Patient Personality and Therapist Response: An Empirical Investigation

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Objective: The aim of this study was to examine the relationship between therapists' emotional responses and patients' personality disorders and level of psychological functioning.

Method: A random national sample of psychiatrists and clinical psychologists (N=203) completed the Therapist Response Questionnaire to identify patterns of therapists' emotional response, and the Shedler-Westen Assessment Procedure–200 to assess personality disorders and level of psychological functioning in a randomly selected patient currently in their care and with whom they had worked for a minimum of eight sessions and a maximum of 6 months (one session per week).

Results: There were several significant relationships between therapists' responses and patients' personality pathology. Paranoid and antisocial personality disorders were associated with criticized/mistreated countertransference, and borderline personality disorder was related to helpless/inadequate, overwhelmed/disorganized, and special/overinvolved countertransference. Disengaged countertransference was associated with schizotypal and narcissistic personality disorders and negatively associated with dependent and histrionic personality disorders. Schizoid personality disorder was associated with helpless/inadequate responses. Positive countertransference was associated with avoidant personality disorder, which was also related to both parental/protective and special/overinvolved therapist responses. Obsessive-compulsive personality disorder was negatively associated with special/overinvolved therapist responses. In general, therapists' responses were characterized by stronger negative feelings when working with lower-functioning patients.

Conclusions: Patients' specific personality pathologies are associated with consistent emotional responses, which suggests that clinicians can make diagnostic and therapeutic use of their responses to patients.

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A therapist's emotional response to a patient can inform both diagnostic and therapeutic interventions (in this context, we use the term "emotional response" interchangeably with "emotional reaction" and "countertransference") (1–5). Concepts such as complementary and concordant countertransference, role responsiveness, projective identification, cognitive interpersonal cycle, and interpersonal complementarity suggest that a patient may engage with a clinician in a manner that leads the therapist to experience emotions and thoughts that may in turn provide greater awareness of the patients' feelings and perspectives (6–10). Personality disorders are by definition dysfunctional schemas of the self, others, and relational interactions. These patterns of relating often appear in the therapeutic relationship, drawing the clinician into interactions that reflect the patient's enduring and maladaptive relationships (3, 5, 8, 11–18). As a consequence, therapists' recognition of their emotional responses and experience is an important vehicle for assessing and understanding patients' relationship patterns.

Although clinical descriptions of therapists' emotional responses to patients are often rich, systematic empirical research to date has been limited. Only a few studies have examined the associations between specific personality disorders and therapists' emotional responses (19, 20). Betan et al. (19) asked 181 clinicians of various theoretical orientations to evaluate their emotional responses to a nonpsychotic patient with the Therapist Response Questionnaire (21). The therapists also rated their patient's personality on the presence or absence of each DSM-IV axis II criterion. Factor analysis yielded eight countertransference dimensions (for a detailed description, see the data supplement that accompanies the online edition of this article): 1) overwhelmed/disorganized indicates a desire to avoid or flee the patient and strong negative feelings, including dread, repulsion, and resentment; 2) helpless/inadequate describes feelings of inadequacy, incompetence, hopelessness, and anxiety; 3) positive indicates the experience of a positive working alliance and close connection with the patient; 4) special/overinvolved describes a sense of the patient as special relative to other patients and includes "soft signs" of problems in maintaining boundaries, including self-disclosure, ending sessions on time, and feeling guilty, responsible, or overly concerned about the patient; 5) sexualized describes sexual feelings toward the patient or experiences of sexual tension; 6)

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disengaged is marked by feeling distracted, withdrawn, annoyed, or bored in sessions; 7) parental/protective is marked by a wish to protect and nurture the patient in a parental way, above and beyond normal positive feelings toward the patient 8); criticized/mistreated describes feelings of being unappreciated, dismissed, or devalued by the patient. These patterns were associated with the three DSM-IV axis II clusters: cluster A correlated with the criticized/mistreated pattern; cluster B was associated with overwhelmed feelings, helplessness, hostility, disengagement, and sexual attraction; and cluster C correlated with therapists' protective and warm feelings. In general, cluster B was associated with a broader range of therapist emotional responses than the other two clusters. Clinicians working with patients with narcissistic personality disorder reported feelings of inadequacy, devaluation, and ambivalence.

