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Patient Personality and Therapist Countertransference

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Patient Personality and Therapist Countertransference

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Abstract

Purpose of the review:

The purpose of this review is to provide a comprehensive and critical examination of the empirical literature about the relation between patient personality and therapist countertransference.

Recent findings:

The therapist's countertransference can play a crucial role in psychotherapy outcomes, especially in the treatment of personality disorders. The therapist's emotional responses to patients can accomplish the following: a) inform the clinician about the patient's personality, b) impact therapy outcome, c) influence patient resistance and elaboration, d) mediate the influence of the therapist's interventions, and e) influence therapeutic alliance.

Summary:

In the last years, several studies have empirically demonstrated the presence of a specific pattern of therapist responses that are related to different patient personality disorders. Other works showed how the effects of the therapist's technique depend on the emotional context in which they are delivered and in particular countertransference experiences. Moreover, researchers suggest that the therapist's emotional responses occur across all kinds of therapy and are independent of the therapist's theoretical preferences.

Keywords: personality disorder, countertransference, emotional responses

Introduction

The therapist's countertransference (in this context, we use the term "emotional response" interchangeably with "emotional reaction" and "countertransference") can play a crucial role in psychotherapy [1], especially in the treatment of personality disorders [2]. Although the concept of countertransference originated in psychoanalytic theory [3], it is considered a trans-theoretical construct, occurring across any kind of therapy [4]. The therapist's emotional responses to patients can: a) inform the clinician about the patient's personality [4,5**], b) impact the therapy outcome [1], c) influence patient resistance and elaboration [6,7**], d) mediate the influence of therapist interventions [8**,9*], and e) influence therapeutic alliance [10,11] and alliance ruptures' resolution [12,13].

The present review provides a conceptual framework about the relationship between patient personality and therapist countertransference, provides a critical introduction to methodological and assessment issues, and discusses recent studies about the relationship between patients' level of functioning, personality disorders, and therapists' emotional responses.

Theoretical framework

Two main contrasting approaches in regard to the concept of countertransference could be considered: the classical and the totalistic approaches [14]. The classical point of view defined countertransference as the unconscious reaction of the clinician to the patient's transference and conceptualized it as an obstacle to the psychotherapy process that must be overcome [15].

From the totalistic perspective, however, the therapist's reactions (conscious and unconscious, emotional and cognitive, intrapsychic and behavioral) reflect, in part, the patient's interpersonal

functioning. Using this definition, theorists and clinicians have recognized the importance of focusing on countertransference reactions in the therapist–patient relationship [16].

Several concepts, such as concordant countertransference, cognitive interpersonal cycle, and interpersonal complementarity, originated in different theoretical fields; however, they share the idea that our interpersonal actions evoke "restricted classes" of reactions from persons with whom we interact [17]. From this point of view, a large percentage of the variance in a therapist's feelings toward the client is attributed to the recurrent evocative pattern of the client's behavior during the therapy sessions and is generalizable to other therapists and to other significant persons in the patient's life.

Personality disorders are, by definition, dysfunctional schemas of the self, others, and relational interactions. These patterns of relating often appear in the therapeutic relationship, leading the clinician into interactions that reflect the patient's enduring and maladaptive relationships [2]. A careful consideration of the clinician's responses to the patient's personality has critical relevance to tailoring and managing the diagnostic and therapeutic process with personality-disordered patients [2,18,19,20]**.**

Methodological issues

There are two main methodological problematics in countertransference empirical research: the perspective of evaluation and the research design. Countertransference (CT) is typically assessed from three individuals' different perspectives: the clinician's, the observer's, and the supervising observer's. The clinician perspective has been employed in studies that focused on the examination of CT in terms of internal emotional state, investigating clinicians' emotional experience during sessions [4,5**,21**]. To measure clinicians' emotions, researchers generally have used clinicians' self reports (Tab.1) and less frequently qualitative methods and interviews [33,34,35,36]. The main advantage of using the therapist as an informant is that we can directly ask the participants about their inner voice regarding the relational experience with the patients. However, the clinician's CT

self report or interview is affected by social desirability bias.

