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Understanding the Distinctive Presentations of Therapist Countertransference with Cluster B Personality Disorders

Sara Ashley Florence

UNDERSTANDING THE DISTINCTIVE PRESENTATIONS OF THERAPIST COUNTERTRANSFERENCE WITH CLUSTER B PERSONALITY DISORDERS

by

Sara Ashley Florence

Nova Southeastern University

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Approved:

7/28/2020

Date of Defense

DocuSigned by:
Jennifer Davidtz
3BDACD76FB4940F...

Jennifer Davidtz, Ph.D., Chairperson

DocuSigned by:
Christian DeLucia
3390335F6B0248D...

Christian DeLucia, Ph.D.

DocuSigned by:
Paula Brochu
2DC516DE28694C8...

Paula Brochu, Ph.D.

DocuSigned by:
Stephen Campbell
BD4CDC3853D5489...

Stephen Campbell, Ph.D.

8/9/2020

Date of Final Approval

DocuSigned by:
Jennifer Davidtz
3BDACD76FB4940F...

Jennifer Davidtz, Ph.D., Chairperson

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Sara Ashley Florence

Name

July 28, 2020

Date

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UNDERSTANDING THE DISTINCTIVE PRESENTATIONS OF THERAPIST COUNTERTRANSFERENCE WITH CLUSTER B PERSONALITY DISORDERS

by

Sara Ashley Florence, M.S.

Nova Southeastern University

Abstract

Countertransference is one of several therapist variables that have been demonstrated to impact the quality of the therapeutic alliance. CT that is understood and managed by the therapist has the potential to serve as a tool in better understanding the patient, which puts the therapist in a better position to intervene therapeutically. CT that are emotionally charged can be more difficult to manage, and CT reactions tend to be especially emotionally intense when working with patients with Cluster B personality disorders (PDs). A better understanding of specific CT reactions to each Cluster B PD might aid in diagnosis and treatment and CT management, which may, in turn, contribute to more positive therapy outcomes. To date, no authors have specifically examined and compared the distinct CT presentations that are elicited from Cluster B personality diagnoses. The aim of this study was to examine whether the presentation of therapist CT differs systematically between Cluster B PD groups. A sample of psychologists and psychology trainees completed an online survey on their experience with a patient with a cluster B PD. Participants provided demographic information and completed the Level of Personality Functioning Scale to assess severity of the patient's pathology as well as the Therapist Response Questionnaire to evaluate their CT response to the patient. ANOVAs revealed significant differences between PD groups on 3 of 8 TRQ CT variables and

distinct CT presentations were identified for each PD group. Antisocial PD was associated with a low criticized/mistreated response; borderline PD was associated with a low disengaged, low criticized/mistreated, high parental/protective response; narcissistic PD was associated with a high disengaged, high criticized/mistreated, and low parental/protective response; and no associations were identified with histrionic PD. These results contribute to a developing framework of identifying specific CT associated with each Cluster B PD, which will be utilized to inform future treatment decisions and improve CT management on the part of the clinician.

Keywords: personality disorders; Cluster B; counseling; therapy; countertransference

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Statement of the Problem

The relationship between a therapist and patient, referred to as the therapeutic alliance, is an essential component of the therapeutic process (Raj, 2014). A strong therapeutic alliance has been shown to be more predictive of positive outcome than the type of intervention and has been linked to positive therapy outcomes in patients of different ages, different types of treatment, and therapy contexts (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Martin et al., 2000; Shirk & Karver, 2003; Karver et al., 2006). Critical to the therapeutic alliance is the concept of countertransference, or the therapist's reactions to the patient (Colli & Ferri, 2015). These emotional responses arise as a combination of patient and therapist factors, in that the source of the therapist's reactions to the client originates within the therapist, but the catalyst for this reaction may be some patient characteristic or behavior (Hayes, 2004).

Countertransference (CT) responses are vital as they can impact therapeutic interventions and outcomes, influence patient resistance and elaboration, mediate the influence of therapist interventions, and inform the clinician about the patient's personality and psychiatric diagnosis (Colli & Ferri, 2015; Lingiardi et al., 2015). For example, a meta-analysis conducted by Gelso and Hayes (2018) found that the uncontrolled acting out of CT is typically harmful to psychotherapy and that an effective psychotherapist can be aware of and manage internal countertransference reactions to improve therapy outcome. In addition, a study by Westra et al. (2012) observing therapeutic relationships between four therapists and 30 patients found that greater therapist early positive reactions to clients, especially liking, enjoyment, and attachment, were associated with significantly lower levels of client resistance midtreatment and

greater reductions in client resistance from early to midtreatment. Furthermore, a study conducted by Ulberg, Amlo, Hersoug, Dahl, and Høglend (2014) found that therapists experiencing a higher "disengaged" emotional response to a patient (i.e., bored, tired of, sleepy, indifferent, aloof) showed poorer implementation of therapeutic interventions as well as poorer treatment outcomes.

As mentioned previously, therapist countertransference can also provide crucial information regarding patient personality and psychiatric diagnosis. Previous research has shown that therapists experience different emotional reactions when exposed to different patient diagnoses, such as borderline personality disorder, depression, or schizophrenia (Brody & Farber, 1996; Røssberg et al., 2007). Expanding on this, recent research has identified distinct patterns of countertransference emerging in response to different personality clusters (Colli & Ferri, 2015; Colli et al., 2014; Gazzillo et al., 2015), supporting the idea that clinicians' responses to their patients and their personalities can have critical relevance to tailoring and managing diagnosis and treatment (Betan et al., 2005).

Cluster B personality disorders are noted to be extremely difficult to treat and associated with intense CT reactions due to their dramatic, emotional, and erratic presentation (Kraus & Reynolds, 2001). Though the presentations are similar, each of the disorders requires different considerations for treatment and is best treated with a specific psychological intervention. Working with these patients can be difficult both due to the intensity of their symptoms, as well as the effects of their interpersonal impairments on the therapeutic relationship. A better understanding of clinicians' CT reactions to each of the Cluster B personality disorders can be extremely beneficial clinically both for

diagnosis and treatment planning, as well as management of CT reactions.

Given the growing understanding of the importance of countertransference in the process and outcome of therapy, more research is being conducted in this area. However, this research has either focused on comparing different diagnoses, comparing only different personality disorders, or comparing clusters of personality disorders. Despite the literature supporting a link between countertransference and personality disorders, as well as those identifying the difficulties in conducting psychotherapy with patients with Cluster B personality disorders, no research has been published to date specifically investigating the differential presentations of CT when treating patients with Cluster B personality disorders. Given this background, one might expect that each of the four Cluster B personality disorders induces a distinct countertransferential emotional reaction in the therapist.

In order for a therapist to utilize their countertransference as a tool for diagnosis and treatment, the countertransference must be well understood and managed (Gelso & Hayes, 2018). Thus, there may be some clinical benefit to differentiating the countertransference reactions to these specific disorders. The current paper reviews the literature examining countertransference and its relationship to personality in general and specifically Cluster B personality, and subsequently details a study conducted to tease apart the countertransference presentation of each disorder.

Literature Review

Countertransference

The concept of countertransference (CT) was first introduced into the literature by Sigmund Freud in 1910, who stated that countertransference arises in the physician as a result of the patient's influence on the analyst's unconscious feelings (Betan et al., 2005; Gabbard, 2001). According to this initial view, the analyst unconsciously experiences the patient as someone from their past, and this phenomenon is conceptualized as the analysts's transference to the patient (Gabbard, 2001). Because of this perspective, countertransference was considered an obstacle to overcome, and a force that interfered with psychoanalytical treatment (Betan et al., 2005; Gabbard, 2001). This traditional Freudian definition is commonly referred to as the classical definition of countertransference (Hayes, 2004). In this classical perspective, countertransference represented the analyst's childhood-based unresolved conflicts, and interfered with the therapeutic process; therefore, countertransference was to be avoided at all costs (Hayes, 2004).