These results were consistent with the findings of other studies that have found that patients with cluster A and B disorders evoke more negative therapist reactions than cluster C patients, and that cluster B patients evoke more mixed feelings in therapists (20). Some research has also demonstrated that cluster B patients, especially those with borderline pathology, elicited higher levels of anger and irritation and lower levels of liking, empathy, and nurturance (22, 23) and tend to be perceived as more dominant, hostile, and punitive than patients with depressive disorders (23).

These studies have generally focused on comparing therapist reactions in relation to DSM diagnosis at cluster level (19, 20) or on single disorders, mostly borderline personality disorder (22, 23). They have not examined the differential responses of clinicians to the broadest possible scope of personality disorders. In addition, some of this work has been constrained by the use of artificial stimuli, such as responses to case vignettes or recordings rather than ongoing interaction with actual patients (22, 23). There have been other limitations, such as the use of the same therapist to evaluate several patients and thus allowing for potential interdependencies among the ratings (i.e., therapist effects) (20).

We attempted to address these limitations in this study, which is both a replication and an extension of work by Betan et al. (19). We explored the following hypotheses: 1) specific personality disorders evoke distinct countertransference responses in therapists; 2) these countertransference responses cannot be accounted for by therapist theoretical orientation; and 3) globally lower-functioning patients evoke the most intense negative emotional responses in therapists.

Method

Sampling

From the rosters of the two largest Italian associations of psychodynamic and cognitive-behavioral psychotherapy and from centers specializing exclusively in the treatment of personality disorders, we recruited by e-mail a random sample of clinicians with at least 3 years' postpsychotherapy licensure experience who performed at least 10 hours per week of direct patient care. We requested that they select a patient who was at least 18 years old; who had no psychotic disorder or syndrome with psychotic symptoms or any pathology that could complicate differentiation between psychological states and personality traits (for example, severe depressive or bipolar disorders); who was not on drug therapy for psychotic symptoms; and whom the therapist had seen for a minimum of eight sessions and a maximum of 6 months (one session per week). To minimize selection biases, we directed clinicians to consult their calendar to select the last patient they saw during the previous week who met the study criteria. To minimize rater-dependent biases, each clinician was allowed to describe only one patient. Clinicians did not receive any remuneration, and we had a response rate of approximately 81% (203 therapists). All participants provided written informed consent.

Therapists. The therapist sample consisted of 203 Caucasians, 111 of whom were women; 65% were psychologists and 35% were psychiatrists. Their mean age was 43 years (SD=9, range=34–52). Two main clinical-theoretical approaches were represented: psychodynamic (N=103) and cognitive-behavioral (N=100). A portion of cognitive-behavioral clinicians (N=30) had a metacognitive interpersonal orientation (13, 14). The average length of clinical experience as a psychotherapist was 10 years (SD=3, range=3–17), and the average time spent per week practicing psychotherapy was 16 hours (SD=3.9, range=13–25). Seventy percent of the patients described were from private practice and the remaining 30% from public mental health institutions.

Patients. The patient sample consisted of 203 Caucasians, 118 of whom were women; their mean age was 34 years (SD=4.5, range=29.5–38.5). Fifty-nine patients had only a DSM-IV axis I diagnosis, 71 had only an axis II diagnosis, 46 had comorbid axis I and axis II diagnoses, and 27 had a double axis II diagnosis.

Among patients with axis I diagnoses (alone and comorbid with axis II disorders), 28 had a generalized anxiety disorder, 25 had a panic disorder, 23 had an eating disorder, 15 had a substance (cannabis) use disorder, and 14 had a dysthymic disorder. The mean Global Assessment of Functioning (GAF) score was 56 (SD=11.9). The length of treatment (one session per week) averaged 5 months (SD=0.9; range=2–6).

Measures

Shedler-Westen Assessment Procedure–200 (SWAP-200). The SWAP-200 is a psychometric system designed to provide a comprehensive assessment of personality and personality pathology (24–28). It consists of 200 items that the assessor sorts into eight categories, from not descriptive to most descriptive of the person.

