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The Dance of Empathy and Objectivity: An Inquiry into Countertransference in Clinical Interviews with Patients Diagnosed with Schizophrenia Featuring Positive Symptoms and Bipolar I Disorder with Manic and Psychotic Features

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Abstract

Background & Objectives: Schizophrenia and bipolar disorder are among the most prevalent psychiatric conditions. Owing to the overlap in symptomatology and clinical manifestations, it is hypothesized that similar underlying dynamics may elicit comparable countertransference reactions in clinicians working with individuals diagnosed with these disorders. Accordingly, the present study undertakes a qualitative exploration of countertransference in clinical interactions with patients diagnosed with schizophrenia presenting positive symptoms and those with bipolar I disorder exhibiting manic and psychotic features.

Materials & Methods: This qualitative study involved psychiatric residents and faculty members at Kerman University of Medical Sciences, with 1 to 30 years of clinical experience, as well as patients admitted to Shahid Beheshti Hospital in Kerman. Patients were interviewed, after which the clinicians' emotional responses and experiences of countertransference were discussed within a structured focus group session lasting approximately thirty minutes. This process was repeated for multiple selected patients until data saturation was achieved. A conventional content analysis approach was employed to analyze the collected data.

Results: The findings revealed that nineteen distinct emotional responses were elicited during interviews with patients diagnosed with bipolar I disorder with manic and psychotic features, whereas fourteen emotional responses were reported in relation to patients with schizophrenia exhibiting positive symptoms.

Conclusion: The results indicated that feelings of restlessness, happiness, affection, and respect were more prominently evoked in response to patients with schizophrenia exhibiting positive symptoms, whereas intense feelings of anger and rage were more frequently reported in interactions with patients with bipolar I disorder presenting manic and psychotic features. These emotional patterns may thus serve as valuable clinical cues in the differential diagnosis of these two disorders.

Keywords: Countertransference, Differential diagnosis, Schizophrenia with positive symptoms, Bipolar Type 1, Interview

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Introduction

Psychiatric disorders exhibit a notably high prevalence among medical conditions. The World Health Organization estimates that one in four

individuals globally will experience a psychiatric disorder during their lifetime, and approximately 19% of the adult population is affected by mental disorders at any given moment. According to the 2008 World Health Organization Mental Health Gap Program, around 14% of the global burden of disease is attributed to mental, neurological, and substance use disorders, with approximately three-quarters of these cases occurring in low- and middle-income countries (1, 2).

Bipolar disorder and schizophrenia are among the most common psychiatric illnesses (3). Bipolar disorder is generally categorized into two types: Type I and Type II. It is characterized by alternating episodes of mania and depression. Individuals with bipolar I disorder exhibit fully manic or mixed episodes. In contrast, those with bipolar II disorder experience only hypomanic episodes (4). The symptoms of schizophrenia are typically classified into two domains: (1) positive symptoms, including hallucinations, delusions, and disorganized behavior; and (2) negative symptoms, such as emotional blunting, social withdrawal, apathy, and diminished motivation (5, 6). Because of the overlapping symptomatology between schizophrenia with positive symptoms and bipolar I disorder with manic and psychotic features, clinicians may encounter difficulties in establishing an accurate diagnosis (7, 8).

The concept of countertransference has evolved significantly over time. Originally introduced by Freud in 1910, it was defined as a set of therapist responses directed toward the patient and was viewed primarily as obstacles to be managed. In contemporary clinical practice, countertransference encompasses the therapist's emotional reactions to the patient, including both conscious and unconscious feelings that emerge during therapeutic interactions. While some theorists attribute all emotional responses to countertransference, others distinguish those rooted in the therapist's personal history and triggered during clinical encounters (9).

In psychiatric diagnostics, clinicians typically emphasize objective patient symptomatology. However, each clinical encounter is also imbued with unique emotional experiences that are often overlooked. Within the field of psychoanalysis, countertransference refers to the projection of the patient's internal world onto the therapist, which provides a valuable source of information for gaining insight into the patient's psychodynamic landscape (10). According to emerging evidence, countertransference responses, when considered along with symptom profiles and illness trajectories, may contribute meaningfully to the differential diagnosis of psychiatric disorders (11-13).

