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The Relationship between Theoretical Orientation and Countertransference Expectations: Implications for Ethical Dilemmas and Risk Management

Robert M. Gordon,[1]* Francesco Gazzillo,[2] Andrea Blake,[3] Robert F. Bornstein,[4] Janet Etzi,[5] Vittorio Lingiardi,[2] Nancy McWilliams,[6] Cheryll Rothery[7] and Anthony F. Tasso[8]

[1] *Independent Practice, Allentown, PA, USA*
[2] *Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Rome, Italy*
[3] *Psychology, Cedar Crest College, Allentown, PA, USA*
[4] *Gordon F. Derner Institute of Advanced Psychological Studies, Adelphi University, Garden City, NY, USA*
[5] *Department of Graduate Psychology, Immaculata University, Immaculata, PA, USA*
[6] *Graduate School of Applied and Professional Psychology, Rutgers University, Flemington, NJ, USA*
[7] *Department of Professional Psychology, Chestnut Hill College, Philadelphia, PA, USA*
[8] *Department of Psychology and Counseling, Fairleigh Dickinson University, Madison, NJ, USA*

Countertransference (CT) awareness is widely considered valuable for differential diagnosis and the proactive management of ethical dilemmas. We predicted that the more practitioners' theoretical orientation (TO) emphasizes insight into the dynamics of subjective mental life, the better they will be at using their CT expectations in differential diagnosis with high-risk patients. To test this hypothesis, we compared psychodynamic therapy (PDT) practitioners who emphasize insight into subjective mental life with practitioners who do not emphasize this epistemology. Results indicated that PDT practitioners expected significantly more CT than practitioners of cognitive–behavioural therapy (CBT) and other practitioners (e.g., family systems, humanistic/existential and eclectic) to patients with borderline personality organization overall. PDT practitioners had significantly more CT expectations to patients with borderline-level pathologies as compared with neurotic-level patients than both CBT and other practitioners. PDT practitioners were significantly more expectant of CT issues than CBT practitioners with respect to the personality disorders most associated with acting out and risk management problems (e.g., paranoid, psychopathic, narcissistic, sadistic, sadomasochistic, masochistic, hypomanic, passive–aggressive, counterdependent and counterphobic). The other practitioners generally had CT expectations between PDT and CBT. These findings suggest that clinical training into CT may be useful in differential diagnoses and in helping to avoid ethical dilemmas regardless of one's theoretical preference. **Copyright © 2015 John Wiley & Sons, Ltd.**

*Correspondence to: Robert M. Gordon, Independent Practice, Allentown, PA, USA, 18103.
E-mail: rmgordonphd@gmail.com
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Key Practitioner Message:

- Insight into countertransference can be used to help with differential diagnoses and to help prevent possible management problems with acting out patients. The Psychodynamic Diagnostic Manual is a useful taxonomy in that it includes countertransference as a diagnostic aid.

Keywords: Countertransference, Psychodynamic Diagnostic Manual, Ethics, Theoretical Orientation

Many of the complaints to ethics committees and licensing boards, as well as many malpractice suits against mental health professionals, involve inaccurate or missed diagnoses, boundary violations and mismanaged countertransference (CT), specifically with personality disordered patients (Gordon, 2007; Pope & Tabachnick, 1993; Williams, 2000). Gutheil (2005) reviewed types of boundary violations in working with histrionic, dependent, antisocial and borderline personality disorders (BPDs) that led to civil lawsuits, complaints to licensing boards and reports to professional societies. The investigation identified that difficulties in understanding and managing CT issues were frequently associated with these clinical transgressions. Differential diagnosis is important in anticipating and managing CT. Liebman and Burnette (2013) found that individuals with BPD appear more likely than individuals with other mental disorders to evoke negative CT reactions.

Williams (2000) wrote, 'The Borderline, or other personality disordered patient might file a complaint because of a very deteriorated therapeutic relationship based on the characteristic misperceptions and exaggerated emotional reactions which are common to individuals with personality disorders' (p. 79).

Countertransference is generally considered to be jointly created '…part of the therapist's reaction to the patient is based on the therapist's past relationships brought into the present as in transference. In addition, however, other aspects of the therapist's feelings are *induced* by the patient's behavior' Gabbard (2010, p. 16). Racker (1957) and, more recently, Tansey and Burke (2013) also have written about CT being co-created.

In psychodynamic theory, insight into the dynamics of subjective mental life, such as transference/CT is fundamental to making diagnoses about personality organization (i.e., neurotic, borderline or psychotic level of organization) and personality disorders (e.g., antisocial, histrionic and narcissistic; Betan, Heim, Conklin, & Westen, 2005; Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; McWilliams, 2011). Gabbard (2010) emphasizes the centrality of CT in the assessment process by noting that 'Countertransference is now considered a major therapeutic and diagnostic tool that tells the therapist a great deal about the patient's internal world' (p. 15).