In studies based on observer perspective, trained raters evaluate with observer-based methods (Tab. 1) therapist responses through the analysis of sessions transcripts or audio-/video-recorded sessions [37,38]. Raters evaluate therapists' overt behaviors related to internal emotional state [6] that have been operationalized generally as the therapist's avoidance or distortion of the patient's material [30,39].

Observers' evaluations have the potential to contribute to what the ''clinical facts'' are [40], furnishing a more "objective" evaluation. Nevertheless, observers can only infer the therapist's inner experience, and one may question how accurate an observation of the therapist's emotional response from the outside can be. Studies based on supervisor evaluations can be considered a compromise between clinicians' self reports and observers' evaluations. The supervisor knows his or her supervisee, and the supervisor's evaluations are probably much more accurate than evaluations made by external observers. At the same time, supervisor evaluations can be affected by the supervisee's defensive processes and are influenced by the quality of the relationship between the supervisor and the supervisee. Studies based on supervisor evaluations use generally the same or similar measures applied by the external observer (Tab. 1) .

Insert Table 1

An additional methodological problem is the stimuli used to investigate the therapist's emotional responses [40]. A number of researchers have studied countertransference, investigating CT clinician reactions to clinical vignettes or audio-recorded sessions [22,41,42]. These works have been constrained by the use of artificial stimuli, rather than ongoing interaction with actual patients. As a consequence, many of these studies have the advantage of great internal validity, but they can rightfully be criticized as lacking ecological validity. Conversely, other studies that investigated, through naturalistic studies, therapists' CT reactions in everyday clinical practice [4,5**,21**] have

the advantage of good ecological validity but are lacking in terms of internal validity.

Level of patient psychological functioning and therapist emotional responses

Several studies have shown significant associations between the level of the patient's psychological functioning and the therapist's emotional responses.

Røssberg and colleagues [43] examined the extent to which the patients' subjective psychiatric symptoms evoked specific emotional reactions among therapists, and their findings indicated that the amount of symptomatology was positively associated with clinicians' feelings of being inadequate, on guard, and rejected.

Dahl et al. [21**] found a strong negative relationship between the amount of fulfilled Personality Disorders (PD) criteria and the therapists' experiences being in a safe and helpful position. In another study [5**], the results confirmed that a low level of patient psychological functioning, assessed with the SWAP-200 [44], was associated with the therapist's negative feelings, such as feeling criticized/mistreated, helpless/inadequate, and overwhelmed/disorganized.

These results have been confirmed by another recent research [45**] that investigated the relationship between the therapist's emotional responses and the overall level of personality organization, as described by Kernberg [46] and assessed with the Psychodiagnostic Chart [47] .

It is important to observe that the above mentioned studies obtained converging results using different measures to assess personality functioning (the amount of psychiatric symptoms, the amount of fulfilled *DSM IV* PD criteria, the SWAP-200, and the Psychodiagnostic Chart).

In a recent study [8**], the authors investigated the long-term effects of relationship work in the context of patients' level of personality pathology and therapists' self-reported parental feelings. The results suggested that parental feelings were differentially associated with long-term effects of relationship work, depending on the level of personality pathology. In the context of low parental feelings, relationship work was positive for all patients. However, when parental feelings were strong, the specific effects of such interventions were even more positive for patients with high

levels of personality pathology but negative for patients with low levels of personality pathology.

Therapist responses and patient personality disorders

Several studies have focused on comparing the therapist's reactions in relation to *DSM* diagnosis at the cluster level (Table 2). The study by Betan et al. [4], which can be considered a key paper in this field, found significant positive partial correlations between *DSM IV* Cluster A disorders (paranoid, schizoid, and schizotypal personality disorders) and criticized/mistreated therapist responses. Cluster B personality disorders (antisocial, borderline, hystrionic, and narcissistic) were strongly associated with overwhelmed/disorganized, helpless/inadequate, and sexualized therapist responses. In the end, the Cluster C personality disorders (avoidant, dependent, and obsessive-compulsive) were associated with parental/protective responses.