Following the classical definition, authors began to consider that all therapy reactions could be considered countertransference, whether conscious or unconscious, conflict or reality based, or in response to transference or some other material (Hayes, 2004). Over time, theorists broadened the concept of countertransference, recognizing that the clinician's reactions to the patient have the potential for diagnostic and therapeutic benefit rather than hindering treatment (Betan et al., 2005). Beginning with Paula Heiman (1950), countertransference began to be seen not only as an obstacle to overcome in therapy but also as an important tool in understanding the patient's

unconscious (Gabbard, 2001). Thus developed the totalistic definition of countertransference, in which clients are thought to elicit these reactions from the therapist either by engaging similar reactions as they routinely do with others through projective identification or by role responsiveness (Hayes, 2004). In this definition, countertransference can be thought of as a tool to understand what the client is eliciting from them, while still requiring them to respond thoughtfully and intentionally (Hayes, 2004). More specifically, it is considered a more objective form of countertransference in which the therapist reacts to the patient not from their own personal history or internal conflicts, but in a way that is similar to the reactions evoked from others in the patient's as well, due to their own behavior (Gabbard, 2001). However, this definition has also been met with criticism, as authors have suggested that by conceptualizing countertransference solely as a reflection of the client, it may facilitate "blaming" of the patients for the analyst's countertransference problems (Hayes, 2004).

The integrative conception of countertransference emerged from those dissatisfied with both the classic and totalistic perspectives. According to the integrative definition, countertransference is shaped by both client and therapist factors, in that the source of the therapist's reactions to the client originates within the therapist, but the catalyst for this reaction may well be some client characteristic or behavior (Hayes, 2004). Our current understanding is that countertransference is a jointly created phenomenon that involves contributions from both the patient and the clinician, in which the patient draws the therapist into playing a role that reflects the patient's internal world, but the specific dimensions of that role are colored by the therapist's own personality (Gabbard, 2001; Gelso & Hayes, 1998, 2007; Hayes et al., 2018).

With the idea of an integrative perspective of CT in mind, Hayes (1995) developed a framework of CT that categorizes it into five main components: origins, triggers, manifestations, effects, and management. According to Hayes (1995), the "origins" of CT are areas of unresolved intrapsychic conflict within the therapist that provide a context that will give rise to CT reactions. These unresolved conflicts may be related to power and authority issues, need for approval, unresolved family issues, separation and individuation, issues with abandonment, or any other multitude of past or present conflicts (Hayes, 1995). For example, a therapist who played the role of "rescuer" in their own alcoholic family may be prone to reenacting this role in therapy (Hayes, 1995).

CT "triggers" refer to "therapy-related events that touch on therapists' unresolved conflicts and generate countertransference reactions" (Hayes, 2004). While all therapists possess unresolved intrapsychic conflicts, not all of one's conflicts become stimulated every session. Therefore, the "trigger" refers to what it is that occurs to elicit the CT reaction in the therapist (Hayes, 1995). According to the Countertransference Interaction Hypothesis (Gelso & Hayes, 2007), it is this combination of origins and triggers that are the cause of a countertransference reaction, and as such, the conflict is constructed by both the patient and the therapist. Following this assertion, it is not sufficient to understand the origin of the therapist's triggers (the therapist's contribution to the CT); one must also understand how those triggers are provoked by working with certain patients and in given situations (the patient's contribution to the CT) (Hayes, 2004). For example, research has shown that, for therapists who possess an origin conflict of homophobia, greater levels of CT were exhibited in reaction to gay and lesbian patients

(Gelso et al., 1995; Hayes & Gelso, 1993). This underscores that countertransference greatly depends on the conflict of the therapist, in addition to the patient's triggering feature or behavior.

When CT origins are triggered, therapists experience cognitive, affective, and behavioral reactions called "manifestations". Research has shown that anxiety appears to be the most common affective state experienced by therapists experiencing conflicts with a patient's material (Gelso & Hayes, 2007); however, a study by Hayes and colleagues (1998) found that a majority of therapists felt angry, bored, sad, nurturing, or inadequate in as many as half of their sessions. In terms of cognitions, Hayes and Gelso (2001) found that distortions were at the core of countertransference, in that therapists were more likely to under- or overestimate the frequency with which patients talked about certain material if it was related to CT origins. While CT reactions are inevitable and may provide valuable information about the patient and the therapy, the behavioral manifestations of CT are viewed as directly detrimental to the alliance (Gelso & Hayes, 2002). Behaviors such as hostility, avoidance, or changes in activity level have been posited by Hayes (1995) to be examples of potential CT manifestations.

The fourth category, "effects", refers to the subsequent effects of CT manifestations on the quality of psychotherapy process and outcome. While there exist both positive and negative CT behaviors, positive being friendly or supportive toward the patient and negative being critical or punitive toward the patient, both positive and negative CT behaviors negatively impact the alliance, because both serve the therapist's needs rather than the patient's needs (Friedman & Gelso, 2000). This was evidenced in a study by Ligiero and Gelso (2002) that examined the relationship between

countertransference behaviors, therapist attachment styles, and working alliance. The results of this study found that CT behaviors were associated with poorer working alliances, which then predicted poorer therapy outcome. Additionally, a case study by Rosenberger and Hayes (2002) found that better management of CT behaviors led to greater session depth and appeared to benefit the working alliance. Gelso, Latts, Gomez, and Fassinger (2002) also examined the effects of behavioral manifestations of CT and found that therapist trainees who exhibited better management of behavioral manifestations of CT had better patient outcomes than those who exhibited poorer CT management. This is consistent with modern literature that asserts that CT that is understood and managed tends to facilitate effective treatment, thereby enhancing treatment outcome (Gelso & Hayes, 2002).

Hayes's (1995) final component of CT was the therapeutic management of countertransference. The management of CT has been theorized to consist of five integrated factors: self-insight, self-integration, empathy, anxiety management, and conceptualizing ability (Gelso & Hayes, 2002; Hayes, 2004; Van Wagoner et al., 1991). Self-insight is defined as the therapist's awareness of their own feelings and their origin (Gelso et al., 2002). According to Bandura (1956), the therapist who has greater insight into themself is better able to control their reactions and how they will impact the therapeutic process. Self-integration refers to the therapist's possession of a basically healthy character structure, which allows for a recognition of ego boundaries and an ability for the therapist to differentiate self from patient (Gelso & Hayes, 2001). Empathy refers to the therapist's ability to be attuned to the client's emotion and understand their experience without the thoughts of one's own needs, and despite the difficulties the

therapist may experience with the work (Gelso & Hayes, 2001; Gelso et al., 2002). Anxiety management refers to the therapist allowing themself to experience anxiety, but also being able to understand and control the anxiety so that it does not affect their responses in therapy (Gelso & Hayes, 2001). Lastly, conceptualizing ability reflects the therapist's ability to theoretically understand the patient's dynamics in the context of the therapeutic relationship (Gelso & Hayes, 2001; Gelso et al., 2002).

The Countertransference Factors Inventory (CFI; Hayes et al., 1991; Van Wagoner et al., 1991) was developed to examine these five aspects of CT management and their effect on treatment outcome. This assessment consists of 50 items related to CT management on which a therapist is rated by someone familiar with their clinical work (e.g. a colleague or supervisor), and the results load onto five subscales, each measuring one of these attributes. Research has indicated that these five factors distinguish excellent from average therapists (Van Wagoner et al., 1991) and that therapists in training who possess more of these characteristics demonstrate better treatment outcomes (Gelso et al., 2002).

Personality Disorders

The 5th edition of the Diagnostic and statistical manual of mental disorders describes a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (American Psychiatric Association, 2013, p.645). Given this presentation of pervasive and inflexible behavior, one would expect that a therapist would have a strong countertransference reaction to a patient with a personality disorder

diagnosis. This hypothesis has been long-held based on anecdotal evidence, and the literature has mostly focused on countertransference reactions evoked by patients with borderline personality disorder (BPD) (Røssberg et al., 2007). Previous studies have found that vignettes of patients with BPD evoked more negative countertransference reactions than those of patients with depression or schizophrenia (Røssberg et al., 2007). A study by Brody and Farber (1996) found that therapists reported mostly positive CT toward depressed patients, negative CT toward borderline patients, and a mix of CT reactions toward patients with a schizophrenia spectrum disorder. Yakeley (2019) noted that trainee psychiatrists' attitudes towards patients with BPD were more negative than their attitudes towards patients with depression. More specifically, there is a large body of clinical and anecdotal literature indicating that not only do certain psychiatric diagnoses tend to evoke either positive or negative CT, but different diagnoses evoke distinct and specific CT reactions among therapists (Røssberg, Karterud, Pedersen, Friis, 2010). McIntyre and Schwartz (1998) found that patients with DSM-IV Axis II disorders, particularly Cluster B and borderline patients, evoked much more dominant and hostile feelings than did patients with major depressive disorder. Schwartz, Smith, and Chopko (2007) found that patients with antisocial personality disorder evoked stronger feelings of being exploited and manipulated, and patients with schizophrenia evoked stronger feelings of being liked and welcomed. Yakeley (2019) found that professionals felt less motivated when working with patients with personality disorders and that these patients often evoked negative feelings such as anxiety, condemnation, therapeutic nihilism, guilt, hopelessness, devaluation, and loss of one's professional identity. When studying instant CT (iCT) in a first emergency or outpatient consultation, Michaud et al. (2019) found that

overall therapist response scores and all sub-scores were significantly higher for clinical encounters with patients with PDs. Moreover, they found that caregivers had a lower affinity for this population and felt more dismissed or devalued, guilty, manipulated, disliked, disappointed, indifferent, bored, frustrated, and aloof with these patients, and less liking the patient, receptive, interested, affectionate, objective, motherly, trustful, and helpful. These studies seem to indicate that patients with personality disorders tend to elicit more extreme and negative countertransference reactions than patients with unrelated psychiatric diagnoses.