The SWAP-200 assessment furnishes 1) a personality diagnosis expressed as the matching of the patient assessment with 10 personality disorder scales, which are prototypical descriptions of DSM-IV axis II disorders, and 2) a personality diagnosis based on the correlation/matching of the patient's SWAP description with 11 Q-factors/styles of personality derived empirically. It also includes a dimensional measure of psychological strengths and adaptive functioning and makes it possible to obtain both categorical and dimensional diagnoses.

Therapist Response Questionnaire. The Therapist Response Questionnaire (21), which is filled out by a clinician, is designed to assess countertransference patterns in psychotherapy. It consists of 79 items measuring a wide range of thoughts, feelings,

and behaviors expressed by therapists toward their patients (see the online data supplement). The statements are written in everyday language so that clinicians of any theoretical approach can use the tool without bias. The questionnaire comprises eight countertransference dimensions derived by factor analysis: overwhelmed/disorganized, helpless/inadequate, positive, special/overinvolved, sexualized, disengaged, parental/protective, and criticized/mistreated (19).

In the present study, the eight factor-derived scales demonstrated excellent internal consistency (29). The following Cronbach's alpha values were obtained: overwhelmed/disorganized, 0.83; helpless/inadequate, 0.81; positive, 0.78; special/overinvolved, 0.76; sexualized, 0.71; disengaged, 0.79; parental/protective, 0.73; and criticized/mistreated, 0.81.

Clinical questionnaire. We constructed an ad hoc questionnaire for clinicians to provide general information about themselves, their patients, and the therapies they used. Clinicians provided basic demographic and professional data, including discipline (psychiatry or psychology), theoretical approach, employment address, hours of work, number of patients in treatment, and gender, as well as patients' age, gender, race, education level, socioeconomic status, and DSM-IV axis I diagnoses. Clinicians also provided data on the therapies, such as length of treatment and number of sessions.

Procedure

After we received the clinicians' agreement to participate, we provided them with the material to conduct the study. They were asked first to evaluate their emotional response concerning the selected patient using the Therapist Response Questionnaire, and then, between 1 and 3 weeks later, to evaluate the same patient's personality using the SWAP-200. We used this interval because of the different time commitment required by the measures. That is, we wanted the clinicians to complete the faster and user-friendly Therapist Response Questionnaire immediately after a session with the designated patient, and to complete the more structured and time-consuming SWAP-200 later, allowing them to plan for this more involved personality assessment. Separating the two evaluations was also aimed at reducing any possible effect that evaluating their emotional response might have on a concurrent rating of that same patient's personality. Thus, we sought to limit the impact of the clinicians' emotional response when they completed personality ratings of that same patient.

Statistical Analysis

All analyses were conducted with SPSS 20 for Windows (IBM, Armonk, N.Y.) To study the relationship between countertransference patterns and specific personality disorders, we calculated the partial correlations (partial r, two-tailed) between Therapist Response Questionnaire factors and each personality disorder scale in SWAP-200, removing the effect of the other nine personality disorders in each analysis. We used these partial correlations to obtain results specific and unique to each disorder/countertransference pattern, controlling for the overlap between different personality disorder diagnoses.

To explore whether specific associations were dependent on clinicians' approaches, we calculated the partial correlations between each personality disorder and therapist response pattern, eliminating from the sample all the psychodynamic clinicians (remaining N=100).

Finally, to investigate the relationship between patients' psychological functioning and clinicians' emotional responses, we calculated the bivariate correlations (Pearson's r, two-tailed) between the SWAP-200 high-functioning scale and Therapist Response Questionnaire factors.

Results

Therapist Response and Patient Personality Pathology

Our first hypothesis was that there is a relationship between specific patient personality disorders and therapist emotional responses. We found that the SWAP-200 paranoid and antisocial disorder scales were associated with criticized/mistreated countertransference, and the borderline personality disorder scale was related to helpless/inadequate, overwhelmed/disorganized, and special/overinvolved countertransference. Disengaged countertransference was positively associated with the schizotypal and narcissistic personality disorder scales and negatively with the dependent and histrionic personality disorder scales. The schizoid personality disorder scale was associated with the helpless/inadequate response. A positive countertransference pattern was associated with the avoidant personality disorder scale, which was also related to both parental/protective and special/overinvolved therapist responses. The obsessive-compulsive personality disorder scale was negatively associated with the special/overinvolved response (Table 1).