Subsequent studies confirmed the results of Betan et al.'s study in relation to therapist responses toward Cluster B patients, while contradictory results emerged about therapists' responses in relation to Cluster A and Cluster C patients [48,49,51]. Thylstrup et al. [49] found that Cluster A patients tend to have very little impact on the therapist, while Meehan et al. [51] found that higher Cluster A symptoms were significantly associated with therapists experiencing the relationship with the patient as being predominated by negative affect. Regarding therapists' responses toward Cluster C patients, Meehan et al. [51] found a significant relationship between Cluster C symptoms and the therapist experiencing the relationship as less enlivened and with less negative affect, while Thylstrup et al. [49] found that therapists' responses with this kind of patient were characterized by the presence of negative affect.

From our point of view, these results are in part contradictory for several reasons, such as the use of different measures and the differences in samples' compositions but in particular because therapist responses have been investigated in relation to patient *DSM* diagnosis at the cluster level, ignoring the differences between patients' personality disorders that belong to the same *DMS IV* cluster.

To resolve this limitation, some studies have investigated the relationship between the differential responses of clinicians and specific personality disorders (Table 2).

Colli and colleagues [5**] examined the therapist patterns of responses in relation to specific patient personality disorders assessed with the SWAP-200. The results suggested that paranoid and antisocial personality disorders were related to criticized/mistreated therapist responses, while disengaged responses were positively related to schizotypal and narcissistic personalities. Avoidant personality disorder was related to both parental/protective and special/over-involved therapist responses. Schizoid personality disorder was related to the helpless/inadequate response, while being dependant can evoke protective feelings but also helplessness and inadequacy responses. Finally, helpless/inadequate, overwhelmed/disorganized, and special/over-involved countertransference were associated with borderline personality disorder. These results extended previous studies in which researchers investigated therapists' reactions in relation to *DSM* diagnosis by cluster level [4,48,49,51] and showed how specific personality disorders can evoke distinctive and specific patterns of responses in therapists.

Using the Psychodynamic Diagnostic Manual (PDM) classification of personality disorders (PDM, 2006), which mirror the *DSM IV* Axis II categories for the most part but with some significant differences such as the removal of some disorders (borderline, schizotypal, and avoidant personality disorders) and the addition of new categories (for example, sadistic, masochistic, somatizing, and depressive personality disorders), Gazzillo et al [45**] replicated and confirmed several of the findings of the study of Colli et al. One exception, however, was of the narcissistic personality disorder that was predicted by hostile/criticized and parental therapist responses (instead of disengaged therapist responses). An explanation can be found in the different descriptions of the narcissistic personality disorder presented in the PDM, which differ from SWAP and *DSM* descriptions and include both the covert and the overt subtypes of narcissistic pathology. The results of these two studies confirmed the clinical literature on the therapist reactions with narcissistic

personality disorder [53*].

Moreover, in Gazzillo et al., the disengaged therapist responses resulted in being associated with the somatizing personality disorder that characterizes patients with alexithymia, who experience emotional problems as physical symptoms and encounter difficulties in exploring the psychological aspects of their problems. This result confirmed previous research that suggested the negative effect of alexithymia, on therapists' emotional reactions [50].

Several studies compared therapist reactions with BPD patients with therapist reactions with patients with different disorders, especially depression [22,42].

A recent research, based on the analysis of therapists' narratives elicited using the Relationship Anecdotes Paradigm Interview [54], investigated therapists' reactions toward patients with borderline personality disorder and compared them to patients with major depressive disorder (MDD). The emotional valences of therapists' responses were significantly more negative toward patients with BPD: therapists differentially experienced patients with BPD as typically withdrawing and patients with MDD as attending within sessions, and they felt less satisfied in their therapeutic role with patients with BPD, despite a consistent wish to help patients with MDD [36]. This result confirmed previous studies based on artificial stimulus materials, such as audio-recorded diagnostic interviews and clinical vignettes, that have shown that patients with depression evoke more friendly feelings among therapists than do patients with borderline personality disorders [42,22].

It is important to observe that all of the above cited studies have not addressed the possible mediating effect of patients' levels of self-reported symptoms on therapists' responses. The separation between patients' symptoms and personalities in the investigation of their relationship with therapists' emotional reactions is not justified by clinical and empirical literature [55,56].

A recent study [52**] investigated the possible mediating effect of patient symptoms on the relationship between the patient's personality and the therapist's emotional responses. The findings showed that a broad range of personality disorders (paranoid, schizoid, antisocial, narcissistic, dependent, and obsessive) was not mediated by symptom severity or global psychopathology.