The Colli *et al*. (2014) study of 203 psychologists and psychiatrists found that patients' specific personality pathologies are significantly associated with consistent emotional responses in the practitioners. For example, paranoid and antisocial personality disorders were associated with criticized/mistreated CT, while disengaged CT was associated with schizotypal and narcissistic personality disorders. Overall, they found that patients with *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-IV cluster B personality disorders seem to elicit more mixed and negative responses in their therapists than do patients with cluster A and C disorders.

Non-psychodynamic taxonomies such as the DSM and *International Classification of Diseases* (ICD) are based primarily on overt symptoms, which make them easier for clinicians to assess irrespective of theoretical orientation. Although this categorical, non-inferential approach is believed to increase the reliability of some diagnoses, that reliability often comes at the cost of decreased validity of the diagnostic category (Bornstein, 2011; Gordon & Cosgrove, 2013; Westen, Defife, Bradley, & Hilsenroth, 2010).

For example, with the DSM-III in 1980, 'BPD' was created as a distinct personality disorder and not a level of severity of personality organization as originally conceived and researched (Kernberg, 1984). This was a compromise classification necessitated by the DSM having abandoned dimensional taxa of personality organization (i.e., neurotic or psychotic level); as a result of this decision, the only place for 'borderline' was as a personality disorder (Aronson, 1985).

Borderline personality organization (BPO) in psychodynamic theory and research is viewed as a level of pathology that can be found in any of the personality disorders (McWilliams, 2011). A person with dependent personality disorder, e.g., at the borderline level of personality organization, would present with the same primitive defences as the DSM's BPD. However, if a practitioner relies on the DSM-5, he or she may not anticipate that a patient with a dependent personality at the borderline level of personality organization may pose a risk management problems (see Bornstein, Becker-Matero, Winarick, & Reichman, 2010, for a discussion of borderline dynamics in dependent personality disorder).

Gazzillo *et al*. (2014) recently found that of the 621 patients with personality disorders, 11.8% ($n = 72$) functioned at the psychotic level of personality organization, 55.1% ($n = 365$) were at the borderline level of personality organization (BPO) and 30.9% ($n = 193$) were at the neurotic level of personality organization. All personality disorders had at least some patients at the borderline level of personality organization (BPO). This means that many patients not classified as borderline in the DSM-5 will favour

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primitive defences and thus present risk management problems to practitioners.

Differential diagnosis among neurotic, borderline and psychotic levels of personality organization is informed by transference/CT reactions that require the practitioner's insight into his or her own subjective states (Eagle, 2000). Borderline-level pathology tends to produce the strongest transference and CT reactions (Colli *et al.*, 2014; McWilliams, 2011). Brody and Farber's (1996) study of 336 therapists found that borderline patients evoked the greatest degree of anger and irritation within the practitioner.

Thomas' (2005) investigation found that most psychologists who face licensing board complaints needed more awareness of problematic CT issues. Pope and Tabachnick (1993) found that practitioners felt that their graduate training did not adequately prepare them to deal effectively with risk management challenges, while Jacobs-Caffey (1995) suggested that therapists' tendency to blur interpersonal boundaries when paired with a low level of experience and a high level of intolerance of ambiguity was related to insufficient openness to CT reactions.

Although the concept of CT evolved from psychoanalytic theory, the phenomenon characterizes all human relationships and has been understood in numerous different ways. Humanistic psychologists, for example, may consider transference and CT as artefacts of a power differential, cognitive–behavioural therapy (CBT) therapists may talk about it in terms of stimulus generalization, and both family systems therapists and CBT therapists may consider CT issues as less relevant to the therapeutic work. Multimodal theorist Arnold Lazarus (2003) felt that any attention to 'so-called' transference and CT only interferes with the therapy. A recent search of PsycINFO indicated the relationship between frequency of published articles on CT and theoretical orientation. Results of the search revealed that the psychoanalytic orientation had the most number of articles devoted to CT and the least to CBT: psychoanalytic (5998), family systems (446), humanistic (58) and CBT (11).