In addition to differentiating the phenotype of CT in response to different psychiatric diagnoses, past research has attempted to distinguish distinct patterns of CT across different therapist personality types. A study by Betan et al. (2005) determined that patients with DSM-IV Cluster A PDs tended to evoke CT feelings of being criticized or mistreated, whereas patients with Cluster B PDs evoked CT feelings of being overwhelmed, helpless, sexually aroused, and/or disengaged, and patients with Cluster C PDs induced CT feelings of protectiveness and having a warm connection. In addition, Røssberg et al. (2007) found that clinicians' emotional responses to patients with Cluster A and B diagnoses were generally more negative and troublesome than their responses to those with Cluster C diagnoses, which were less mixed and less complex. Similarly, Bradley, Heim, and Westen (2005) found that patients with PD diagnoses from different DSM-IV clusters tended to develop unique, distinct relationships with their therapists. Patients with Cluster A diagnoses tended to not feel a secure engagement with their clinicians, those with Cluster B diagnoses tended to develop an angry/entitled or sexualized relationship, and those with Cluster C diagnoses tended to develop an

anxious/preoccupied relationship. Similarly, when studying clinicians' reactions when working with adolescent patients, Tanzilli et al. (2019) found that distinct therapist emotional reactions were related to specific adolescent personality disorders in a clinically coherent and systematically predictable way. More specifically, they noted that adolescent patients with Cluster A and B personality disorders tended to evoke more negative therapist reactions than those with Cluster C personality disorders, and that Cluster B patients elicited intense and more mixed feelings in their therapists. In addition, patients with lower personality and psychological functioning were found to arouse stronger levels of negative emotional responses in clinicians. These results overall indicate a pattern of clinicians being more comfortable with patients diagnosed with anxious personality disorders (Cluster C) than they are with those who are more emotionally dysregulated and show signs of cognitive slippage under stress (Clusters A and B).

Countertransference as a Diagnostic Tool

Given the evidence that different patterns of CT emerge in response to patients with different personality disorder diagnoses, more recent research has attempted to identify whether specific PDs elicited particular characteristic CT reactions.

A recent study conducted by Colli, Tanzilli, Dimaggio, and Lingiardi (2014) sought to examine the relationship between therapist CT and patient PD and found that different personality styles were associated with specific therapist emotional responses. In particular, paranoid and antisocial personality disorders were associated with Criticized/Mistreated feelings on the part of therapists. Schizoid personality disorder is associated with helpless responses, and schizotypal disorder was associated with

disengaged responses. Antisocial personality disorder was connected with feelings of helplessness/inadequacy, whereas borderline personality disorder was associated with Helpless/Inadequate, Overwhelmed/Disorganized, and Special/Overinvolved emotional reactions. Narcissistic personality disorder was associated with a disengaged response, whereas histrionic personality disorder showed the opposite pattern, being negatively associated with this kind of emotional reaction. Dependent and obsessive compulsive personality disorders were both negatively associated with feelings of disengagement and overinvolvement. Finally, avoidant personality disorder was associated with a positive emotional reaction, similar to that of a good therapeutic alliance, in addition to a Parental/Protective emotional response.

A study by Gazzillo et al. (2015) similarly attempted to explore the relationship between personality and CT, but did so using level of personality organization and type of personality disorder as assessed with the categories in the Psychodynamic Diagnostic Manual (PDM Task Force, 2006) instead of the DSM, as in other studies. Results supported the hypothesis that distinct personality types would evoke distinct reactions. More specifically, a parental and disengaged response was associated with the depressive, anxious, and dependent personality disorders; an exclusively parental response with the phobic personality disorder; and a parental and criticized response with narcissistic disorder. Dissociative disorders evoked a helpless and parental response in the treating clinicians, whereas somatizing disorder elicited a disengaged reaction. An overwhelmed and disengaged response was associated with sadistic and masochistic personality disorders, with the latter were also associated with a parental and hostile/criticized reaction; an exclusively overwhelmed response with psychopathic

patients; and a helpless response with paranoid patients. Finally, patients with histrionic personality disorder evoked an overwhelmed and sexualized response in their clinicians, whereas there was no specific emotional reaction associated with the schizoid and the obsessive-compulsive disorders.

Tanzilli et al. (2019) attempted to examine the differential emotional responses of clinicians to adolescent patients with a broad range of personality styles/disorders. They found distinct associations between clinician responses and the personality of their adolescent patient. Borderline patients led to CT reactions characterized by strong feelings of dread, confusion, anxiety, concern, and anger in therapy; narcissistic patients evoked a sense of frustration, disengagement, withdrawal, and boredom; histrionic patients provoked sexual tension in their therapists; antisocial patients evoked feelings of detachment and difficulty with empathy and establishing a confident and warm clinical relationship; patients with schizoid and schizotypal PDs tended to elicit withdrawal and severe emotional disattunement in therapists; those with paranoid PDs tended to provoke CT reactions combining anger, irritation, and helplessness; and, lastly, adolescents with avoidant and dependent PDs elicited positive CT and good levels of collaboration in therapy.

This association between CT patterns and personality disorder characteristics support the idea that clinicians can use their emotional reactions to inform their understanding of the personality styles of their patient, and ultimately, as one of several tools to inform diagnosis (Betan et al., 2005). To the extent that patients sharing diagnostic features have similar ways of thinking, feeling, and behaving interpersonally, it seems that they may also evoke similar reactions from others, including therapists

(Betan et al., 2005). Gazzillo et al. (2015) noted that the CT reactions identified in their study correlate with those described for each disorder in the PDM, which suggests that the emotional reaction of the therapist could be used as one source of data informing the process of diagnosing the personality style of the patient. However, while these studies have identified distinct CT patterns, researchers have also questioned how the individual factors of the therapist might affect the relationship between patient personality and therapist's emotional reaction (Colli & Ferri, 2015; Gazzillo et al., 2015).

"Cluster B" Personality

Within the DSM-5 (American Psychiatric Association, 2013), personality disorders are separated into three clusters. While Cluster A personality disorders (Paranoid, Schizoid, and Schizotypal personality disorders) are described as odd or eccentric and Cluster C disorders (Avoidant, Dependent, and Obsessive-Compulsive personality disorders) are deemed anxious or fearful, Cluster B personality disorders have been characterized as "dramatic, emotional, or erratic" (American Psychiatric Association, 2013).

Research on antisocial personality disorder (APD) has become more prevalent than any other personality disorder, perhaps due to the implications for public safety and the economic well-being of society, as well as cinematic representations such as that of Hannibal Lecter in *The Silence of the Lambs* (Kraus & Reynolds, 2001). Previously, this disorder has also been referred to as the psychopathic, sociopathic, and criminal personality (Kraus & Reynolds, 2001). Typical of this disorder is a flagrant disregard for and violation of the rights of others, which is evidenced by repeated criminal offenses, manipulation and mistreatment of others for personal gain, amusement, or in the throes of

passion, and little or no remorse for misdeeds (Hare et al., 1991). The Psychodynamic Diagnostic Manual (PDM; Lingiardi & McWilliams, 2017) describes personality according to several dimensions, including affect, self, defenses, and capacity for relatedness, which includes transference and countertransference considerations. According to the PDM, typical therapist reactions to antisocial (or psychopathic) character pathology include feeling apprehensive, jittery, or "under the thumb" of their psychopathic patient. The PDM contends that if a clinician conveys a powerful presence, behaves with scrupulous integrity, and recognizes that the patients' motivations revolve primarily around the desire for power, it is possible to have a therapeutic influence. In an individual therapy setting, boundaries and limits are essential with a patient with APD and kindness may be regarded as a sign of weakness (Lingiardi & McWilliams, 2017), as they often threaten therapists, demand money or prescriptions, proposition them, or violate other rules (Kraus & Reynolds, 2001).