Furthermore, where the mediated effect of symptomatology was present (with schizotypal, borderline, histrionic, and avoidant personality disorders), the impact was fairly moderate (about 30%). This result seems to suggest that the personality characteristics and interpersonal functioning of patients suffice to elicit distinct emotional responses in clinicians. This confirms a previous study that suggested that the patient's personality adds considerably to other factors in explaining therapists' reactions toward adolescents patients with eating disorders [57]

Another critical point is represented by the possible influences of clinician theoretical orientation. Three studies ruled out this hypothesis [4,5**,52**], suggesting that the associations between personality disorders and therapist reactions do not appear to be an artifact of clinicians' theoretical preconceptions. This confirms the results of a previous study based on therapists' responses to clinical vignettes that demonstrated that theoretical orientation was not associated with therapists' reactive responses toward patients [24].

Conclusions

In the last years, several studies have empirically demonstrated the presence of specific therapist patterns of responses in relation to different patients' personality disorder. Other works showed how the effects of therapists' techniques depend on the emotional context in which they are delivered and, in particular, the therapist's countertransference experience [8**,9*]. Moreover, studies suggest that therapists' emotional responses occur across any kind of therapy and are independent of therapist theoretical preferences.

Even though these findings are significant, it is important to remark on some problematics.Nearly all studies used evaluations furnished by the clinicians or used only one perspective of evaluation. For future research, it will be necessary to use at least two types of evaluations in order to increase the reliability of the results. Moreover, several studies ignored the influences of time in relation to therapists' reactions: the same therapists' reactions can assume different meanings in relation to different phases of treatment.

In conclusion, even though we are aware that CT is a multidimensional construct that originated from several factors, including the therapist's personality, the most important point that future research has to address about this topic regard the relationship between what happens inside the therapist, how this influences the actual process with the patient, and finally in which way the interaction between therapist CT and psychotherapy process will impact therapy outcomes with different kinds of patients.

Keynotes

The therapist's reaction to the patient's personality can play a crucial role in psychotherapy, especially in the treatment of personality disorders.

The therapist's emotional responses can inform clinicians about the patient's personality.

The therapist's responses influence important process variables, such as patient resistance, depth of elaboration, and therapeutic alliance, and mediate the influence of therapist interventions.

The therapist's emotional responses occur across all kinds of therapy and are independent of therapist theoretical preferences.

The results suggest that clinicians can make diagnostic and therapeutic use of their responses to patients.

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Table 1

TAB1. CORE MEASURES FOR THE ASSESSMENT OF THERAPIST RESPONSES

MEASURE	RATER	DESCRIPTION	SUBSCALES/FATCORS
Experience And Attitude Scale (EAS) [22]	C	It is a 25 items scale designed to address therapist's overall experiences in doing psychotherapy and their attitudes toward their emotional reactions within treatment. Therapist were asked to indicate, on a scale of 1 to 5 the intensity or frequency of their reaction to each item.	1.Therapist's overall experiences in doing psychotherapy 2.Attitudes toward their emotional reactions within treatment
Vignettes Rating Scale (VRS) [22]	C	It is designed to assess on a five point likert type scale (20 items) therapist reactions and feelings toward clinical vignettes describing diferent disorders.	1.Positive countertransference 2.Negative transference 3.Countertransference-related behavior
Feeling Word Checklist – 58 (FWC-58) [23]	C	It is a 58-item self-report measure in which therapist rate their emotional responses toward the patient on a 5 point Likert scales.	1.Important 2.Confident 3.Rejected 4.On guard 5.Bored 6.Overwelmed 7.Inadequate
Countertransference Rating System (CRS) [24]	O	The CRS operationalizes three therapist mental activities (rational-objective, reactive, and reflective). .The assessment is based on a transcript of the session therapy.	1.Objective-rational 2.Reactive 3.Reflective
Rating Of Emotional Attitudes To Clients By Treaters (REACT) [25]	C	It is a 40-item self-report measures in which therapists rate their emotional responses to clients on a 1 to 5 point scale.	1.Positive connection to the client 2.Therapist in conflict with self 3.Therapist focused on own needs 4.Therapist in conflict with the client
Affective Communication Questionnaire (ACQ) [26]	C	It is a 28-item self-report measure rated in a 5-point Likert scale. Items ask therapist to rate their patients in term of degree to which they felt enlivened and engaged by them, the nature of the affect experienced in the session with the patients and the degree to which patient imbued their language with the patients. The items were derived from clinical and empirical literature focused on implicit communication of affect in the therapeutic context.	1.Disengadged 2.Full range of emotion 3.Negative effect 4.Enlivened
Therapist Response Questionnaire (TRQ) [27]	C	It is a 79-item designed to assess countertransference in patterns psychotherapy. It is filled out by clinician and the items measuring a wide range of thought, feelings, and behavior expressed by therapist toward their patients.	1. Overwhelmed/disorganized 2. Helpless/inadequate 3. Positive 4. Special/overinvolved 5. Sexualized 6. Disengaged 7. Parental/protective 8. Criticized/mistreated
Inventory of Countertransference Behavior (ICB) [28]	O, S	It was developed to assess supervisor perceived countertransference behavior during the therapy sessions. The negative CT factor is composed of 11 items that describe therapists' behaviors that inappropriately criticize or withdraw from the patient. The 10 item composed the positive CT factor describe therapists' behaviors that are	1. Positive countertransference 2. Negative countertransference