Our second hypothesis evaluated whether the association between clinician countertransference and patient personality, found in previous analyses, was dependent on the therapist's theoretical orientation. The partial correlations calculated with a sample of cognitive therapists did not differ from those in the full sample (including psychodynamic therapists), suggesting that the results were not affected by clinicians' theoretical preconceptions.

In Table 2, we present narrative descriptions of the therapist emotional responses associated with each personality disorder.

Therapist Response and Patient Psychological Functioning

Concerning our third hypothesis, we found a positive correlation between level of patient psychological functioning and therapist emotional response, with higher levels of patient functioning related to more positive therapist reactions ($r=0.29$, $p\leq0.001$). Higher levels of patient functioning also demonstrated a significant and negative relationship with criticized/mistreated ($r=-0.43$, $p\leq0.001$), helpless/inadequate ($r=-0.35$, $p\leq0.001$), and overwhelmed/disorganized ($r=-0.33$, $p\leq0.001$) therapist responses.

Discussion

The primary goal of this study was to examine the relationship between therapist response and patient personality pathology. The findings support our hypothesis that there would be significant and consistent relationships between therapist reactions and specific

TABLE 1. Partial Correlations Between Therapist Response Questionnaire Factors and SWAP-200 Personality Disorders (N=203)[a]

Personality Disorder	Countertransference Factor							
	Criticized/ Mistreated	Helpless/ Inadequate	Positive	Parental/ Protective	Overwhelmed/ Disorganized	Special/ Overinvolved	Sexualized	Disengaged
Paranoid	0.24***	0.10	–0.08	–0.06	–0.06	–0.10	–0.11	0.11
Schizoid	0.04	0.14*	–0.08	–0.07	–0.03	–0.07	–0.05	0.08
Schizotypal	0.02	–0.08	–0.10	–0.11	–0.13	–0.08	–0.11	0.39***
Antisocial	0.31***	0.07	–0.12	–0.11	0.08	0.10	0.02	0.13
Borderline	0.12	0.36***	–0.01	–0.01	0.51***	0.22***	0.08	–0.11
Histrionic	0.10	0.09	–0.06	–0.04	0.11	0.13	0.05	–0.27***
Narcissistic	0.12	0.06	–0.09	–0.02	0.01	0.04	0.04	0.16*
Avoidant	–0.09	0.11	0.16*	0.28***	–0.07	0.18*	–0.09	–0.12
Dependent	–0.09	0.14*	0.02	0.27***	–0.13	0.19**	0.03	–0.16*
Obsessive	–0.04	0.09	–0.02	–0.13	–0.07	–0.16*	–0.01	0.13

[a] SWAP-200=Shedler-Westen Assessment Procedure–200. The table lists partial r, two–tailed.
*p≤0.05. **p≤0.01. ***p≤0.001.

personality disorders (Table 1). Moreover, confirming the results of Betan et al. (19), we found that clinicians of different therapeutic approaches produced similar data, suggesting that these results are not artifacts of their theoretical preferences and that patient interpersonal patterns are quite robust in evoking emotional responses from therapists employing different technical styles. This demonstrates that if clinicians have and recognize countertransference feelings, they can use them to inform themselves about their patients' interpersonal patterns (1, 17).

Another aim of this study was to investigate the relationship between therapist response and patient level of personality functioning. Our results are consistent with those of Dahl et al. (30), suggesting that therapists feel more helpless, inadequate, and disorganized with low-functioning patients.

Turning to the more specific and nuanced findings of our study, patients with cluster B personality disorders seem to elicit more mixed and negative responses in their therapists than do patients with cluster A and C disorders. Our results further support previous findings that cluster B patients evoke more negative and difficult-to-manage emotions in their therapists (11, 12, 19, 20, 22, 23, 31, 32). Among cluster B disorders, borderline patients seem to arouse stronger and more heterogeneous reactions in clinicians, who tend to feel overwhelmed with high levels of anxiety, tension, and concern. Clinicians treating borderline patients report feeling incompetent or inadequate and experiencing a sense of confusion and frustration in sessions. They report apprehension about failing to help these patients, and they experience guilt when they see these patients distressed or deteriorating (Table 2). This heterogeneity among therapists' emotional responses could reflect the contradictory self and other representations that characterize borderline patients (2, 11).