Despite the growing recognition of countertransference in psychiatric practice, existing research suggests that our understanding of therapists' experiences in this domain remains limited. Numerous subjective and nuanced emotional responses may elude measurement through quantitative methods, which highlights the importance of qualitative approaches such as in-depth interviews. In light of the clinical significance of countertransference and the apparent lack of comparative studies exploring therapists' emotional responses to patients with schizophrenia (positive symptoms) compared with those with bipolar I disorder (mania and psychosis), this study aims to qualitatively examine and contrast therapists' countertransference experiences in interviews with these two patient groups.

Materials and Methods

Consent and Confidentiality Considerations

In view of the psychiatric status of the patients, written informed consent was obtained from their legal guardians or designated caretakers before participation. Guardians were thoroughly briefed on the study's purpose, procedures, voluntary nature, and the participants' right to withdraw at any stage without affecting the quality of clinical care. All interviews were

conducted in a confidential, respectful, and private setting. To ensure the privacy and rights of all participants, all data were anonymized and restricted to authorized members of the research team. No identifying information was included in any analysis or published materials. These procedures were designed to maintain full compliance with ethical standards and to uphold the dignity, rights, and privacy of all individuals involved.

Setting and Participants

The study was conducted at Shahid Beheshti Hospital, which is a psychiatric teaching and treatment facility affiliated with Kerman University of Medical Sciences, Iran. Participants were selected using purposive sampling from among psychiatric residents and faculty members affiliated with the university. The residents, who were undergoing training in psychiatry, were assigned to focus groups consisting of five to seven individuals. Faculty members, who were practicing psychiatrists, were interviewed individually to explore their previous clinical experiences.

Inclusion Criteria

The inclusion criteria for this study comprised third-year psychiatric residents at Kerman University of Medical Sciences who had either completed or were currently enrolled in psychotherapy training and were familiar with the concept of countertransference; patients hospitalized at Shahid Beheshti Hospital in Kerman with a confirmed diagnosis of schizophrenia presenting with positive symptoms or bipolar I disorder with manic and psychotic features; and psychiatric faculty members affiliated with Kerman University of Medical Sciences who had between 1 and 30 years of clinical experience and were able to reflect on their past encounters with patients from the specified diagnostic categories. In designing the study sample, efforts were made to ensure maximum variation and diversity among participants in order to capture a broad range of clinical perspectives and emotional responses.

Data Collection

This qualitative research employed a content analysis approach to explore therapists' emotional reactions and countertransference experiences. Data were gathered through a combination of focus group discussions and individual interviews, which continued until thematic saturation was reached. During each session, a third-year psychiatric resident conducted a 15-minute diagnostic interview with a patient, which was followed by a brief question-and-answer exchange facilitated by the other group members. After the patient left the room, participants engaged in a 30-minute structured group discussion to reflect on and articulate their emotional responses and countertransference experiences. This procedure was repeated with selected patients until no new emotional patterns emerged. Prior to data collection, the research team developed an emotional response checklist based on established affective models, most notably Robert Plutchik's Wheel of Emotions (Figure 1). After minor revisions, the final version of the checklist (Figure 2) was distributed to all participating therapists to assist in the identification, categorization, and verbalization of their emotional experiences during the interviews.

All interviews were audio recorded and subsequently transcribed verbatim. The transcripts were then reviewed multiple times by the research team to ensure a comprehensive understanding and deep familiarity with the content. In parallel with the transcription process, the lead researcher maintained a reflexive journal throughout the study, documenting observational notes, emotional reactions, and analytic insights. These reflections were later incorporated into the data analysis process, thereby enhancing interpretive depth and contributing to the refinement of subsequent data collection strategies.