		inappropriately supportive or friendly.	
Countertransference Factors Inventory (CFI) [29]	S, O, C	It is a 50-item measure of therapist characteristic and skills that facilitate CT management.	1. Self-integration 2. Anxiety Management 3. Conceptualizing Skills 4. Empathy 5. Self-insight
Countertransference Behavior Measure (CBM) [30]	S, O	The 10 item wich compose the instrument describe negative behavior as hostility, predominance and distance.	1. Dominant Countertransference Behavior 2. Distant Countertransference Behavior 3. Hostile Countertransference Behavior
Therapist Appraisal Questionnaire (TAS) [31*]	C	it is a self-rated questionnaire based on a 5-point Likert scale assess 22 affects the therapist may experience during a session with a client.	1. Threat 2. Harm 3. Challenge
Impact Message Inventory (IMI) [32]	C	it is a 90-item self-report. Each item is scored with a Likert-type scale according to how similar each statement is to the individual's personal reactions to the client.	1. Dominant 2. Hostile 3. Submissive 4. Friendly
Note. C = Clinician, O = Observer, S = Supervisor			

Table 2

TAB.2-STUDIES THAT EXAMINED THE RELATIONSHIP BETWEEEN THERAPIST'S COUNTERTRANSFERENCE AND PATIENT'S PERSONALITY

STUDY	SAMPLE		MEASURES		RESULTS
	Therapists	Patients	Therapist	Patient	
Brody, Farber, 1996 [22]	N=336 therapists, 66% psychodynamic or psychoanalytic, 19% eclectic, 8% cognitive-behavioral and 7% other.	3 clinical vignettes representing three diagnoses: Borderline Personality Organization, Schizophrenia, Major Depression.	*EAS*, V*ignettes*, *VRS*.		Borderline patients resulted able to evoke the greatest degree of anger and irritation and the last degree of liking, empathy and nurturance.
McIntyre, Schwartz, 1998 [42]	N= 155 clinician with several theoretical orientation. 53 male, 102 female.	Clinician listened to two characteristically diagnostic interview session with either a client displaying Major Depression or Borderline Personality Disorder.	*IMI, SAS.*		BPD evoked negative response such as competition, dominance mistrust, hostility while MDD evoked reactions of nurturance and caring.
Betan, Heim, Conklin, Westen, 2005 [4]	N= 181, 40 psychiatrist and 141 psychologists. 40.5% psychodynamic, 30.4% eclectic, 20.4% cognitive behavioral.	Was asked to clinician to describe nonpsychotic patients whom they had treated for minimum of eight sessions.	*TRQ.*	Clinicians rated as present or absent each criterion of each of the DSM-IV axis II diagnoses.	Cluster A showed a significant association with the criticized/mistreated factor. Cluster B was associated with: overwhelmed/disorganized, helpless/inadequate, special/overinvolved, sexualized and disengaged factors and had negative correlation with the positive factor. Cluster C was associated with the parental/protective factor.
Schwartz et al. 2007 [41]	N = 73, a range of theoretical orientations	Videotape of Antisocial Personality Disorders and Schizophrenic patients have been used as target stimuli	*IMI*		Therapist rated as higher reactions of Dominance with APD than with Schizophrenic patients
Røssberg, Karterud, Pedersen, Friis, 2007 [48]	N=11 therapists. 1 psychiatrist, 1 resident, 1 psychologist, 1 art therapist, 1 physiotherapist, 1 social worker, and 5 psychiatric nurses.	N= 71 patients with Axis II disorders.	*FWC-58.*	*DSM-IV, SCID II.*	There was one significant difference in countertransference reactions, between patients with cluster A + B PDs and patients with cluster C PDs 2 weeks after the start of treatment. The staff reported they felt more confident toward cluster C PDs. Clinician felt more confident and less rejected, on guard overwhelmed, and inadequate toward patients with cluster C.
Thylstrup, Hesse, 2008 [49]	Staff members recruited through a workshop.	83% men, 17% women. 92% was the prevalence of personality disorder.	*FWC-58.*	*DIP-Q.*	Cluster B were associated with feeling distance to the patients. Cluster C were associated with feeling helpful towards patients. Cluster A had no significant impact on emotional reactions.