How a practitioner deals with CT is not just an issue of risk management; it can also affect the treatment process and outcome. For example, Markin, McCarthy and Barber (2013) found that negative transference predicted a difficult session, positive transference predicted a deep session and a too positive CT and positive affect predicted a smooth but superficial session and a negative impact on the depth of therapy. Rossberg, Karterud, Pedersen and Friis (2010) found that symptom change was positively correlated with positive CT feelings and negatively correlated with negative CT feelings. Hayes, Gelso and Hummel's (2011) three meta-analyses showed that (1) CT reactions are related inversely and modestly to psychotherapy outcomes; (2) CT management factors (which are merely informational) play little to no role in actually attenuating CT reactions; and (3) however, the final meta-analysis revealed that managing CT successfully is related to better therapy outcomes. The latter involves more than just education, but using insight to contain inappropriate behaviours.

In contrast to other diagnostic systems (e.g., DSM-5 and ICD-10), the *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006) considers transference/CT an important factor in differential diagnosis. The PDM also considers level of personality organization, which would alert practitioners about clients of various personality styles who may be at the borderline level of organization and possibly pose risk management issues:

> *…patients at the Borderline end of the continuum evoke strong feelings that clinicians may have to struggle to manage or contain*. (p. 25)
> *Countertransference with higher-functioning people tends to be mild and usually is experienced by the therapist as more interesting than emotionally disruptive*. (p. 27)

In diagnosing persons with personality disorders, '…we also mention the characteristic emotional reactions of therapists when relating to patients with the various personality disorders (i.e., the usual countertransference evoked by the kind of patient in question)' (p. 31).

The purpose of this study is to assess how practitioners from the spectrum of theoretical orientations (TO) consider CT in differential diagnosis to be helpful in anticipating management issues with difficult patients. We used the PDM's diagnostic taxonomy in this research since the PDM (1) uses transference/CT in diagnostic formulations; (2) uses borderline as a level of pathology with any of the personality disorders; and (3) provides many more personality disorders that are associated with acting out that are not in the DSM-5 and ICD-10 (Gordon, 2007).

To test this hypothesis, we compared psychodynamic therapy (PDT) practitioners who emphasize insight into subjective mental life with practitioners who do not emphasize this epistemology. Gordon (2008) proposed an epistemological dimension from the additive–overt–concrete behavioural/CBT theories to the complex–covert–abstract psychoanalytic theories, which values subjectivity and insight, with family systems and humanistic/existential as theoretical midpoints between PDT and CBT. CBT practitioners place emphasis on conscious cognitions, and CBT has no systemized taxonomy of personality. Family systems theory is dynamic but overt and concrete with no theory of individual personality. Humanistic/existential has a theory of personality growth, but it is not a dynamic developmental model of the interaction of the psychological constructs at various levels of consciousness that can account for the various forms of mental and behavioural disorders.

Therefore, we predict that since PDT practitioners emphasize insight into subjective mental life and have a well-developed taxonomy of personality, they should have a higher level of CT expectation to high-risk patients

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than practitioners who are not psychodynamic. CBT practitioners should have the lowest CT expectation. Other theoretical orientations (e.g., family systems and humanistic/existential) should tend to lie between PDT and CBT in their use of CT expectations.

HYPOTHESES

Hypothesis 1a. We predict that the only significant differences in theoretical orientation with respect to issues related to risk management such as CT expectation, boundary issues, patient's transference, role clarifications and use of supportive therapy would be with CT expectation. CT expectation requires a higher degree of abstraction and self-reflective capacity than do the other risk management issues.

Hypothesis 1b. We predict that CBT practitioners will be significantly lower in rating their CT to their own patients than both PDT and other practitioners as indicted on the Diagnostic Considerations Survey (DCS).

Hypothesis 2a. We predict that regardless of TO, the highest expected CT would be to patients with borderline level of personality organization.

Hypothesis 2b. When considering TO, we predict that there will be significant differences between the TO in expected CT only to patients with BPO, with PDT having the most CT expectation and CBT the least.

Hypothesis 2c. Since neurotic-level patients generally evoke the least intense CT and borderline-level patients generally evoke the most CT reactions, we will use the difference between the expected CT scores between neurotic and borderline patients as the CT insight index. We predict that PDT practitioners would judge that the CT to patients with a BPO would be much higher than the CT to patients with a neurotic-level personality organization than both CBT practitioners and other practitioners.

Hypothesis 3. We predict that PDT practitioners would have more expectation of CT than CBT practitioners with personality disorders that are highly associated with acting out (e.g., paranoid, psychopathic, narcissistic, sadistic, sadomasochistic, masochistic, hypomanic, passive–aggressive, counterdependent and counterphobic). The other orientations (e.g., family systems, humanistic/existential and eclectic) should generally fall somewhere between PDT and CBT practitioners.

[1]For more information and free copies of the Psychodiagnostic Chart (PDC), search the Web for 'Psychodiagnostic Chart.'