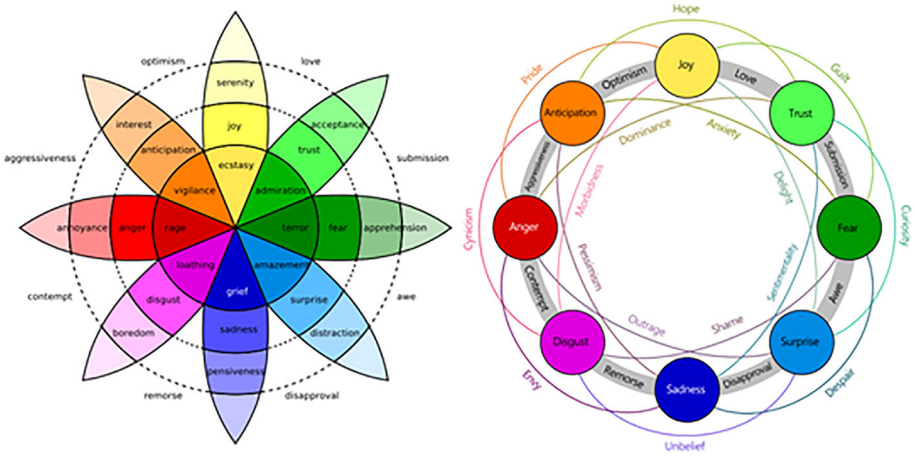


Figure 1. Robert Plutchik's Wheel of Emotions. A theoretical model illustrating eight primary emotions and their polar opposites, arranged in a wheel format. This model was used as a basis for developing the Feeling Checklist utilized in the present study.

I feel ..... when I talk to this patient.

☐ important	☐ helpful
☐ admired	☐ idealized
☐ confident	☐ dominating
☐ enthusiastic	☐ happy
☐ seduced	☐ curious
☐ overwhelmed	☐ surprised
☐ in the know	☐ confused
☐ bored	☐ sleepy
☐ disappointed	☐ devaluated
☐ inadequate	☐ frustrated
☐ manipulated	☐ disliked
☐ invaded	☐ rejected
☐ threatened	☐ anxious
☐ suspicious	☐ feared
☐ envious	☐ angry
☐ distressed	☐ sad
☐ indifferent	☐ emotionless
☐ caring	☐ aloof
☐ motherly	☐ on guard
☐ receptive	☐ over-controller
☐ sympathetic	☐ empathic
☐ attentive	☐ affectionate
☐ helpless	☐ unimportant
☐ guilty	☐ embarrassed
☐ engulfed	☐ controlled
☐ important	☐ dominated

Figure 2. Feeling Checklist used in the present study. A customized list of emotional terms adapted from Plutchik's model and further refined by the research team. The checklist was provided to therapist participants as a reference tool to support the identification and labeling of their emotional responses during and after patient interviews.

Data Analysis

Data were analyzed using the qualitative content analysis approach as outlined by Lundman and Graneheim. Each interview was transcribed verbatim immediately after completion, and the transcripts were read repeatedly by members of the research team to achieve a holistic and nuanced understanding of the participants' narratives. The analysis began with the identification of meaning units, defined as segments of text that conveyed distinct emotional responses or therapeutic reactions. These units typically captured therapists' reflections during or after clinical interviews and described their affective or cognitive responses to patients' behaviors, verbal expressions, or diagnostic presentations. Each meaning unit was then condensed to its essential message, removing redundancy while preserving core meaning and emotional tone.

Condensed meaning units were subsequently assigned initial codes based on their emotional or thematic content. For instance, when a therapist expressed feeling "mentally disconnected due to the patient's constant hallucinations and irrelevant speech," this was condensed to "disconnection due to hallucinations" and coded as "lack of communication." Similarly, the statement "I wanted to help the patient because of their family neglect and repeated hospitalization" was categorized as "mercy and compassion." Once initial coding was completed, related codes were grouped into subcategories and overarching emotional classes. For example, codes such as "empathy," "helplessness," and "protective instinct" were clustered under the emotional class "mercy and compassion," while codes like "irritation," "anger due to loud speech," and "resistance to treatment" were categorized under "anger and rage."

The analysis followed an iterative process, in which codes were continuously compared with the original data and revised to ensure conceptual clarity and internal consistency. Additional emotional classes were identified, including "confusion," often triggered by disorganized speech or rapid thought patterns; "curiosity," evoked by unusual or unpredictable behaviors; "excitement," in response to elevated mood or humorous speech; and "sadness and unhappiness," frequently associated with patients' traumatic life histories or evident social isolation. To ensure credibility and methodological rigor, the lead researcher remained actively immersed in the data collection and analysis process. Reflexivity was sustained through continuous engagement with field notes and analytic memos. Member checking was conducted by presenting selected transcript excerpts and their corresponding codes to participants for validation of interpretive accuracy. Furthermore, the emerging categories and emotional classes were systematically reviewed and approved by academic supervisors and experts in qualitative methodology.

Results

Participants

The study sample included professors, psychiatric residents, and patients affiliated with Shahid Beheshti Hospital in Kerman in 2020. A total of nine professors, ranging in age from 35 to 60 years and possessing between 1 and 30 years of clinical experience, participated in the study. Additionally, nine third-year psychiatry residents, aged 30 to 50 years, were included; all had successfully completed coursework in psychotherapy. The patient group consisted of sixteen individuals, aged 20 to 50 years, diagnosed with either bipolar I disorder with psychotic features or schizophrenia with positive symptoms. Interviews continued until data saturation was achieved, meaning that no new categories or subcategories emerged from the final interviews. A comprehensive summary of the participants' characteristics is presented in Table 1.

