CT increased over the session, as expected in any medical context, although the possibility of social desirability bias, especially for training psychiatrists under supervision cannot be ruled out. Notwithstanding this, we think that this is a remote possibility because feelings like boredom and accusation, which are not socially desirable, also increased during the appointment. Finally, in view of the sample´s moderate size, stepwise multiple regression analysis was performed to prevent a moderating effect.

Currently, most research projects are focusing on increasing knowledge regarding the contribution of therapists to the performance of psychiatric treatment.[9,20] Parts of the CT can present coherent and predictable patterns, especially in trauma, due to the similarity and specificity between the experiences.[8] Nonetheless, studies have yet to confirm this hypothesis.[3,15] Further studies with different profiles of patients and therapists should investigate CT and treatment outcomes, and consider studying CT both during, as well as at the end of the treatment.

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Disclosures

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* Modest
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