Borderline personality disorder (BPD) is the most prevalent personality disorder in clinical settings and is associated with severe functional impairment, substantial treatment utilization, and high rates of mortality by suicide (Grant et al., 2008). Individuals with BPD are frequently in a state of crisis, due to significant impairments in tolerating affect, controlling impulses, and coping with feelings of aloneness (Caligor et al., 2018; Kraus & Reynolds, 2001; Lingiardi & McWilliams, 2017). For many clinicians, a history of self-harming or self-destructive behavior is the central feature of BPD (Kraus & Reynolds, 2001). All known therapy approaches for patients with BPD emphasize the centrality of the working alliance and the importance of repairing it when it is damaged; the critical role of boundaries and the therapist's willingness to tolerate the patient's rage

and hurt when boundaries are maintained; the discouragement of regression; the expectation of intensity; the inevitability of either-or dilemmas; the importance of the patient's sense of the therapist as an affectively genuine person; and the development of capacities for self-reflection, mentalization, or mindfulness (Lingiardi & McWilliams, 2017). All of these therapy approaches also emphasize the need for ongoing clinical supervision and consultation with this population. In an individual therapy setting, similar to APD, patients with BPD require strict limits, as they will often make extravagant requests from therapists, such as asking for hugs, extended sessions, decreased fees, and around-the-clock availability (Kraus & Reynolds, 2001).

Histrionic personality disorder (HPD) is characterized by an excessively dramatic and emotionally exhibitionistic presentation (Kraus & Reynolds, 2001). Previously known as the "hysterical personality", histrionic personality disorder is typified by a preoccupation with gender, sexuality, and their relation to power (Lingiardi & McWilliams, 2018). Their prominent interpersonal style leads them to present as demanding of attention and aggressively seductive (Caligor et al., 2018). This pseudohypersexuality serves as a defense mechanism, warding off feelings of weakness, defectiveness, or fearfulness (Lingiardi & McWilliams, 2018). Of all the Cluster B personality disorders, the least amount of research has been devoted to the HPD (Kraus & Reynolds, 2001). Long-term supportive psychodynamically-oriented individual therapy has typically been the most common treatment for HPD, though cognitive and behavioral treatments are gaining support (Kraus & Reynolds, 2001). In therapy, an important issue in working with HPD is conceptualizing and managing the patient's seductiveness, which may manifest in many ways ranging from sexual acting out to efforts to seduce the

therapist into providing more treatment time, to their overdramatization of insights (Kraus & Reynolds, 2001). A critical step in treatment is increasing insight into the patient's primary defensive mechanisms and their role in conflicts around gender, power, and sexuality (Kraus & Reynolds, 2001; Lingiardi & McWilliams, 2018).

Interpersonal exploitation, grandiosity, the need for admiration, and a lack of empathy represent the core features of narcissistic personality disorder (Caligor et al., 2018; Kraus & Reynolds, 2001). Individuals with NPD often have a pattern of short-term, superficial relationships in which they use people to support their sense of self-esteem (Gabbard et al., 1994). They have a characteristic sense of inner emptiness and meaninglessness that requires recurrent infusions of external affirmation of their importance and value such as relationships, jobs, or physical appearance (Kraus & Reynolds, 2001; Lingiardi & McWilliams, 2018). An integrative approach to therapy is recommended for patients with NPD, confronting defenses when they are salient, and empathetically attuning to underlying hurt and vulnerability when those feelings are accessible (Kraus & Reynolds, 2001; Lingiardi & McWilliams, 2018). In individual therapy, patients with NPD may initially approach the therapeutic relationship superficially or may focus on goals that are related to their need to be admired and impress others (Kraus & Reynolds, 2001). Their "narcissistic envy" may create a subtle fear of progress in therapy, because improvement would reveal that there was originally something to improve (Lingiardi & McWilliams, 2018). Additionally, the patient may experience a "narcissistic rage" in which they lash out as a result of feeling injured, helpless, or overwhelmed (Kraus & Reynolds, 2001). Therapy can be helpful to understand narcissistic rage and aggression as attempts to actively protect themselves

from further emotional or psychic injury (Kraus & Reynolds, 2001).

When a therapist is treating a patient with a Cluster B personality diagnosis, their dramatic, emotional, or erratic nature often leads to a therapeutic relationship that is highly charged with affect (American Psychiatric Association, 2013; Kraus & Reynolds, 2001). While these patients are difficult to work with due to the severity of their psychopathology, difficulty also arises due to the therapist's response to their behavior (Kraus & Reynolds, 2001). Cluster B patients are repeatedly compelled to act out troublesome aspects from their own relationships through the therapeutic relationship, which can lead the therapist to be affected internally, stimulating affects and activating representations of self and others in the therapist's internal world (Caligor et al., 2018; Kraus & Reynolds, 2001). Clinicians may be unaware of the cause of these feelings and may act them out through relation or withdrawal, or may attempt to cope with them by disparaging the patient, questioning their own competence, or feeling guilty over what they may have said or done (Kraus & Reynolds, 2001).

Cluster B personality disorders can appear very similar, as they all present as different signs of the same dramatic, emotional, and erratic coin. In therapy, they are all difficult to treat, and all produce affectively intense therapeutic relationships that lead to a strong CT for the clinician. A better understanding of clinicians' CT reactions to each of the Cluster B personality disorders can be extremely beneficial clinically. Firstly, by developing an understanding of typical CT reactions to specific Cluster B PDs, a therapist can use this information clinically to aid in diagnosis and treatment planning. Secondly, if a clinician is aware of the typical CT reactions that one may expect when treating a specific PD, this may help promote a more focused observation of their own CT. This

would support better CT management, which is important for treatment process and outcome (Ligiero & Gelso, 2002) and, arguably, especially so when working with patients who evoke such strong emotional reactions.

Previous studies examining the relationship between personality disorder diagnosis and therapist CT either compared personality disorder diagnoses to other diagnoses (Bourke & Grenyer, 2010; Brody & Farber, 1996; McIntyre & Schwartz, 1998), broadly included all personality disorder diagnoses (Colli et al., 2014; Gazzillo et al., 2015; Tanzilli et al., 2019), or grouped personality diagnoses into their clusters (Betal et al., 2005; Meehan et al., 2012; Rossberg et al., 2007; Thylstrup & Hesse, 2008). It does not appear that any study has been published investigating the differential presentations of CT in Cluster B personality disorders.

The Current Investigation

Statement of Purpose

As discussed in the preceding literature review, there is a well-established literature on countertransference and its role as a tool to inform the diagnosis of personality disorders. However, to date, no authors have examined the distinct features of CT in psychotherapy with different Cluster B PD diagnoses. A better understanding of clinicians' CT reactions to each of the Cluster B personality disorders would be beneficial clinically in that this information can be used to aid in diagnosis and treatment planning, as well as to promote a more focused observation of therapists' own CT for better CT management, which is important for treatment process and outcome (Ligiero & Gelso, 2002). Therefore, the purpose of this study is to assess whether a diagnosis of one of the four Cluster B personality disorders (antisocial PD, borderline PD, histrionic PD, narcissistic PD) has an effect on each of eight distinct countertransference factors (Overwhelmed/Disorganized, Helpless/Inadequate, Positive/Alliance, Special/Overinvolved, Sexualized, Disengaged, Parental/Protective, and Criticized/Mistreated). The results will inform which CT factors, if any, are distinct to each PD diagnosis, and will contribute to an understanding of the diagnosis and treatment of Cluster B personality disorders.