Table 1. Profile of participants

Participants	Sex(female/male)	Age (year)	Experience (year)
Professors	4/5	35-60	1-30
Residents	8/1	30-50	Studying in the third year
Bipolar patients	5/5	20-50	-
Schizophrenia patients	2/4	20 -50	-

Findings of Qualitative Content Analysis

The study was conducted using qualitative content analysis, and interviews were carried out through both focus group sessions and individual formats. At the conclusion of the analytic process, emotional constructs and associated terms were identified from participants' accounts and were preliminarily categorized accordingly. To improve theoretical clarity, the emotional categories were subsequently organized into two principal domains: positive and negative countertransference reactions, grouped by emotional valence. This arrangement enabled a direct, comparative overview of therapist responses across the diagnostic groups. Utilizing a qualitative interpretive lens, the researchers examined relative frequency patterns between schizophrenia and bipolar disorder. Although statistical analysis was not performed, differences were described in terms of clinical relevance rather than statistical significance. Overall, 19 categories were identified in relation to bipolar disorder and 14 for schizophrenia, as summarized in Table 2. Positive countertransference emotions encompassed themes such as mercy and compassion, supportiveness, curiosity, excitement, passion, familiarity, and happiness, whereas negative reactions included anger and rage, lack of communication, stress and helplessness, inadequacy, disappointment, irritation, rejection, and envy.

The distribution of emotional responses across the two diagnostic groups is depicted in Figure 3. In cases of bipolar disorder with manic and psychotic symptoms, the most frequently reported emotions were mercy and compassion (17%), anger and rage (14%), and excitement (11%), whereas the least frequent responses including envy, stress and helplessness, passion, and familiarity each represented 1%. Conversely, in schizophrenia with positive symptoms, the most prevalent reactions were mercy and compassion (24%) and lack of communication (23%), while the least frequently observed responses were curiosity (2%), rejection (1%), and disappointment (under 1%). Overall, positive countertransference reactions predominated in therapists' encounters with bipolar patients, whereas negative reactions, especially lack of communication and anger, were more pronounced during interactions with schizophrenia patients.

Discussions

This study employed a comparative interpretive framework to investigate differences in countertransference responses between schizophrenia and bipolar disorder. Emotional reactions were classified by valence and compared across diagnostic groups based on relative frequency. Although no statistical testing was undertaken, these descriptive contrasts were interpreted in the context of relevant clinical and psychodynamic literature, permitting an initial exploration of how diagnostic characteristics might shape therapists' emotional experiences.

Research on countertransference in bipolar disorder is scarce. It has been reported that clinicians treating patients during severe manic or depressive relapses often encounter compulsory interventions that can provoke profound emotional reactions such as sadness, guilt, grief, and anger (14). In the present study, anger, rage, and sadness emerged as prominent therapist reactions to bipolar mania with psychotic

features, corroborating previous findings. Another study noted that clinicians working with irritable, aggressive, or restless manic patients frequently experienced anxiety and fear (15), which is consistent with the anxieties and irritability reported by participants here.