METHOD

Instruments

The Psychodiagnostic Chart[1]

Gordon and Bornstein (2012) developed the PDC as a brief practitioner rating form that integrates the adult section of the PDM with ICD or DSM symptoms. Gordon and Stoffey (2014) found very good construct validity and very good 2-week test–retest reliability.

The dimensions on the PDC are personality organization (neurotic–healthy, borderline and psychotic), dominant personality patterns and disorders (schizoid, histrionic, narcissistic, etc.), mental functioning (e.g., capacity for intimacy, defensive level, self observing capacity, etc.), ICD or DSM symptom diagnoses (e.g., mood disorder, anxiety disorder, etc.) and cultural/contextual dimension (e.g., immigration trauma, divorce, etc.). The practitioner rates these constructs on Likert scales (1 = *low*, 10 = *high*). We used the PDC in this study to guide the practitioner to give a diagnosis to their patient and to see if the practitioners of the different TO had patients at significantly different levels of personality organization.

Diagnostic Considerations Survey

The Diagnostic Considerations Survey (DCS) is a survey specifically developed for this study to test our hypotheses and asks practitioners to pick a recently seen patient and rate to what degree (1–7) they would use clarification of tasks, roles boundaries, expected confusion of their patient, CT reactions and use of supportive treatment. The DCS asks the practitioner the following questions about their patient: (1) 'How important do you think it is to establish roles, tasks and boundaries with this patient at the outset of treatment?'; (2) 'How important do you think it will be to have ongoing discussions about clarifying roles, tasks and boundaries with this patient throughout the course of treatment?'; (3) 'How much confusion do you expect this patient to have regarding boundaries in the professional relationship?'; (4) 'How strong a CT reaction might you expect to experience with this patient?'; and (5) 'How much more supportive treatment would you do with this patient as compared to other patients?'

Diagnostic Dimensions and Countertransference

The Diagnostic Dimensions and Countertransference (DDC) is also a survey specifically developed for this study to test our hypotheses. The DDC is projective, asking about other practitioner's expected CT to patients from various diagnostic groups. The DDC operationally defines CT in simple language assessable to all theoretical orientations. Although we acknowledge that CT is complex, for the purposes of this research, CT is defined simply and limited to those practitioner reactions that are likely to interfere with treatment and possibly lead to

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ethical dilemmas and risk management problems. This simplified definition is often consistent with how CT is used in ethics education.

It asks the practitioner, 'Every therapist has at times problematic countertransference reactions (anger, fear, boredom, too much sexual attraction, frustration and dislike). How likely would these diagnostic dimensions affect most therapists' countertransference?' The participant is asked to rate 'How strong a countertransference?', 1 = *none* to 7 = *very strong*. The survey lists the three levels of personality organization (neurotic, borderline and psychotic) and 19 PDM personality disorders and sub-types from the PDM. Unlike the DCS, the DDC is projective, asking what the practitioner thinks is common to other practitioners in order to help control for defensiveness. That is, some therapists might be reluctant to admit that they would have CT feelings.

Psychodynamic Diagnostic Prototypes

Gazzillo, Lingiardi and Del Corno (2012) operationalized the PDM's personality patterns and disorders (P) axis with their PDP assessment tool. The PDP is composed of 19 prototypic descriptions of personality disorders, one for each disorder of the Axis P of the PDM. Gazzillo *et al*. showed that the PDP has good inter-rater reliability, convergent, discriminant validity and criterion validly. In the current study, we had participants rate their patient on the PDP. The PDP served to help the participants in this study to understand the PDM's personality pattern and disorder dimension so that they could later rate how much CT they expected their colleagues to have to each personality disorder. The PDP provided clear definitions of the personality disorders so that practitioners of all theoretical orientations would be using the same definitions.

Participants

We collected data from 510 practitioners and clinical or counselling graduate students. The first author collected most of the data from mandatory continuing education workshops on the topic of comparing diagnostic systems and ethical considerations. The mandatory requirement helped to produce a sample of participants from the most common theoretical orientations. Participants were asked to assess a patient they have recently seen (within a week or so) for at least three sessions, who is 18 years or older and who was not actively psychotic or neurologically impaired at the time of treatment. Participants were provided a unified and consistent understanding of the operationalized definitions used in the study. Participants were not aware of the hypotheses of the investigation other than that the investigators wanted help in understanding diagnostic and ethical issues. Participation was voluntary.

RESULTS

Demographics

In this sample, 46% held doctoral degrees, 67% were female and 60% were age 50 or older, and their primary orientations were 26% psychodynamic, 33% CBT and 41% other (e.g., family systems, humanistic/existential and eclectic). The sample size for the statistical analyses varied due to missing data. Of the 510 participants, 494 filled out their primary TO, and 411 completed all the surveys for this study.