Ogrodniczuk, Piper, Joyce, 2008 [50]	N=3 therapists with experience practicing group therapy.	N=107 patients. 73.8% had axis I diagnosis,55.1% had axis II diagnosis.	*TCQ.*	*TAS-20.*	Higher level of alexithymia and the less expression of positive emotion by the patient were associated negative the therapist's reaction.
Røssberg , Karterud, Pedersen, 2010 [43]	N=11 therapists.	N=42 patients with Axis II diagnosis. 34patients had also Axis I diagnosis.	*FWC-58.*	*SCL-90.*	There was a correlation between therapist' CT and scores on the SLC-90 Subscales. Feeling of being rejected were significantly and negatively associated with symptoms of

					obsessive-compulsive characteristic, interpersonal sensitivity and phobic anxiety. Feeling of being on guard were significantly and negatively associated with interpersonal sensitivity and phobic anxiety.
Bourke, Grenier, 2010 [36]	N=20, 17 female, 3 male; 14 practiced cognitive-behavioral therapy, 6 interpersonal-dynamic therapy	N=40 with BPD, N=40 with MDD.	*CCRT-LU, RAP.*	*GAF, DSM-IV.*	They commonly reported that they wanted to support patients with MDD and assist their patients with BPD to be independent. MDD group was frequently perceived as attending while the BPD group was perceived as withdrawing.
Normandin, Bouchard, 1993 [24]	2 judges.	N=90, 50% psychological student, 50% therapists.	*C.R.S.*		Overall proportion for the three main reactive, objective-rational and reflective states show that reflective processes take the larger part, with 69% of words produced while reactive and objective-rational share an almost equal proportion of the remaining activity.
Dahl, Røssberg, Bøgwald, Gabbard, Høglend, 2012 [21**]	N=7 therapist had 10-25 years of experience in practicing psychodynamic psychotherapy.	N= 75 patients. 89% with one o more Axis I diagnosis: 34 had depressive disorders, 13 anxiety disorders and 7 both. 50% with one or more Axis II diagnosis.	*FWC-58.*	SCID II, SCL-90, IIP-C, GAF.	There are a significant relationship between number of PD criteria and Confident and Disengaged CT. Motivation for insight and change correlates negatively with Inadequate CT. Higher level of psychological mindedness seems to amplify the therapists' Parental CT feelings.
Meehan, Levy, Clarkin, 2012 [51]	N=16 therapist:4 DBT, 6SPT, 6TFP.	N=73 patients with borderline personality disorder.	*TRQ.*	*IPDE ,AAI, Reflective Function.*	Cluster A symptoms were significantly associated with therapists experiencing the relationship with the patient as being predominated by negative affect, but this cluster were no associated with disengaged climate and less full range of emotion. Cluster C symptoms were associated whit therapist's experience of relationship as less enlivened and with less negative affect. ACQ components were not found to relate to Cluster B symptoms.
Colli, Tanzilli, Dimaggio, Lingiardi, 2014 [5**]	N= 203, 65% psychologists, 35% psychiatrists. 103 psychodynamic, 100 cognitive-behavioral.	N= 203. 59 had only axis I diagnosis, 71 had only axis II diagnosis, 46 had comorbid axis I and II diagnoses, and 27 had a double axis II diagnoses.	*TRQ.*	*SWAP- 200.*	The SWAP-200 paranoid and antisocial disorder scales were associated with criticized/mistreated CT. Borderline was related with helpless/inadequate, overwhelmed/disorganized, special/overinvolved. Schizotypal and narcissistic disorder ware associated with disengaged CT. Dependent and histrionic personality disorder were negatively related with disengaged CT. Schizoid personality disorder was associated with helpless/inadequate response. Avoidant personality disorder scale was related to positive, parental/protective and special/overinvolved therapist responses. Obsessive- compulsive personality disorder scale was negatively associated with special/overinvolved response.
Dahl, Røssberg, Crits-Christoph, Gabbard, et. al.	N=7 therapists. 4 male, 2 female. 5	N=75 patients. 46%female. 89% who fulfilled criteria	*FWC-58.*	*PFS, SCID II, SCL-90*	There was a strong negative relationship between amount of fulfilled PD criteria and Confident CT. There was a strong negative