Table 2. Classes extracted from qualitative content analysis

	Classes		Reasons	Examples of quotes from participants
Bipolar mania phase with psychotic symptoms	Positive	Mercy and compassion	Lack of vision of the patient, the nature of the disease, constant hearing hallucinations with annoying content, inappropriate behavior of others and even the medical staff, the current living conditions and poverty of the patient's family, failure to meet his demands, divorce, failure to meet his wishes despite many efforts, lack of understanding and family support, patient helplessness, repeated hospitalization	"There was a feeling of compassion, especially when he said that they used to eat half a sheep before, and now they can't afford it."
		Excitement	Interesting professions, type of speaking, elevated mood, high energy of the patient, and childish behavior	"At first, the patient exhibited humorous behavior and speech, which I found entertaining and amusing."
		Happiness	The memory of the therapist's friend, the memory of the trip to Mecca for the therapist, and the high morale of the patient	"During the interaction with the patient, the contagious nature of her manic affect became apparent; I experienced a sense of elevated mood and found myself wanting the conversation to continue. "
		Lovely and respectable	Being active and helpful despite the illness, the type of talking, the elevated mood, honest, the association of a therapist friend to him and reminding him of past conversations	"I found her endearing, and despite her excessive talkativeness, I felt no urge to interrupt, as the interaction elicited a sense of warmth and respect."
		Caution	Lack of ethical boundaries in patient speech, irritability, evaluated mood, and patient control	"Her boundaryless behavior evoked an instinctive need to withdraw slightly and prompted a heightened sense of caution in the interaction."
		Being a supporter	Patient helplessness, severe dependence on family members, the nature of the disease, and elevated mood	"When the topic of divorce arose and she appeared frightened, it felt as though her fear was projected onto me. I found myself pulled out of a neutral observational stance, emotionally impacted by her deep sense of vulnerability. This evoked a strong empathic and supportive response in me, accompanied by an internal urgency to determine what I could say or do to help alleviate her fear."
		Curiosity	Skipping thoughts, not fully answering questions, and the patient world	"At times, she made statements that carried a degree of ambiguity, which aroused a sense of curiosity in me to understand what she was truly attempting to express."

		Passion	Familiarity with the patient's face and having seen him or her before, and the patient's face and movements during the interview	"During the session with the patient, I did not initially experience strong emotional responses; however, I found her discussion about Mars intriguing. I became captivated by her narrative and briefly imagined myself in the environment she described."
		Familiarity	Familiarity with the patient's face and flashing a friend into the therapist's mind	"At the same time, I felt a genuine liking for the patient; she appeared to be straightforward and sincere, openly expressing her thoughts and emotions. Her demeanor reminded me of a close friend of mine."
	Negative	Anger and rage	Patient dissatisfaction, family poverty compared to previous, patient talkativeness, forced hospitalization and lack of family understanding, the association of therapist previous problems, patient hasty movements and irritability, patient anger towards others, marginalization in response to questions, frequent hospitalizations, the patient's exaggerated professions about the previous situation of the family, the patient's requests, the patient's refusal to accept treatment and insistence, the patient's loud tone, the patient's confusion about the patient's talkativeness, the patient was admitted against his will, lack of understanding of others, non-observance of moral boundaries while talking by the patient	"I experienced a sense of anger when she spoke about becoming a second wife or merely a romantic partner."
		Sadness and unhappiness	Lack of insight into the disease, lack of family attention, nature of the disease, living conditions and failure to meet the demands despite the ability, living conditions, professions, and inappropriate behavior of the family, the patient's sense of victimhood, lack of knowledge of her divorce, twinning with the patient and having a similar experience with the patient during adolescence	"Alongside the sense of anger, I also experienced significant feelings of compassion and sorrow, particularly when the patient spoke about enduring ten years of domestic violence, being expelled from her home, and experiencing infidelity by her husband. These accounts evoked a strong emotional response of sadness and distress in me."

		Confusion	Ignorant expression of her divorce, ill patient insight, turbulent life, the crisis of identity formation, despite the educational differences between parents, the patient's confused thoughts, marginalization and high speed while speaking, hurried movements, the content of the patient's speeches and fantasies	"At the same time, she evoked a sense of confusion in me, seemingly rooted in the conflicting behaviors of her parents and the turbulence she had experienced in her life, as well as her ongoing efforts to construct a personal identity. She left little room for reflection and often induced a sense of mental disorientation."
		Anxiety	Non-observance of boundaries by the patient while talking	"Toward the end of the session, a mild sense of anxiety emerged, stemming from concerns that some of the questions might cross professional boundaries."
		Boredom	Lack of two-way communication, loud tone of voice of the patient, marginalization, accelerated movements, and content of the patient's speech	"Toward the end of the session, I experienced a sense of boredom and emotional fatigue, and found myself wishing for the encounter to conclude sooner."
		Lack of communication	Distraction	"The patient frequently jumped abruptly from one topic to another, making it difficult for me to stay connected or maintain a coherent flow in the conversation."
		Disappointment	The nature of the disease and the patient's extensive delusions, lack of patient vision, feelings of hopelessness, despair about recurrent relapses and rejection by the family	" The patient appeared to be under the influence of an external force—expressed in her saying, "If God is pleased, I feel good"—which gave me the sense that she was not in control of her own emotional state. In turn, I began to feel as though I was being drawn into her inner world and losing my own therapeutic footing. Ultimately, I felt disappointed, as the persistence and rigidity of her well-structured delusions made me question the possibility of meaningful therapeutic progress."
		Incompetence	Recurrent recurrences, nature of the disease, and recurrent hospitalizations	"I felt a deep sense of compassion for her, accompanied by a strong feeling of professional inadequacy upon learning that she had been hospitalized again."
		Envy	The good mood of the patient	"There was a sense of envy; in other words, one could feel jealous of her."
		Stress and helplessness	Patient talkativeness	"I felt as though time was controlling me, which induced a sense of pressure and constraint."
	Positive	Mercy and compassion	Patient's lack of vision, annoying auditory hallucinations, the nature of her illness, lack of understanding by the family, lack of pleasure by the patient, not being understood even by her/his therapist, and the negligence of the family	"I felt a deep sense of compassion for the patient upon learning that they had been hospitalized again."