Hypotheses

The current study will examine whether therapist countertransference (as measured by clinician-reported overwhelmed/disorganized, helpless/inadequate, positive/alliance, special/overinvolved, sexualized, disengaged, parental/protective, and criticized/mistreated feelings) differs by Cluster B personality disorder diagnosis

(antisocial PD, borderline PD, histrionic PD, narcissistic PD). It is hypothesized that the observed level of each of the aforementioned eight CT factors will differ significantly between Cluster B PD groups. More specifically, it is hypothesized that compared to the other groups, APD will be significantly higher on criticized/mistreated (Colli et al., 2014); BPD will be significantly higher on helpless/inadequate and special/overinvolved (Colli et al., 2014); HPD will be significantly higher on disengaged, sexualized, and positive/alliance (Colli et al., 2014; Gazzillo et al., 2015); and NPD will be significantly higher on disengaged and criticized/mistreated, as well as significantly lower on positive/alliance (Colli et al., 2014; Gazzillo et al., 2015; Tanzilli et al., 2015).

Method

Procedures

A sample of psychologists and psychology trainees was recruited via Facebook postings in the Nova Southeastern University College of Psychology Facebook group, emailing the College of Psychology listserv, emailing training directors from APPIC internship listings, and word of mouth.

Clinical psychologists and clinical psychology trainees were emailed an explanation of the study and a link to complete the survey online. After consenting to participate, they completed an initial online survey in which they were asked to indicate which of the four Cluster B personality disorders they have treated. To keep the groups as equal as possible, participants were (1) automatically assigned to complete the survey based on a patient with a diagnosis that was underrepresented in the collected data, and (2) asked to complete the survey based on a patient whom they consider to have the most severe presentation of the assigned Cluster B personality disorder.

Participants were asked to provide demographic information, including their profession, years of experience, theoretical orientation, employment location, employment setting, gender, race, and number of sessions and length of time treating the patient. They were also asked to provide patient demographic information including the patient's age, gender, race, and education level.

Following the provision of demographic information, participants completed the Level of Personality Functioning Scale (LPFS; American Psychiatric Association, 2013) to assess severity of the patient's Cluster B personality pathology. Lastly, they completed the Therapist Response Questionnaire (TRQ; Betan et al., 2005) to assess their

countertransference response to the patient.

Participants

Clinicians

A total of 204 clinicians participated in the study; however, 99 completed enough of the survey to be included in the analyses. Their mean age was about 36 years (SD = 10.27, range = 23-67). The sample was predominately female (86%) and Caucasian (75%). The sample was approximately evenly split between clinical psychologists (50.5%) and clinical psychology trainees (49.5%). The majority (55.4%) were employed at a medical or psychiatric hospital program. The most prominent theoretical orientation was eclectic/integrative (31.7%), followed by cognitive behavioral (28.7%), psychodynamic/psychoanalytical (24.8%), and other (14.9%). Clinicians had an average of 9 years of clinical psychotherapy experience (SD = 8.14, range = 1-37).

Patients

The mean age of the patients that were reported on was about 38 years (SD = 13.97, range = 17-72). Patients were predominantly male (51.5%), Caucasian (63.4%), and had a college level education or above (57.4%). Patients were in treatment with their respective therapists for an average of 27 sessions (SD = 46.22, range = 3-450) over an average of 38 months (SD = 13.97, range = 17-72).

Measures

Cluster B Personality Disorder Diagnosis

Clinicians were assigned one of the four Cluster B personality disorders that they had endorsed having treated and were asked to complete the survey based upon a patient whom they consider to have the most severe presentation of the assigned Cluster B

personality disorder. Thirty clinicians reported on patients with APD (30.30%), 34 reported on patients with BPD (34.34%), 18 reported on HPD (18.18%), and 17 reported on NPD (17.17%).

Severity of Patient Personality Pathology

Level of Personality Functioning Scale (LPFS; American Psychiatric Association, 2013). The LPFS is a scale for assessing the global level of impairment in personality functioning with respect to the domains of identity, self-direction, empathy, and intimacy. Each of the four domains contains three facets, each of which is described on a 5-point continuum ranging from "little or no impairment" (0), to "some" (1), "moderate" (2), "severe" (3), and "extreme" (4) level of impairment. As done in previous studies (Zimmerman et al., 2013), participants rated each of the 12 facets on a 5-point scale, with each of the five response options anchored with the respective short paragraph from the LPFS. For example, one of the three facets of self-direction is "pursuit of coherent and meaningful short-term and life goals." The response options for the respective facet scale were (with level of severity in parentheses): "Sets and aspires to reasonable goals based on a realistic assessment of personal capacities" (0), "Excessively goal-directed, somewhat goal-inhibited, or conflicted about goals" (1), "Goals are more often a means of gaining external approval than self-generated, and thus may lack coherence and/or stability" (2), "Difficulty establishing and/or achieving personal goals" (3), and "Poor differentiation of thoughts from actions, so goal-setting ability is severely compromised, with unrealistic or incoherent goals" (4). The other two facets of the self-direction domain were assessed by two separate scales, and so were the nine facets of the three remaining domains, yielding 12 5-point scales altogether. Prior to analyses, these 12

items were aggregated into four domain scores, which were then aggregated into a single LPFS total score.

Zimmerman et al. (2013) found that interrater reliability for the LPFS total score demonstrated an intraclass correlation = .51 for a single rater, and = .96 when aggregated across the 22 raters. The reliability of individual raters' judgments of the targets' impairments in specific LPFS domains included empathy (ICC = .25), identity (ICC = .41), self-direction (ICC = .46), and intimacy (ICC = .63).

The authors noted perceiver variance in the ratings for empathy and suggested that raters may differ in their individual calibrations of the empathy indicators. The internal consistency/ coefficient alpha for these aggregated markers was greater than .75 for both domain and total scores. In addition, Zimmermann et al. (2013) presented external criterion validity findings, reporting that LPFS global ratings were significantly higher in patients meeting criteria for any DSM-IV PD diagnosis than for those without such a diagnosis. In addition, rated LPFS severity was positively associated with the number of DSM-IV PD diagnoses assigned, supporting the hypothesized link between the severity of these impairments and DSM-IV comorbidity. Finally, there was a high degree of correspondence between participants' LPFS ratings and expert ratings of impairments in personality structure in these patients, providing additional evidence of convergent validity. In the present study, internal consistency as indicated via Cronbach's alpha values is as follows: identity, .64; self-direction, .51; empathy, .73; intimacy, .63; total, .984 when using the four subscales as variables and .75 when using all 12 questions as variables.

Therapist Countertransference

The Therapist Response Questionnaire (TRQ; Betan et al., 2005), previously called the Countertransference Questionnaire, is a 79-item clinician report questionnaire designed to assess the emotional responses of clinicians to their psychotherapy patients. The items measure a wide range of thoughts, feelings, and behaviors expressed by therapists toward their patients, written in jargon-free language and ranging from relatively specific to more complex constructs. Each item is assessed on a 5-point Likert scale (1 = not true; 5 = very true). The TRQ items can be synthesized into eight factors/dimensions of the therapist's emotional response to the patient: Overwhelmed/Disorganized, Helpless/Inadequate, Positive/Alliance, Special/Overinvolved, Sexualized, Disengaged, Parental/Protective, and Criticized/Mistreated.

With respect to reliability, the eight factor-derived scales have been shown to demonstrate good criterion validity and excellent internal consistency (Betan et al., 2005) with the following Cronbach's alpha values: Overwhelmed/Disorganized, 0.90 (current study: $\alpha = .76$); Helpless/Inadequate, 0.88 (current study: $\alpha = .82$); positive, 0.86; Special/Overinvolved, 0.75 (current study: $\alpha = .68$); Sexualized, 0.77 (current study: $\alpha = .64$); Disengaged, 0.83 (current study: $\alpha = .80$); Parental/Protective, 0.80 (current study: $\alpha = .86$); and Criticized/Mistreated, 0.83 (current study: $\alpha = .87$).

Statistical Analysis

Initially, associations were tested between covariates and PD groups (Antisocial, Borderline, Histrionic, and Narcissistic PD) using ANOVA or chi-square analyses. The potential covariates included clinician and patient demographic variables, as well as

LPFS score. Covariates that were significantly associated with diagnostic group (i.e., clinician profession, theoretical orientation, employment setting, race, patient education level, and LPFS) were retained for the next stage of analysis. The retained covariates were then tested for associations with each of the eight Therapist Response Questionnaire outcome variables. These analyses found that therapist profession was a significant covariate for the TRQ scales Criticized/Mistreated, Parental/Protective, and Positive/Alliance, and that patient symptom severity as measured by the LPFS was significant for the TRQ scales Criticized/Mistreated, Helpless/Inadequate, Parental/Protective, and Positive/Alliance (Covariate by diagnostic group interactions were nonsignificant.) An analysis of variance (ANOVA) was calculated comparing Cluster B personality disorder diagnoses for each of the eight TRQ outcome variable scales for a total of eight analyses. The aforementioned covariates were included in the analyses in which they were identified to have a significant effect. A least significant difference (LSD) pairwise comparison was conducted for each significant ANOVA.