2014 [8**]	psychiatrists, 1 psychologist.	for one or more axis I criteria. 50% fulfill criteria for PD.		*R.*	relationship between Disengaged CT and PD criteria.
Gazzillo, Lingiardi, Del Corno, Genova, Bornstein, Gordon, Mc Williams, 2014 [45**]	N=148 clinician. 58.4% female, 40.9 % male. 61 dynamic theoretical orientation, 48 eclectic, but mainly dynamic, 20 an eclectic, but mainly biological and 15 cognitive-behavioral orientation.	N=148 patient. 55% female, 45% male.67 had an anxiety disorder,46 mood disorder, 25 somatoform disorder, 8 psychotic disorder, 5 impulse control disorder, 4 sexual disorder,2 eating disorder, 1 adjustment disorder.	*TRQ.*	*PDP*.	Depressive and anxious PD associated was predicted with parental and disengaged therapists' responses. Phobic disorder by parental response. Narcissistic disorder by parental and hostile/criticized reactions. Dissociative disorder by helpless and parental responses. Dependent disorder was predicted by disengaged and parental response. Histrionic disorder by sexualized, overwhelmed and positive (in reverse) response. Paranoid disorder by hostile/criticized reactions.
Lingiardi, Tanzilli, Colli, [52**]	N=198 clinician. 55%female, 45%male. 65% were psychologists and 35% were psychiatrists. N=103 psychodynamic, N=95 cognitive-behavioral .	N=198 patients. 58% female, 42%male. 59 had only a DSM-IV axis I diagnosis, 70 had only an axis II diagnosis, 44 had comorbid axis I and axis II diagnoses, and 25 had a double axis II diagnosis	*TRQ.*	*SWAP-200, SCL-90R.*	Patients with higher symptom severity tend to evoke in clinicians of different therapeutic approaches stronger degrees of negative emotional responses. Clinicians' emotional responses evoked by other personality disorders appear affected to a lesser degree by patients' symptomatology.

Note: *AAI=Adult Attachment Interview; CCRT-L= Core Conflictual Relationship Theme- Leipzig/Ulm method ; CRS= Countertransference Rating System; CTQ= Countertransference Questionnaire; EAS= Experience and Attitude Scale; FWC-58= Feeling Word Checklist-58; GAF= Global Assessment Functioning; IIP-C= Inventory of Interpersonal Problems- circumplex version; IMI= Impact Message Inventory; IPDE= Interpersonal Personality Disorder Examination; PDP= Psychodynamic Diagnostic Prototype; PFS= Psychodynamic Functioning Scale; PRQ= Psychotherapist Relationship Questionnaire; SAS= Stress Appraisal Scale; SCID II= Structured Clinical Interview for DSM-Axis II; SCL-90= Symptoms Checklist-90; SWAP-200= Shedler-Westen Assessment Procedure- 200; TAS- 20= Toronto Alexithymia Scale-20; TCQ= Therapist Cohesion Questionnaire; TRQ=Therapist Response Questionnaire; VRS= Vignettes Rating Scale.*

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