Schizophrenia with positive symptoms		Support	Lack of support and the nature of the disease	“Hearing that the patient was being abused by their family brought tears to my eyes and made me feel distressed, but above all, it evoked a strong urge to provide support and protection.”
		Excitement	Fantasies, conversations, and face of the patient	"In general, the patient’s fantastical and childlike speech captured my attention and evoked a sense of engagement and excitement.”
	Negative	Lack of communication	Being a patient in one’s own world, the nature of the disease, not understanding the patient’s words, the patient speaks for herself and does not answer questions, the patient’s kind of world and boredom	“It was difficult to establish a meaningful connection with the patient, and at times, I found myself becoming distracted during the session.”
		Anxiety	Patient paranoia, inadequacy in treatment due to the nature of the disease, co-occurrence or assimilation with the patient, and the patient’s irritability	“The patient’s paranoid attitude evoked feelings of distrust and wariness, and it led to a noticeable increase in my own anxiety during the interaction.”
		Boredom and fatigue	Monotonous talking, lack of communication, and prior knowledge about the patient	"The patient is currently under my care in the ward. As a chronic case with limited response to treatment, the interactions often feel monotonous and emotionally draining. During clinical rounds, I notice a lack of motivation, and today, the predominant feeling I experienced was boredom, with little to no other emotional engagement.”
		Curiosity	Given the content of the patient’s conversations and fantasies, the therapist was curious about the patient’s diagnosis	"During the first ten minutes, I was deeply engaged in listening, with a growing sense of curiosity about the patient’s internal world.”
		Confusion	Jumping thoughts due to the patient’s speaking model, lack of concentration and distraction, confusion, lack of vision of the patient and the patient’s world, and the form of the patient’s speech that does not convey the concept	"The patient evoked a sense of confusion and appeared to be immersed in their own world, often providing answers unrelated to the questions asked.”
		Incompetence	Recurrent recurrences, the nature of the disease, the patient’s sense of entanglement, and helplessness	"When I learned that the patient had been hospitalized multiple times, I experienced a sense of professional inadequacy.”
		Sadness and grief	Lack of vision, appearance and sound and helplessness of the patient, the nature of the disease and conception with the patient	"Recognizing that the patient exists in such a difficult world brings about feelings of deep sadness and mourning.”
		Pressure	Hoarseness, being discomfort in the meeting and the psychotic world of the patient	"As the patient spoke with a strained voice, I felt overwhelmed by a sense of pressure and suffocation, both emotionally and physically.”

		Anger and rage	Patient resistance to follow orders and patient irritability	"At the start of the session, the patient refused to wear a mask, which immediately triggered anger in me. This emotional reaction persisted as the session continued. I became aware of an internal judgment forming, as I perceived the patient to be self-important or entitled."
		Rejection	Rejection of the patient by others	"During the interview, the patient's abrupt refusals to engage left me feeling rejected and distanced. When they dismissed my attempts to connect as manipulative or intrusive, I experienced a strong sense of being pushed away, which made it difficult to maintain empathy and stay present in the session."
		Disappointment	The nature and recurrence of the disease	"In that moment, when the patient mentioned having been hospitalized multiple times and needing to continue medication and treatment, I felt a sense of disappointment being projected onto me."