Such intense feelings in work with borderline patients could lead therapists to perform in an erratic manner. For example, therapists could have difficulties in setting and maintaining boundaries or, conversely, could set extensive and rigid limits on their patients' requests. Clinicians could also avoid the expression of their thoughts and feelings during a session because they fear an angry reaction, or instead offer sudden and aggressive interpretations or confrontations of patient behavior. Likewise, with narcissistic patients, therapists may come to feel bored, distracted, disengaged, and frustrated (Table 2). These kinds of emotional responses could provoke an emotional disattunement, with lack of interest and empathy ultimately leading to impasse and treatment termination.

Regarding cluster C patients, we found several significant patterns of therapist response. Of particular note was the protective and positive feelings of therapists toward avoidant patients, perhaps experiencing a wish to repair some deficiencies or failures in their patients' relationships with parents or significant others. Overprotective feelings could induce the therapist to avoid the exploration of the patients' painful feelings or aggressive affects, considering these individuals to be too fragile and vulnerable.

Our results partially diverge from previous studies that found that cluster C patients do not seem to evoke negative feelings in their therapists (19, 20). In our sample, clinician responses to patients with dependent personality were characterized by positive and protective feelings but also by feelings of helplessness and inadequacy; therapists can feel like their hands have been tied or that they have been put into an impossible bind. These results may indicate that if the therapist "buys into" the patient's view of him- or herself as helpless or incapable, such a perception is capable of arousing first parental and warm feelings, and secondly negative feelings (3, 33, 34).

This study has some limitations. First, the same clinician provided data about both a patient's personality pathology and his or her own countertransference, which may be a source of measurement bias. A more rigorous research design would include an independent assessment of patients' personality disorders or the use

TABLE 2. Narrative Descriptions of Countertransference Factors Measured Using the Therapist Response Questionnaire and Correlated With Each SWAP-200 Personality Disorder[a]

Personality Disorder	Narrative Description of Countertransference
Paranoid	Clinicians tend to feel criticized, unappreciated, and devalued by these patients. They feel afraid to say the wrong thing, or have to stop themselves from doing something aggressive, lest these patients explode, fall apart, or walk out. Paranoid patients tend to stir up strong feelings and animosity in therapists, who can experience resentment and anger and endorse intense feelings of being mistreated and rejected when working with them.
Schizoid	Clinicians tend to feel incompetent or inadequate working with these patients. They feel hopeless and frustrated and have more difficulties establishing a comfortable relationship with, being more attuned with, and developing a sense of intimate connections with a schizoid patient. They worry that they will not be able to help them, or feel they are failing them. In fact, they are pessimistic about any gains they may be making or are likely to make in treatment. They can sometimes think the patient might do better with another therapist or a different kind of therapy.
Schizotypal	Clinicians tend to feel bored, distracted, and annoyed in sessions with patients. They do not feel engaged in sessions but experience a sense of detachment and withdrawal (for example, their minds can often wander to things other than what they are talking about).
Antisocial	Clinicians tend to feel mistreated, criticized, or repulsed and can experience an intense anger and irritation working with antisocial patients. They often feel used or manipulated by them and pushed to set firm limits in the clinical setting. They can sometimes feel they are being cruel, mean, or aggressive when working with these patients and wish they had never taken them on in therapy.
Borderline	Clinicians tend to feel overwhelmed by strong emotions and intense needs. In particular, more than with most patients, therapists feel like they have been pulled into things but do not realize it until after the session is over. Borderline patients can "frighten" clinicians, who experience high levels of anxiety, tension, and concern when working with them. Therapists can also feel incompetent or inadequate and often experience a sense of confusion and frustration in sessions. They are afraid they are failing to help these patients and can sometimes feel guilty when they see them distressed or deteriorating, as they feel they must be somehow responsible. Clinicians talk about them with significant others more than about other patients. They are "special" patients, and in sessions therapists can do things for them, or go the extra mile for them, in ways that they do not do for other patients (for example, they end sessions late with them more than with other patients).
Histrionic	Clinicians tend not to feel bored or distracted with these patients. On the contrary, they feel fully engaged in sessions and engrossed by them. Histrionic patients tend to require a lot of attention from their therapists, who feel overinvolved and have more difficulties maintaining set boundaries. For example, more than with most patients, they refrain from stating opinions or views on topics the patient discusses, and they may disclose their feelings toward them and self-disclose about their personal life.
Narcissistic	Clinicians tend to feel bored, distracted, and annoyed in sessions with these patients. They do not feel engaged when working with them and often feel frustrated. Therapists also sometimes feel interchangeable, as if they could be anyone to the patient. They can feel ineffectual, invisible, and deskilled.
Avoidant	Clinicians tend to be more protective of and caring toward these patients and hold back their vulnerabilities and fears. They can experience a sort of overinvolvement and, for example, may feel a wish to repair some deficiencies or failures in patients' relationships with their parents or significant others. In fact, when working with avoidant patients, therapists can often feel sad in sessions, or angry at people in their own lives who do not give them what they need. At the same time, therapists tend to feel pleased or satisfied and are hopeful about the results these patients are making or are likely to make in treatment.
Dependent	Clinicians tend to feel nurturant toward these patients and have warm, almost parental feelings toward them. They wish they could give them what others never could and want to protect them. Therapists talk about these patients with their partners or significant others more than about their other patients. In sessions they disclose their feelings or self-disclose more about their personal life than with their other patients. They feel engaged in sessions with them and do not feel distracted or avoidant. However, they sometimes feel anxious or frustrated and can experience a sense of incompetence and inadequacy. They can feel like their hands have been tied or that they have been put into an impossible bind.
Obsessive	Clinicians do not feel engaged or involved in sessions with these patients. In therapy they can experience feelings of annoyance, boredom, and withdrawal. They do not find it exciting working with these patients and do not talk about them with significant others more than about their other patients.