Results

A between-subjects ANOVA was conducted to compare the effect of Cluster B personality disorder diagnosis on each of eight therapist response dimensions (Disengaged, Criticized/Mistreated, Helpless/Inadequate, Overwhelmed/Disorganized, Parental/Protective, Positive/Alliance, Sexualized, and Special/Overinvolved) for a total of eight separate analyses. Models varied somewhat by covariate inclusions based on whether or not the covariate had a significant effect on the outcome in question.

Table 1. Means and standard deviations of TRQ outcome variables by personality disorder group

Therapist Response		Antisocial	Borderline	Histrionic	Narcissistic
Disengaged	*M*	1.94	1.69	2.10	2.35
	SD	0.86	0.59	0.90	1.01
Criticized/	*M*	2.17	2.15	2.48	2.77
Mistreated	*SD*	0.14	0.13	0.18	0.18
Helpless/	*M*	2.69	2.66	2.85	2.87
Inadequate	*SD*	0.15	0.14	0.20	0.20
Overwhelmed/	*M*	2.00	2.42	2.48	1.95
Disorganized	*SD*	0.79	0.98	0.95	0.61
Parental/	*M*	2.22	2.43	2.25	1.65
Protective	*SD*	0.17	0.16	0.22	0.22
Positive/	*M*	2.17	2.44	2.28	2.02
Alliance	*SD*	0.12	0.11	0.15	0.15
Sexualized	*M*	1.15	1.17	1.14	1.41
	SD	0.37	0.34	0.36	0.67
Special/	*M*	1.33	1.74	1.78	1.37
Overinvolved	*SD*	0.56	0.89	0.84	0.62

Table 2. Pairwise comparisons of TRQ outcome variables by personality disorder group

Therapist Response		A vs. B	A vs. H	A vs. N	B vs. H	B vs. N	H vs. N
Disengaged	Mean Diff.	0.25	-0.16	-0.41	-0.41	-0.66*	-0.26
	Effect Size (*d*)	0.31	-0.19	-0.51	-0.50	-0.82	-0.31
Criticized/ Mistreated	Mean Diff.	0.03	-0.31	-0.59*	-0.34	-0.62*	-0.28
	Effect Size (*d*)	0.03	-0.40	-0.76	-0.43	-0.79	-0.36
Helpless/ Inadequate	Mean Diff.	0.03	-0.15	-0.18	-0.18	-0.21	-0.02
	Effect Size (*d*)	0.04	-0.17	-0.20	-0.21	-0.23	-0.03
Overwhelmed/ Disorganized	Mean Diff.	-0.43	-0.48	0.05	-0.05	0.47	0.52
	Effect Size (*d*)	-0.49	-0.55	0.05	-0.06	0.54	0.61
Parental/ Protective	Mean Diff.	-0.21	-0.04	0.57	0.17	0.78*	0.61
	Effect Size (*d*)	-0.22	-0.04	0.60	0.18	0.82	0.64
Positive/ Alliance	Mean Diff.	-0.28	-0.12	0.15	0.16	0.42	0.26
	Effect Size (*d*)	-0.39	-0.17	0.21	0.23	0.60	0.37
Sexualized	Mean Diff.	-0.02	0.01	-0.26	0.03	-0.24	-0.27
	Effect Size (*d*)	-0.05	0.03	-0.62	0.07	-0.58	-0.65
Special/ Overinvolved	Mean Diff.	-0.40	-0.44	-0.04	-0.04	0.36	0.41
	Effect Size (*d*)	-0.53	-0.59	-0.05	-0.06	0.48	0.54

*$p < .05$

Disengaged

A one-factor ANOVA examining the effect of Cluster B personality disorder diagnosis on the therapists' reported level of feeling Disengaged was significant [$F(3, 95) = 2.75$, $p = .047$, $\eta^2_{partial} = .080$]. The overall analysis was followed by a series of unadjusted pairwise comparisons, which indicated that therapists reported significantly higher levels of disengagement with patients with narcissistic PD than those with borderline PD (Table 2, $d = 0.82$).

Criticized/Mistreated

A three-factor ANOVA was conducted to determine the effect of Cluster B PD diagnosis, level of personality functioning, and therapist profession on feeling Criticized/Mistreated (see Table 3). There was a significant main effect of Cluster B personality disorder diagnosis on therapists' feelings of being criticized or mistreated ($\eta^2_{partial} = .09$).

Pairwise contrasts revealed that individuals with narcissistic PD evoked significantly stronger feelings of criticism and mistreatment than individuals with antisocial PD (Table 2, $d = 0.76$) and borderline PD diagnoses (Table 2, $d = 0.79$).

The two covariates included in the model, level of personality functioning and therapist profession, also had significant effects on therapists' feelings of being criticized or mistreated (Table 3). Higher levels of impairment in personality functioning were significantly associated with stronger feelings of being criticized or mistreated ($\eta^2_{partial} = .14$). Additionally, clinical psychologists reported significantly higher levels of criticism and mistreatment than clinical psychology trainees ($\eta^2_{partial} = .05$).

Table 3. Effect of Cluster B PD Diagnosis on Therapist Criticized/Mistreated Response

Source	Sum of Squares	*df*	Mean Square	*F*	*p*	Partial Eta Squared	Observed Power
Model	13.57	5	2.71	5.16	0.00	0.23	0.98
Cluster B PD	5.04	3	1.68	3.19	0.03	0.10	0.72
Profession	2.47	1	2.47	4.69	0.03	0.05	0.57
LPFS	7.29	1	7.29	13.84	0.00	0.14	0.96
Error	46.86	89	0.53				

Helpless/Inadequate

A two factor ANOVA was conducted to determine the effect of Cluster B PD diagnosis and level of personality functioning on therapists' feelings of being Helplessness/Inadequate (see Table 4). Cluster B personality disorder diagnosis was found to have a nonsignificant effect on therapist response ($\eta^2_{partial} = .012$).

The covariate included in the model, level of personality functioning, had a significant effect on therapists' feelings of being helpless or inadequate (Table 4). Higher levels of impairment in personality functioning were significantly associated with stronger feelings of being criticized or mistreated ($\eta^2_{partial} = .167$).

Table 4. Effect of Cluster B PD Diagnosis on Therapist Helpless/Inadequate Response

Source	Sum of Squares	*df*	Mean Square	*F*	*p*	Partial Eta Squared	Observed Power
Model	13.48	4	3.37	5.05	0.00	0.18	0.96
Cluster B PD	0.73	3	0.24	0.36	0.78	0.01	0.12
LPFS	12.34	1	12.34	18.49	0.00	0.17	0.99
Error	61.40	92	0.67				

Overwhelmed/Disorganized

A one factor ANOVA examining the effect of Cluster B personality disorder diagnosis on the therapists' reported level of feeling Overwhelmed/Disorganized was nonsignificant [$F(3, 95) = 2.36$, $p = .076$, η^2partial = .069].

Parental/Protective

A three-factor ANOVA was conducted to determine the effect of Cluster B PD diagnosis, level of personality functioning, and therapist profession on Parental/Protective feelings (see Table 5). There was a significant main effect of Cluster B personality disorder diagnosis on therapists' feelings of being parental or protective ($\eta^2_{partial} = .09$).

Pairwise contrasts revealed that individuals with borderline PD evoked significantly stronger parental or protective feelings than individuals with narcissistic PD (Table 2, $d = 0.82$).

The two covariates included in the model, level of personality functioning and therapist profession, also had significant effects on therapists' parental and protective feelings (Table 5). Higher levels of impairment in personality functioning were

significantly associated with stronger parental and protective feelings ($\eta^2_{partial}$ = .07). Additionally, clinical psychologists reported significantly higher levels of parental and protective feelings than clinical psychology trainees ($\eta^2_{partial}$ = .11).