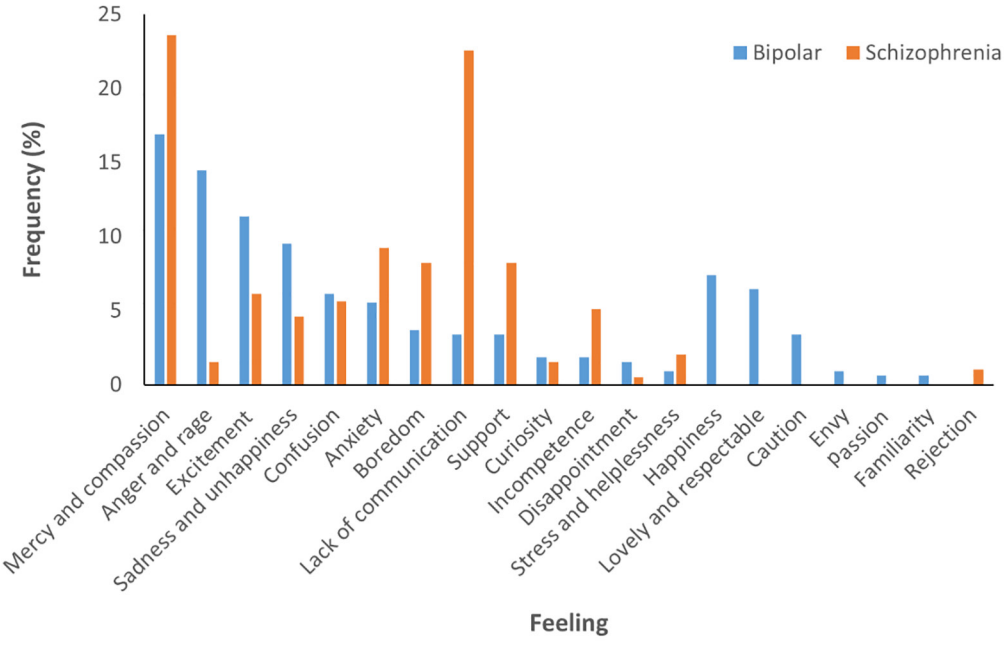


Figure 3. A comparative chart illustrating the relative frequency (in percentages) of therapist-reported emotional reactions in response to patients diagnosed with schizophrenia (positive symptoms) and bipolar I disorder (mania with psychotic features). The most and least prevalent emotional categories for each group are shown.

Further research indicated that psychiatrists encountered higher levels of stress, difficulty coordinating care, and impotence concerns during interactions with bipolar I patients compared to those with unipolar depression or anxiety. Interestingly, coordination challenges were more pronounced with schizophrenic patients, while engagement appeared greater with bipolar or personality disorder cases (16). In the current study, lack of communication was evident in both diagnostic groups. In one case study involving a female bipolar II patient

aged 54, the therapist reported frustration and irritation prompted by the patient's behavior (17). Such incompatibility can also evoke disappointment, particularly when patients repeatedly miss appointments, fail to follow clinical advice, or exhibit resistance to lifestyle changes (15). These observations align with the disappointment countertransference response documented in this study.

While prior investigations have highlighted positive countertransference reactions such as love and respect (18, 19), these studies did not focus directly on bipolar disorder; nonetheless, their findings are in harmony with the positive emotions of affection, respect, happiness, passion, and excitement identified here. In contrast, compassion, confusion, impatience, caution, supportiveness, curiosity, inadequacy, envy, stress, and helplessness have not been widely reported, probably owing to the paucity of research in this specific domain. Countertransference experiences such as guilt and fear have been observed in bipolar clinicians elsewhere (14, 15), though they were not prominent in our sample.

Although schizophrenia countertransference has been more extensively studied than bipolar, the literature remains limited. One study identified emotional intensity or engagement as a prominent countertransference response to schizophrenic patients (20), which parallels the theme of compassion described by participants here. Additional investigations have underscored the challenges of establishing communication and empathy with schizophrenia patients (21-23), corroborating the lack of communication noted by therapists in our research.

Other research revealed that schizophrenia patients elicit greater anxiety than individuals with depression or borderline personality disorder (24), aligning with anxiety reports from participants. However, a study suggesting that schizophrenia patients evoke less frustration or irritation than other patient groups (24) contrasts with our findings, which documented experiences of boredom and fatigue. An American psychiatrist characterized schizophrenia patients as individuals striving to escape a persistent, distressing dream, describing them as confused and disoriented (25). Such descriptions reflect the confusion reported by therapists in this study. Another author noted that schizophrenia patients challenge therapists and may exacerbate doubts about professional competence when unresolved issues persist (26). Therapists in our study expressed feelings of inadequacy, often attributing them to the complex, enduring nature of the illness and the patient's psychological entanglement.