Missing Data and Theoretical Orientation

Questionnaires that had demographic data filled in (which included theoretical orientation) and where the personality disorders and the CT sections were left entirely blank were not included in the data analysis because too much data were missing.

Of the 82 participants that filled in their TO but left out either the personality disorders surveys and/or the CT surveys, 46 or 56% identified themselves as CBT practitioners. The next highest in not filling out the diagnostic areas was eclectic practitioners with 16 or 20%, humanistic/existential practitioners 9 or 11%, systems practitioners 5 or 6%, behavioural practitioners 4 or 5% and psychodynamic practitioners 2 or 2%.

Diagnostic Considerations Survey ($n = 478$)

We used the Kruskal–Wallis test for the overall significance and the Mann–Whitney *U* for the *post hoc* tests.

The DCS asks, 'Now that you made your diagnosis, we would like to ask you a few questions'. These questions are specifically about a current patient that the participant chose to rate.

1. How important do you think it is to establish roles, tasks and boundaries with this patient at the outset of treatment? (1 = *not at all important* to 7 = *very important*). As predicted, there were no significant differences between the theoretical orientations.
2. How important do you think it will be to have ongoing discussions about clarifying roles, tasks and boundaries with this patient throughout the course of treatment? (1 = *not at all important* to 7 = *very important*). As predicted, there were no significant differences between the theoretical orientations.
3. How much confusion do you expect this patient to have regarding boundaries in the professional relationship? (1 = *none* to 7 = *a great deal*). As predicted, there were no significant differences between the theoretical orientations.
4. How strong a countertransference reaction might you expect to experience with this patient? (1 = none

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to 7 = very strong). As predicted, there were significant differences between the TO, Kruskal–Wallis $p = 0.017$: PDT $M = 4.51$, $SD = 1.56$; CBT $M = 4.04$, $SD = 1.62$; and others $M = 4.39$, $SD = 1.60$. Mann–Whitney *U post hoc* comparisons: PDT versus CBT $p = 0.017$, PDT versus other $p = ns$ and CBT versus other $p = 0.043$. CBT practitioners were significantly lower in rating their CT reactions to their own patient than both PDT practitioners and other practitioners.

5. How much more supportive treatment would you do with this patient as compared with other patients? (1 = *very little* to 7 = *a great deal*).

As predicted, there were no significant differences between the theoretical orientations.

Hypothesis 1a was supported. There were no significant difference in theoretical orientation with respect to constructs that are more concrete and external than CT, such as boundary issues, transference, role clarifications and use of supportive therapy. These do not require the degree of abstraction and self-reflective capacity, as does CT expectation.

Hypothesis 1b was supported. CBT practitioners were significantly lower in rating their CT reactions to their own patient than both PDT practitioners and other practitioners as indicted on the DCS.

We tested if CBT practitioners were significantly lower in their CT scores to their own patient as compared with both PDT practitioners and other practitioners—due to the possibility that the CBT practitioners chose higher-functioning patients to rate. We subtracted the overall personality organization score on the PDC (1 = *psychotic*, 10 = *healthy*) of the practitioner's patient, from each of the five scores on the DCS. None were significant by theoretical orientation. In other words, the differences in TO cannot be attributed to actual or perceived differences in the severity of their patients' psychopathology.

Diagnostic Dimensions and Countertransference ($n = 411$)

We used the DDC to test Hypotheses 2a and 2b. Unlike the CT question about one's patient in the DCS, the DDC tries to avoid possible defensiveness by asking about what most practitioners would expect to feel regarding CT. The DDC clarifies in simple terms a definition of CT that is friendly to all theoretical orientations and asks, 'Every therapist has at times problematic countertransference reactions (anger, fear, boredom, too much sexual attraction, frustration, and dislike). How likely would these diagnostic dimensions affect most therapists' countertransferences? Please circle each of the 22 diagnostic categories' (1 = *none* to 7 = *very strong*). The PDM predicts that the greatest amount of CT should be to patients at the BPO.

Countertransfrence Expectation Towards Psychotic–Borderline–Neurotic Personality Organizations

Hypothesis 2a. As predicted overall, regardless of TO, the highest expected CT was to the patients with borderline level of personality organization. The neurotic level of personality organization had the lowest expected CT. Friedman $p < 0.0001$: neurotic (N) $M = 3.21$, $SD = 1.52$; borderline (B) $M = 5.21$, $SD = 1.76$; psychotic (P) $M = 3.92$, $SD = 1.90$; and Wilcoxon *post hoc* comparisons: N versus B $p < 0.0001$, N versus P $p < 0.000$ and B versus P $p < 0.0001$. Practitioners, regardless of TO, all rated an expected low CT reaction to neurotic-level patients. Similarly, there were no significant differences between the TO in expected CT to the psychotic level of personality organization.