[a] These narrative descriptions of therapists' responses to patients with personality disorders are created by aggregating the items making up each Therapist Response Questionnaire factor associated with a specific personality disorder on the Shedler-Westen Assessment Procedure–200 (SWAP-200).

of an observer-rated analysis of therapists' reactions, or both. Second, our sample may not be representative of all patients with psychiatric disorders, as it contained a substantial proportion of patients with axis II disorders and a limited proportion with axis I disorders. Also, our population had a narrow age range, with patients between their mid-30s and early 50s. Finally, it is possible that social desirability biases influenced the therapist ratings. For example, contrary to clinical expectations (3, 5, 11, 34), no significant correlations with the sexualized countertransference factor emerged. The countertransference measure we used was limited to therapist self-report, and defensive biases and failure to recognize unconscious feelings are inherent to this method of evaluation. The analysis of countertransference in session video or transcripts using an observer perspective may help overcome this limitation in future work.

Some important factors, however, partially mitigate concerns that the results simply reflect clinician biases, in particular in relation to patients' personality diagnoses.

Patient Perspective

"Ms. F" is a teacher in her late 30s who presented with concurrent diagnoses of borderline personality disorder and substance abuse. She had trouble maintaining her interpersonal relationships because of difficulty in managing her anger, which had manifested in, among other things, physical assaults and multiple suicide attempts. During the intake sessions, Ms. F was very hostile and aggressive. The therapist felt overwhelmed and fearful, and often felt that he was "walking on eggshells" during his interactions with her. This kind of interaction would often make him feel incompetent, inadequate, and worried, thinking he would not be able to help her. Gradually recognizing his emotional response to the patient, the therapist tries to manage his feelings and to connect them with the patient's personality and history. Ms. F had been physically abused by her father, who beat her for minor infractions and even for no reason at all. The clinician realizes that his feelings of incompetence and disorganization may mirror the patient's own feelings as an abused child. In light of these considerations, the therapist proposes that the patient share and discuss her current feelings in the session. This self-observation and awareness of his countertransference helps the therapist overcome the relational impasse.

Therapist: *I'm wondering if you are still angry at me.*

Patient: *Of course I am. You never do anything right.*

Therapist: *Nothing right?*

Patient: *Yes. It doesn't matter what; you never do anything right.*

Therapist: *Whatever I say … you don't like.*

Patient: *I'm certainly not the one who has to explain what your job is.*

Therapist: *Here we are! Instead, why don't we try to understand why since our first session things don't seem to be working very effectively for either one of us?*

Patient: *So boring …*

Therapist: *Maybe a better thing to say is that we have to find a different way to be together …*

Patient: *Humpf …*

Therapist: *What I am trying to say is that we seem to be frozen in our roles. You say you're often angry and frustrated with me, and I seem to be stuck between the fear of making you angry and the worry of being ineffective.*

Patient: *If you say so …*

Therapist: *Here we are again! It seems like I am your enemy and must be attacked before I can hurt you.*

(Patient mumbles and curls up on the chair.)