Table 5. Effect of Cluster B PD Diagnosis on Therapist Parental/Protective Response

Source	Sum of Squares	*df*	Mean Square	*F*	*p*	Partial Eta Squared	Observed Power
Model	20.42	5	4.08	5.30	0.00	0.23	0.98
Cluster B PD	6.74	3	2.25	2.91	0.04	0.09	0.68
Profession	8.09	1	8.09	10.49	0.00	0.11	0.89
LPFS	4.94	1	4.94	6.40	0.01	0.07	0.71
Error	68.65	89	0.77				

Positive/Alliance

A three-factor ANOVA was conducted to determine the effect of Cluster B PD diagnosis, level of personality functioning, and therapist profession on Positive/Alliance feelings (see Table 6). There was not a significant main effect of Cluster B personality disorder diagnosis on therapists' positive or alliance feelings ($\eta^2_{partial}$ = 0.07).

The two covariates included in the model, level of personality functioning and therapist profession, also had significant effects on therapists' positive and alliance feelings (Table 6). Higher levels of impairment in personality functioning were significantly associated with stronger positive and alliance feelings ($\eta^2_{partial}$ = .16). Additionally, clinical psychologists reported significantly higher levels of positive and alliance feelings than clinical psychology trainees ($\eta^2_{partial}$ = .16).

Table 6. Effect of Cluster B PD Diagnosis on Therapist Positive/Alliance Response

Source	Sum of Squares	*df*	Mean Square	*F*	*p*	Partial Eta Squared	Observed Power
Model	19.42	5	3.89	10.90	0.00	0.38	1.00
Cluster B PD	2.30	3	0.77	2.15	0.10	0.07	0.53
Profession	5.86	1	5.86	16.46	0.00	0.16	0.98
LPFS	7.17	1	7.17	20.12	0.00	0.18	0.99
Error	31.71	89	0.36				

Sexualized

A one way ANOVA examining the effect of Cluster B personality disorder diagnosis on the therapists' reported Sexualized reactions was nonsignificant [$F(3, 95) = 1.75$, $p = .16$, η^2partial = .05].

Special/Overinvolved

A one way ANOVA examining the effect of Cluster B personality disorder diagnosis on the therapists' reported feelings of being Special/Overinvolved was nonsignificant [$F(3, 95) = 2.38$, $p = .074$, η^2partial = .07].

Discussion

The current study sought to examine whether the presentation of countertransference (as measured by clinician-reported overwhelmed, helpless, positive, special, sexualized, disengaged, parental, and criticized feelings) differs by Cluster B personality disorder diagnosis (antisocial PD, borderline PD, histrionic PD, narcissistic PD). It was hypothesized that the observed level of each of the aforementioned eight CT factors would be significantly different between Cluster B PD groups, with APD significantly higher on criticized/mistreated (Colli et al., 2014); BPD significantly higher on helpless/inadequate and special/overinvolved (Colli et al., 2014); HPD significantly higher in disengaged, sexualized, and positive/alliance (Colli et al., 2014; Gazzillo et al., 2015); and NPD significantly higher on disengaged and criticized/mistreated, as well as significantly lower on positive/alliance (Colli et al., 2014; Gazzillo et al., 2015; Tanzilli et al., 2015) compared to the other groups.

Of the eight CT reactions listed above and measured by the Therapist Response Questionnaire (TRQ; Betan et al., 2005), Cluster B personality disorder diagnosis was found to have a nonsignificant effect on Overwhelmed, Helpless, Positive, Special, and Sexualized therapist responses; that is, none of the four Cluster B personality disorders were associated with significant levels of any of those five reactions. Conversely, Cluster B personality disorder diagnosis was found to have a significant effect on therapists' feelings of being Disengaged, Parental/Protective, and Criticized/Mistreated.

NPD was found to evoke significantly higher Disengaged responses than did BPD. This is consistent with previous studies, which have shown that therapists treating patients with NPD traits may feel disengaged, bored, distanced, indifferent, withdrawn,

aloof, or frustrated (Colli et al., 2014; Gazzillo et al., 2015; Lingiardi et al., 2015, Tanzilli et al., 2017). These results could be explained by the superficial manner in which patients with NPD may initially approach therapy (Kraus & Reynolds, 2001), as well as their difficulty acknowledging their need for closeness and intimacy (Tanzilli et al., 2017).

Previous studies have not identified BPD as being associated with a disengaged clinician response in either a positive or negative direction. However, BPD has been noted to evoke strong feelings such as dread, confusion, concern, and anger in therapists (Tanzilli et al., 2019), which would suggest that therapists are likely to feel engaged with their patient more so than withdrawn, even if the quality of that engagement is more negative than positive.

NPD was also found to evoke significantly higher Criticized/Mistreated responses than did BPD and APD. Previous literature has made similar observations, noting a criticized/devalued countertransference pattern with NPD patients, wherein therapists felt devaluated, unappreciated, demeaned, or belittled by their patient (Gazzillo et al., 2015; Lingiardi, 2015; Tanzilli et al. 2015; Tanzilli et al., 2017). This may be due to the characteristic defensive style of NPD patients, who typically criticize and devalue others in a “narcissistic rage” as a self-protective response to feelings of inferiority, injury, or helplessness (Kraus & Reynolds, 2001; Tanzilli et al., 2017).

Similar to the disengaged CT response, previous studies have not identified BPD as being associated with a Criticized/Mistreated clinician response in either a positive or negative direction. This result is inconsistent with the literature on CT with BPD, which has suggested that BPD largely evokes negative attitudes (Røssberg et al., 2007; Yakeley, 2019) and dominant, hostile feelings (McIntyre & Schwartz, 1998) in clinicians.

APD has previously been associated with Criticized/Mistreated feelings on the part of therapists (Colli et al., 2014) as well as feelings of being exploited and manipulated (Schwartz et al., 2007). This is contradictory to the present results, which place APD as having the lowest Criticized/Mistreated response of the Cluster B PDs, and significantly lower than that of NPD. The clinicians participating in this study may have not have experienced feelings of criticism and mistreatment due to these patients' charm and ability to gain social approval and admiration (Lingiardi & McWilliams, 2017). Further research is indicated to better understand these results with respect to BPD and APD in the future.

Results indicated that patients with BPD evoked a significantly higher Parental/Protective response in their therapists than did those with NPD. While previous studies have not specifically found an association between BPD and a Parental/Protective CT reaction, Tanzilli et al. (2019) noted that therapists held strong feelings of concern for their patients with BPD. This may be due to the high risk of self-harming or self-destructive behavior (Kraus & Reynolds, 2001) as well as the high rates of suicide attempts and completions (Frances, 1993) in individuals with BPD.

Our results are consistent with most previous studies, which did not find an association between NPD and Parental/Protective feelings. Interestingly, Gazzillo et al. (2015) noted a significant positive relationship, which is contradictory to our results of low Parental/Protective response in NPD. They interpreted their findings to reflect the idealization portion of the idealization and devaluation defense mechanism characteristic of NPD and hypothesized that this outcome may have been due to the majority of their participants with NPD having a depressed/depleted subtype rather than the

arrogant/entitled subtype. Given that NPD is characterized by exploitative, superficial relationships (Gabbard et al., 1994; Kraus & Reynolds, 2001), it seems intuitive that these individuals would evoke a low Parental/Protective response in their clinicians as shown in the results of this investigation. However, the findings of Gazzillo et al. (2015) suggest that further inquiry focused on distinguishing the characteristics of patients with different subtypes of NPD may have some clinical utility.

There was not a significant difference between Cluster B PD groups on Helpless, Overwhelmed, Positive/Alliance, Sexualized, and Special/Overinvolved CT feelings in therapists. Previous research has noted that Cluster B PDs evoke CT feelings of helplessness in clinicians when compared to other PD groups (Betan et al., 2005), and both APD and BPD have been associated with therapist reports of a sense of helplessness (Colli et al., 2014; Lingiardi et al., 2015). Similarly, Cluster B PDs have been found to elicit CT feelings of being overwhelmed (Betan et al., 2005), and previous studies have identified significant relationships between overwhelmed feelings and treating patients with BPD (Colli et al., 2014), HPD (Gazzillo et al., 2015), and psychopathy (Gazzillo et al., 2015). Positive/alliance feelings have typically been associated with Cluster C personality disorders such as avoidant (Colli et al., 2014; Lingiardi et al., 2015; Tanzilli et al., 2019) and dependent (Tanzilli et al., 2019) personality disorders. While sexualized responses have been noted with Cluster B PDs (Betan et al., 2005; Bradley et al., 2005; Kraus & Reynolds, 2001), specifically HPD (Gazzillo et al., 2015; Kraus & Reynolds, 2001; Gazzillo et al., 2015), no one Cluster B PD was found in this study to present significantly differently from the rest with regard to this factor. Indeed, the sexualized CT factor had the lowest mean score overall, suggesting that perhaps clinicians underreported

their sexualized CT due to discomfort or ethical concerns regarding endorsing sexual feelings toward a patient. While erotic and sexual emotional reactions on the part of the therapist are valid and therapeutically informative (Lijtmaer, 2004), erotic countertransference often evokes anxiety for therapists and can feel overwhelming, or even disturbing (Little, 2018).