As predicted in Hypothesis 2b, there were significant differences between the TO in expected CT to the patients at the borderline level of personality organization. Kruskal–Wallis $p = 0.001$: PDT $M = 5.83$, $SD = 1.21$; CBT $M = 4.77$, $SD = 1.87$; others $M = 5.19$, $SD = 1.82$ and Mann–Whitney *post hoc* comparisons: PDT versus CBT $p < 0.0001$, PDT versus other $p = 0.039$, CBT versus other $p = ns$. PDT practitioners were significantly higher in CT expectations to the patients at the borderline level of personality organization than CBT and other practitioners.

There were no significant differences between the TO in CT expectation to the neurotic or psychotic levels of personality organization.

Theoretical Orientation Differences in Expectant Countertransference Between Neurotic and Borderline Personality Organizations ($n = 411$)

An important diagnostic distinction that can lead to the most ethical problems is discerning the difference between neurotic and BPO. Neurotic-level patients generally evoke the least CT, and borderline-level patients generally evoke the most CT. Expectations of the more intense CT evoked when working with patients with a BPO help in differential diagnosis. We computed a CT insight index by subtracting the CT difference, the neurotic score and the borderline score on the DDC. We have the following findings. Kruskal–Wallis $p < 0.0001$: PDT $M = 2.62$, $SD = 1.76$; CBT $M = 1.65$, $SD = 1.90$; and others $M = 1.92$, $SD = 1.97$. Mann–Whitney *U post hoc*: PDT versus CBT $p < 0.0001$, PDT versus other $p = 0.009$ and CBT versus other $p = ns$.

These results support Hypothesis 2c. When we used the difference between the expected CT scores between neurotic and borderline patients as a CT insight index, we found that PDT practitioners would judge that the expected CT to patients with a BPO would be much higher than the expected CT to patients with a neurotic-level

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personality organization than both CBT practitioners and other practitioners (Figure 1).

Theoretical Orientation Differences in Countertransference Towards the Various Personality Disorders ($n = 411$)

We also predicted that PDT practitioners would have more expectation of CT with personality disorders that are most associated with acting out (e.g., paranoid, psychopathic, narcissistic, sadistic, sadomasochistic, masochistic, hypomanic, passive–aggressive, counterdependent and counterphobic) than CBT practitioners and other practitioners. We used the Kruskal–Wallis for an overall test and the Mann–Whitney *U* for the *post hoc* test of significance. To account for possible Type I errors (false positives) due to the large number of multiple comparisons (19 personality disorders by 3 theoretical orientations), we used a more conservative alpha level of $p < 0.01$.

Schizoid, Mann–Whitney *U post hoc*: PDT versus CBT $p = 0.001$, PDT versus other $p = ns$ and CBT versus other $p = 0.023$.
Paranoid, Mann–Whitney *U post hoc*: PDT versus CBT $p < 0.0001$, PDT versus other $p = ns$ and CBT versus other $p = 0.005$.
Psychopathic, Mann–Whitney *U post hoc*: PDT versus CBT $p < 0.0001$, PDT versus other $p = 0.003$ and CBT versus other $p = 0.003$.
Narcissistic, Mann–Whitney *U post hoc*: PDT versus CBT $p < 0.0001$, PDT versus other $p = 0.009$ and CBT versus other $p = 0.01$.
Sadistic, Mann–Whitney *U post hoc*: PDT versus CBT $p < 0.0001$, PDT versus other $p \leq 0.001$ and CBT versus other $p < 0.0001$.
Sadomasochistic, Mann–Whitney *U post hoc*: PDT versus CBT $p < 0.0001$, PDT versus other $p = 0.034$ and CBT versus other $p = 0.014$.
Masochistic, Mann–Whitney *U post hoc*: PDT versus CBT $p \leq 0.0001$, PDT versus other $p = 0.024$ and CBT versus other $p = 0.046$.
Depressive, $p = ns$.
Hypomanic, Mann–Whitney *U post hoc*: PDT versus CBT $p \leq 0.0001$, PDT versus other < 0.0001 and CBT versus other $p = 0.027$.
Somatizing, Mann–Whitney *U post hoc*: PDT versus CBT $p = 0.001$, PDT versus other $p = 0.017$ and CBT versus other $p = ns$.
Dependent, $p = ns$.
Dependent, passive–aggressive, Mann–Whitney *U post hoc*: PDT versus CBT $p \leq 0.0001$, PDT versus other $p = 0.001$ and CBT versus other $p = 0.011$.
Counterdependent, Mann–Whitney *U post hoc*: PDT versus CBT $p \leq 0.0001$, PDT versus other $p = 0.001$ and CBT versus other $p < 0.049$.
Phobic, Mann–Whitney *U post hoc*: PDT versus CBT $p = 0.006$, PDT versus other $p = ns$ and CBT versus other $p = ns$.
Counterphobic, Mann–Whitney *U post hoc*: PDT versus CBT $p < 0.0001$, PDT versus other $p = 0.001$ and CBT versus other $p = 0.031$.
Anxious, $p = ns$.
Obsessive–compulsive, $p = ns$.
Hysterical (histrionic), $p = ns$.
Dissociative, Mann–Whitney *U post hoc*: PDT versus CBT $p = 0.005$, PDT versus other $p = ns$ and CBT versus other $p = ns$.