Therapist: (After some silence) *It seems like this is different, less confrontational, but also now you seem more frightened than angry.*

Previous research has suggested that clinicians tend to make highly reliable and valid judgments if their observations and inferences are quantified using psychometrically sophisticated instruments such as those used in our study (19, 24, 28, 35, 36). Also, the validity of SWAP diagnoses relies on therapist experience rather than specific instrumental training (28, 37). In regard to the high prevalence of axis II compared with axis I diagnoses in our patient sample, it is important to note that this is likely due to our recruitment strategy, as several of the psychological associations, institutes, and clinicians assisting us in our research specialized in the treatment of personality disorders, and personality disorders are probably more frequent among their clinical populations.

Previous studies examining therapist emotional responses to axis II patients (19, 20) have aggregated patients at the cluster level rather than at the level of the individual disorder as we did. Using the latter approach in this study may have obscured important information regarding specific therapist responses in relation to specific personality pathologies. We found similarities in therapist responses to patients suffering from personality disorders of different clusters. That is, some therapist reactions to borderline and dependent personality disorders were quite similar, such as the capacity of both types of patients to evoke helpless and overinvolved reactions in therapists. Although these two disorders belong to different clusters, they share important core pathological dynamics, such as interpersonal neediness and anxious attachment (3, 5, 11–13, 33). Also of note, the effect sizes obtained in our study are generally larger than those of Betan et al. (19). One possible explanation is that Betan et al. assessed personality disorders only through the DSM-IV axis II personality disorder criteria set. This procedure may offer less breadth and depth with regard to the construct of personality than the use of the SWAP-200. It will be important in future studies to evaluate the impact of therapist emotional response and patient personality style with other process variables directly related to treatment process, such as interaction structures (38), use of technique, or therapeutic alliance ruptures and resolutions (16, 17).