Previously when therapists have written about or discussed their own sexual feelings for patients, they have typically received the traditional advice to control their feelings, go back to analysis, and/or terminate treatment if those feelings were out of control and there was a possibility of acting out (Lijtmaer, 2004). This has led to a fear of shame, which may inhibit thinking about erotic processes (Little, 2018), and lead to defenses such as denial, premature interpretation, or repression (Little, 2018), which may have been exhibited by the clinicians in our sample.

Lastly, while BPD has previously been associated with a Special/Overinvolved therapist CT response (Colli et al., 2014; Lingiardi et al., 2015), the PD groups were not found to differ on this factor. This factor is likely associated more with Cluster C PDs, such as obsessive-compulsive and avoidant personality disorders (Lingiardi et al., 2015). Additionally, special/overinvolved CT has previously been associated with high levels of patient symptomatology (Lingiardi et al., 2015), whereas the average LPFS score for patients in our sample was consistent with a “moderate impairment” in personality functioning (LPFS; American Psychiatric Association, 2013).

Our study found that HPD did not evoke any CT reaction that was significantly different than the other Cluster B PD diagnoses. Other studies found HPD to be positively associated with an overwhelmed and sexualized response (Gazzillo et al.,

2015) and negatively associated with a disengaged response (Colli et al, 2014; Lingiardi et al., 2015). Previous studies have found that that a patient's symptom severity may partially mediate the relationship between their personality pathology and countertransference responses in HPD (Lingiardi et al., 2015), and the patients reported on in the present study were found to have symptoms consistent with a moderate impairment. Additionally, these results may have been due to the small sample size of clinicians reporting on CT with patients with HPD in our study (18 participants).

Implications for Practice

The present findings support the increasingly evidence-based contention that countertransference contains clinically valid information and can be used to aid in diagnosis and treatment planning, as well as improve therapy outcome and effectiveness (Betan et al., 2005; Gazzillo et al., 2015; Hayes et al., 2018).

CT as Clinical Information

The results of this study contribute to the growing body of research identifying differences in CT patterns toward different personality presentations (Colli & Ferri, 2015; Colli et al., 2014; Gazzillo et al., 2015), supporting the hypothesis that clinicians' emotional responses can provide valuable supplemental information for tailoring and managing diagnosis and treatment (Betan et al., 2005). For example, strong feelings of disengagement, criticism, and mistreatment, and low parental and protective feelings, might prompt a therapist to consider the presence of features of narcissistic personality disorder. Similarly, if a therapist recognizes minimal feelings of disengagement, criticism, and mistreatment, and strong parental and protective feelings, they might evaluate the possibility of a diagnosis of borderline personality disorder. In addition, if a

patient already has a diagnosis of a Cluster B PD, a therapist may be better able to observe and manage their feelings of disengagement, criticism and mistreatment, and Parental/Protectiveness if they know to expect these feelings to arise.

CT Management

Previous research has shown the deleterious effects of uncontrolled acting out of CT. Therapists' CT reactions can influence patient resistance later in treatment (Westra et al., 2012), affect the integrity of the implementation of therapeutic interventions (Ulberg et al., 2014), and alter treatment outcomes (Gelso & Hayes, 2018; Ulberg et al., 2014). For these reasons, an effective psychotherapist must be responsible for their awareness and management of CT reactions to provide effective treatment. By gaining more data on what CT reactions therapists may encounter with certain diagnoses, these results provide clinicians with further awareness of their potential reactions that may be a hindrance to therapy, which may support more effective CT management.

Limitations

Several limitations of the current study influence the interpretation of the findings and are therefore worth noting. Firstly, the TRQ shares the inherent limits of all self-report measures, such as defensive biases and failure to recognize nuances that could be identified by an outside observer. Thus, it would have been useful to have therapists' responses in psychotherapy evaluated by other methods of measurement and perspectives (e.g., external observer). Similarly, social desirability may have influenced therapists' responses and affected the results. For example, no significant relationship was found between sexualized countertransference and any Cluster B PD group.

Furthermore, the same rater, the treating clinician, was responsible for completing

all of the assessment tools: Cluster B PD diagnosis, LPFS, TRQ. This is a source of potential bias because the three variables likely are not independent of each other simply due to the clinician's diagnostic prejudices affecting their emotional response. It may be more informative to classify patients based on their presentation and behavior, rather than their clinician-provided diagnosis, using a measure for personality diagnosis such as the Shedler-Westen Assessment Procedure-200 (SWAP-200; Westen & Shedler, 1999a, 1999b). Alternatively, future studies may include patients as participants and assess their personality using a rater other than the treating clinician.

In addition, clinician reports were retrospective and, in some cases, there may have been a significant amount of time between treating the patient and reporting on that treatment in this study. Clinicians' self-report may be biased by their memory and their description of CT may not be an accurate representation of their reaction when in the room with their patient.

An additional limitation is the small sample size, and subsequently the small group sizes. Future studies with larger sample sizes would increase statistical power and potentially yield more robust results.

Furthermore, results may not be generalizable to all clinicians, as the sample of therapists was predominantly female and Caucasian. Caution should be taken when generalizing the current study's findings to other samples. Future research will attempt to obtain a more diverse group of participants to increase generalizability of results.

Lastly, while CT is considered to arise due to a combination of both patient and therapist factors (Hayes, 2004), this study focused solely on the former. While the patient represents a catalyst for a therapist's CT reaction, it is within the therapist that these

reactions originate. Therefore, while the results of this study do suggest that therapist countertransference differs by the patient's Cluster B PD diagnosis, the therapists' emotional reactions likely have much to do with their own personal factors in addition to those of their patients. Further research is necessary in this domain to better extricate the different components that contribute to countertransference.

Future Directions

Several recommendations for future research are identified as a result of the findings from the current study. First, future studies measuring therapist countertransference should include a large, diverse sample of participants. Doing so would lead to resultant data that is more generalizable to various populations, and would provide larger subgroups to allow for more intersectionality in our data analysis.

To improve the data collection method, patient personality should be evaluated using a validated measure of patient personality rather than via a diagnosis provided by the clinician. In addition, future studies should assess therapist countertransference in real time by an independent observer to reduce clinician biases of acknowledging and reporting their own feelings.

Several questions remain as to potential moderators of therapist CT, which are necessary to consider if CT is being used to guide diagnosis. Given that CT originates an interaction between patient and therapist factors, therapist personality and interpersonal factors should be evaluated in the future as potential moderators of countertransference. Additionally, the presence and type of case supervision and/or consultation may moderate the effects of CT due to sharing these feelings with another professional.

As therapist CT has been identified as affecting therapy outcomes, it would be

clinically useful to assess for a potential interaction between CT type/intensity and choice of intervention on treatment outcome. It may be that certain types of therapeutic interventions are more impervious to the effects of strong CT, which could help clinicians choose the most appropriate interventions for improving patient symptoms'.

Future studies assessing the effectiveness of CT management tools on therapy outcome may be useful. As uncontrolled acting out of CT hinders therapy outcome, it would be beneficial to provide clinicians with CT management to better understand the efficacy of these tools in improving patient symptoms.

Conclusions

The findings in the current study provide further support for the validity of therapist countertransference as a clinical tool for diagnosis and treatment. Results suggest that because differences were found between the four groups, countertransference may be used more specifically as a clinical tool to assist in the diagnosis of Cluster B personality disorders. Overall, this information helps contribute to a developing framework of identifying specific countertransference feelings that are associated with each disorder, which will be utilized to inform future treatment decisions and improve countertransference management on the part of the clinician.

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