These results generally supported Hypothesis 3. PDT practitioners had more expectation of CT than CBT practitioners with the range of personality disorders that are highly associated with acting out. In the other orientations

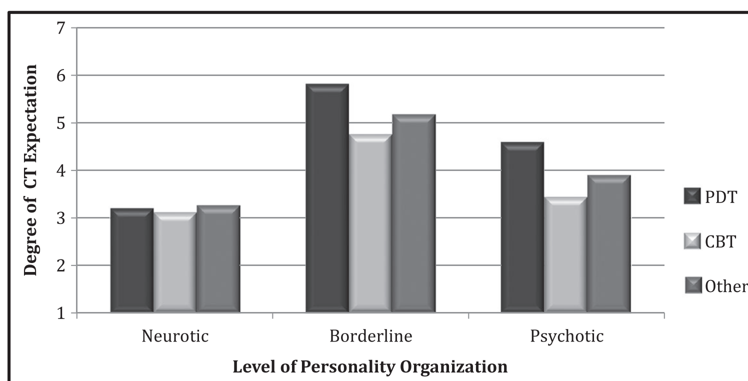

Figure 1. Theoretical orientation (TO) differences in countertransference (CT) expectation. Only the borderline-level patients were associated with significant differences in CT expectation across TO. Psychodynamic therapists (PDT) were significantly more expectant of CT with borderline-level patients than cognitive–behavioural therapists (CBT) and other. PDT versus CBT $p < 0.0001$, PDT versus other $p = 0.039$ and CBT versus other $p = ns$. PDT were significantly greater in the expectation of CT in the differential diagnoses between neurotic-level and borderline-level pathologies than both CBT and other TO. PDT versus CBT $p < 0.0001$, PDT versus other $p = 0.009$ and CBT versus other $p = n$

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(e.g., family systems, humanistic/existential and eclectic), CT expectations generally fell between PDT and CBT practitioners. We did not predict that schizoid and somatizing would also follow the same pattern of PDT, having more expectation of CT than CBT. PDT ranged in CT expectation from 5.87 to 2.98. In contrast, CBT ranged from 4.33 to 2.45. (See Table 1 for main effects, means and standard deviations.)

DISCUSSION

Many practitioners get into trouble with licensing boards, ethics committees and malpractice suits, due to not understanding and managing their CT reactions to difficult patients. Thomas (2005) found that most psychologists who face licensing board complaints needed more awareness of CT issues. Additionally, how a practitioner deals with CT can also affect the treatment process and outcome (Hayes *et al.*, 2011; Markin *et al.*, 2013; Rossberg *et al.*, 2010). However, Pope and Tabachnick (1993) found that practitioners felt that their graduate training did not adequately prepare them to deal effectively with risk management challenges. We feel that even today many practitioners are not exposed to sufficient CT education to help treat high-risk patients and also help them be more proactive to possible ethical dilemmas.

We predicted that the more practitioners' TO emphasizes insight into the dynamics of subjective mental life, the better they will be at using their CT expectations in differential diagnosis with high-risk patients. To test this hypothesis, we compared PDT practitioners who emphasize insight into subjective mental life with practitioners who do not emphasize this epistemology. Gordon's (2008) model of psychological epistemologies range from behavioural/CBT theories, which are largely additive–overt–concrete, to the complex–covert–abstract psychodynamic theories, which values insight into subjective affect states, with family systems and humanistic/existential as theoretical midpoints between CBT and psychodynamic.

One of the most serious errors in differential diagnosis that can lead to risk management issues is failing to tell the difference between patients with a neurotic-level personality organization and patients with a borderline-level personality organization. We computed a CT insight index by subtracting the expected CT difference of the neurotic-level score and the borderline-level score on the DDC. We found that PDT practitioners were significantly higher in the CT insight index than both CBT practitioners and other practitioners.