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References

1. Hayes JA, Gelso CJ, Hummel AM: Managing countertransference, in Psychotherapy Relationships That Work: Evidence-Based Responsiveness, 2nd ed. Edited by Norcross JC. New York, Oxford University Press, 2011, pp 203–223
2. Kernberg OF: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, Conn, Yale University Press, 1984
3. PDM Task Force (ed): Psychodynamic Diagnostic Manual. Silver Spring, Md, Alliance of Psychoanalytic Organizations, 2006
4. OPD Task Force (eds): Operationalized Psychodynamic Diagnosis OPD-2: Manual of Diagnosis and Treatment Planning. Ashland, Ohio, Hogrefe & Huber, 2008
5. Gabbard GO: Textbook of Psychotherapeutic Treatments. Washington, DC, American Psychiatric Publishing, 2009
6. Racker H: The meanings and uses of countertransference. Psychoanal Q 1957; 26:303–357
7. Sandler J: Countertransference and role-responsiveness. Int J Psychoanal 1976; 3:43–47
8. Gabbard GO: A contemporary psychoanalytic model of countertransference. J Clin Psychol 2001; 57:983–991
9. Safran JD: Assessing the cognitive-interpersonal cycle. Cognit Ther Res 1984; 8:333–347
10. Kiesler DJ: The 1982 Interpersonal Circle: a taxonomy for complementarity in human transactions. Psychol Rev 1983; 90:185–214
11. Clarkin JF, Yeomans FE, Kernberg OF: Psychotherapy for Borderline Personality: Focusing on Object Relations. Washington, DC, American Psychiatric Publishing, 2006
12. Bateman AW, Fonagy P: Mentalization Based Treatment for Borderline Personality Disorder: A Practical Guide. Oxford, UK, Oxford University Press, 2006
13. Dimaggio G, Semerari A, Carcione A, Nicolò G, Procacci M: Psychotherapy of Personality Disorders: Metacognition, States of Mind, and Interpersonal Cycles. New York, Routledge, 2007
14. Dimaggio G, Carcione A, Salvatore G, Semerari A, Nicolò G: A rational model for maximizing the effects of therapeutic relationship regulation in personality disorders with poor metacognition and over-regulation of affects. Psychol Psychother 2010; 83:363–384
15. Lingiardi V, Filippucci L, Baiocco R: Therapeutic alliance evaluation in personality disorders psychotherapy. Psychother Res 2005; 15:45–53
16. Colli A, Lingiardi V: The Collaborative Interactions Scale: a new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy. Psychother Res 2009; 19:718–734
17. Safran JD, Muran JC, Eubanks-Carter C: Repairing alliance ruptures. Psychotherapy (Chic) 2011; 48:80–87
18. Lingiardi V, Colli A, Gentile D, Tanzilli A: Exploration of session process: relationship to depth and alliance. Psychotherapy (Chic) 2011; 48:391–400
19. Betan E, Heim AK, Zittel Conklin C, Westen D: Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. Am J Psychiatry 2005; 162:890–898
20. Røssberg JI, Karterud S, Pedersen G, Friis S: An empirical study of countertransference reactions toward patients with personality disorders. Compr Psychiatry 2007; 48:225–230
21. Zittel C, Westen D: The Therapist Response Questionnaire. Atlanta, Emory University, Departments of Psychology and Psychiatry and Behavioral Sciences, 2003. http://www.psychsystems.net/Manuals/Countertransference/Westen%20countertransference%20questionnaire.pdf
22. Brody F, Farber B: The effects of therapist experience and patient diagnosis on countertransference. Psychotherapy 1996; 33:372–380
23. McIntyre SM, Schwartz RC: Therapists' differential countertransference reactions toward clients with major depression or borderline personality disorder. J Clin Psychol 1998; 54: 923–931
24. Westen D, Shedler J: Revising and assessing axis II, part I: developing a clinically and empirically valid assessment method. Am J Psychiatry 1999; 156:258–272
25. Westen D, Shedler J: Revising and assessing axis II, part II: toward an empirically based and clinically useful classification of personality disorders. Am J Psychiatry 1999; 156:273–285
26. Westen D, Shedler J, Lingiardi V: The Evaluation of Personality With the SWAP-200. Milan, Raffaello Cortina, 2003
27. Shedler J, Westen D: Refining personality disorder diagnosis: integrating science and practice. Am J Psychiatry 2004; 161: 1350–1365
28. Shedler J, Westen D: The Shedler-Westen Assessment Procedure (SWAP): making personality diagnosis clinically meaningful. J Pers Assess 2007; 89:41–55
29. Streiner DL: Being inconsistent about consistency: when coefficient alpha does and doesn't matter. J Pers Assess 2003; 80: 217–222
30. Dahl HS, Røssberg JI, Bøgwald KP, Gabbard GO, Høglend PA: Countertransference feelings in one year of individual therapy: an evaluation of the factor structure in the Feeling Word Checklist–58. Psychother Res 2012; 22:12–25
31. Gunderson JG: Borderline personality disorder: ontogeny of a diagnosis. Am J Psychiatry 2009; 166:530–539
32. Bourke ME, Grenyer BFS: Psychotherapists' response to borderline personality disorder: a core conflictual relationship theme analysis. Psychother Res 2010; 20:680–691
33. Perry JC: Dependent personality disorder, in Oxford Textbook of Psychotherapy. Edited by Gabbard GO, Beck JS, Holmes J. New York, Oxford University Press, 2005, pp 321–328
34. McWilliams N: Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process, 2nd ed. New York, Guilford, 2011
35. Hilsenroth MJ, Ackerman SJ, Blagys MD, Baumann BD, Baity MR, Smith SR, Price JL, Smith CL, Heindselman TL, Mount MK, Holdwick DJ Jr: Reliability and validity of DSM-IV axis V. Am J Psychiatry 2000; 157:1858–1863
36. Westen D, Muderrisoglu S: Clinical assessment of pathological personality traits. Am J Psychiatry 2006; 163:1285–1287
37. Westen D, Shedler J: Personality diagnosis with the Shedler-Westen Assessment Procedure (SWAP): integrating clinical and statistical measurement and prediction. J Abnorm Psychol 2007; 116:810–822
38. Jones EE: Therapeutic Action: A Guide to Psychoanalytic Therapy. Northvale, NJ, Jason Aronson, 2000