Karon (1992) asserted that psychotherapy remains unpopular for schizophrenia not due to inefficacy but because it unsettles therapists (27). Similarly, one study documented that patients with schizophrenia, by freely expressing uncensored thoughts, can evoke initial fear and a sense that the patient possesses insider knowledge about the therapist (28). Consequently, some participants in our research reported feelings of pressure, which diverges slightly from other literature. Anger and rage, reported by therapists during schizophrenia interviews in this study, have also been documented previously (26, 29-30). Sullivan theorized that schizophrenic patients may elicit emotions such as fear, hatred, and panic, rooted in early developmental anxieties, and that their world may provoke curiosity in therapists (25). Although curiosity has not been central in prior countertransference studies, participants in this research attributed it to the patient's distinctive internal reality and imaginative world. Some studies have reported feelings of friendliness, despair, or disappointment in response to schizophrenia patients (32, 24), which correspond with the rejection and disappointment reactions observed here. The current investigation also revealed excitement and support as dimensions of therapist emotional response not previously emphasized in the literature. Reactions such as

frustration, exploitation, hatred, narcissism, and helplessness, documented in other studies (24, 31-34), were notably absent in our findings.

This study makes a notable contribution to the countertransference literature by presenting a refined framework that distinguishes positive from negative therapist emotional responses, highlighting their potential diagnostic and therapeutic implications. Specifically, therapists interacting with manic bipolar patients frequently reported positive responses such as compassion, curiosity, and happiness, signifying emotional attunement and relational engagement. In contrast, encounters with schizophrenia patients elicited more negative responses, including anger, helplessness, and detachment, echoing existing evidence on the interpersonal challenges inherent in treating individuals with schizophrenia (20, 21, 23). These patterns underscore the notion that countertransference is not inherently detrimental; rather, both positive and negative reactions may serve as clinical cues, possibly guiding therapeutic decision-making and deepening sensitivity to diagnostic subtleties in acute psychiatric contexts (18, 19, 26).

Research Limitations

Despite the exploratory qualitative design and the limited number of participating therapists at a single site, multiple strategies were implemented to bolster the trustworthiness of the findings. These included prolonged engagement with the clinical setting, triangulation across therapist roles (faculty and residents), peer debriefing, and member checking. Reflexive journaling and repetitive transcript reviews added depth and consistency to the analytic process. Detailed descriptions of the clinical context, participant characteristics, and emotional themes were provided to support transferability. While the findings may not be universally generalizable, they offer meaningful insights applicable to similar psychiatric training and supervision settings. The absence of statistical analysis further limits the generalizability of observed contrasts between diagnostic groups. Nonetheless, given the study's qualitative and exploratory nature, the primary goal was not hypothesis testing but rather conceptually framing therapists' emotional responses with respect to diagnostic categories. Therefore, the reported patterns should be interpreted as tentative clinical observations, rather than statistically validated findings.

Conclusions

The results of this qualitative investigation demonstrated that lack of communication, happiness, and feelings of affection and respect were significantly more frequently elicited by patients with schizophrenia featuring positive symptoms, whereas anger and rage were more vigorously evoked by patients with bipolar I disorder exhibiting mania and psychotic features. Hence, these emotional patterns may be proposed as potential clinical indicators for differentiating between these two psychiatric conditions. Although the relatively small sample size may restrict generalizability which is a limitation acknowledged within qualitative research paradigms, mitigation strategies were employed, including avoiding monotony, providing in-depth descriptive analysis, and thoroughly reviewing participants' diverse experiences. Future research should enlist larger, more diverse samples to further refine these insights in a structured, generalizable manner. Developing a deeper understanding of such emotional dynamics may serve as a valuable resource for navigating intricate therapeutic interactions, particularly in acute psychiatric settings, by enhancing practitioners' emotional attunement and reducing the risk of emotional exhaustion in high-stress clinical environments.

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Conflict of Interest

Authors declare that they have no conflict of interest.

Ethics Approval

This study has been approved by the Vice-Chancellor for Research of Kerman University of Medical Sciences, with the Ethics Committee number IR.KMU.AH.REC.1399.170.

Availability of data and material

Datasets related to this project can be obtained from the corresponding author based on a reasonable request.

Authors' Contribution

AB, and NK: data collection. AB, NK, and PM: manuscript writing. NK, and PM: idea conception and study design. AB, and PM: statistical analysis. AB, NK, and PM: review and proof-reading. All authors approved of the final version.

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