This study shows that PDT practitioners expected more CT with patients at the borderline level of personality organization than those patients at the neurotic level than both CBT practitioners and other practitioners

Table 1. Theoretical orientation and expectant countertransference to personality disorders

Personality disorder		Theoretical orientation						*p*
		PDT		Other		CBT		
		M	*SD*	*M*	*SD*	*M*	*SD*	
Psychopathic	4.96	5.87	1.35	4.92	2.11	4.33	2.20	0.000
Narcissistic	4.90	5.61	1.14	4.89	1.78	4.39	1.99	0.000
Sadistic	4.89	5.85	1.54	4.94	2.10	4.12	2.20	0.000
Passive–aggressive	4.55	5.33	1.25	4.52	1.74	4.03	1.88	0.000
Sadomasochistic	4.20	4.85	1.79	4.22	2.11	3.71	2.24	0.000
Counterdependent	3.91	4.54	1.38	3.87	1.66	3.50	1.79	0.000
Hysterical	3.78	4.14	1.74	3.80	1.90	3.49	2.11	0.055
Paranoid	3.76	4.25	1.76	3.87	1.86	3.27	1.87	0.000
Dependent	3.72	3.97	1.67	3.63	1.80	3.63	1.90	0.254
Hypomanic	3.70	4.47	1.48	3.62	1.61	3.24	1.54	0.000
Masochistic	3.65	4.23	1.84	3.63	2.06	3.25	2.03	0.001
Schizoid	3.29	3.61	1.75	3.41	1.93	2.92	1.83	0.003
Dissociative	3.23	3.58	1.73	3.22	1.73	2.97	1.96	0.013
Depressive	3.21	3.38	1.56	3.17	1.63	3.13	1.75	0.486
Somatizing	3.19	3.67	1.68	3.13	1.63	2.92	1.76	0.002
Anxious	3.13	3.21	1.58	3.14	1.61	3.05	1.74	0.735
Obsessive–compulsive	3.10	3.31	1.64	3.15	1.60	2.90	1.72	0.145
Counterphobic	3.18	3.80	1.41	3.11	1.49	2.80	1.55	0.000
Phobic	2.72	2.98	1.41	2.78	1.56	2.45	1.43	0.024

Psychodynamic therapy (PDT) practitioners were always significantly more expectant of countertransference than cognitive–behavioural therapy (CBT) practitioners, and CBT practitioners were overall least expectant of countertransference for all the hypothesized personality disorders associated with acting out. The other practitioners generally fell between PDT and CBT.

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(e.g., family systems, humanistic/existential and eclectic). PDT practitioners were also more likely to anticipate that the personality disorders most associated with acting out (e.g., paranoid, psychopathic, narcissistic, sadistic, passive–aggressive, sadomasochistic, counterdependent, hypomanic, masochistic and counterphobic) present more CT problems than expected by CBT practitioners. The other orientations (e.g., family systems, humanistic/existential and eclectic) had CT expectations generally between the PDT and CBT practitioners. PDT practitioners ranged in CT expectation from 5.87 to 2.98. In contrast, CBT practitioners' ranged from 4.33 to 2.45 in CT expectation. This shows CBT's narrower band of sensitivity to CT expectations. PDT practitioners were overall more expectant of CT issues than CBT practitioners with all the personality disorders except for those typically 'neurotic-level' disorders, which produced little CT (depressive, dependent, anxious and obsessive–compulsive). As predicted, in these cases, there were no differences in CT expectations.

We tested if CBT practitioners were significantly lower in their CT scores to their own patient as compared with both PDT practitioners and other practitioners—due to the possibility that the CBT practitioners chose higher-functioning patients to rate. We subtracted the overall personality organization score on the PDC from each of the five scores on the DCS. None were significant by theoretical orientation. In other words, the differences in TO cannot be attributed to actual or perceived differences in the severity of their patients' psychopathology.

We also found support for our assumption of our independent variables by the differential response to our questionnaires according to TO. Of the 82 participants that filled in their theoretical orientation but left out either the personality disorders surveys and/or the CT surveys, 46 or 56% identified themselves as CBT practitioners. The next highest in not filling out the diagnostic areas was eclectic practitioners with 16 or 20%, humanistic/existential practitioners 9 or 11%, Systems practitioners 5 or 6%, behavioural practitioners 4 or 5% and psychodynamic practitioners 2 or 2%. This is despite that all participants had the same workshop instructions, exercises and definitions of CT and the levels of personality organization and disorders.

Cognitive–behavioural therapy practitioners might have had difficulties with having realistic CT expectations with the diagnoses most associated with acting out due to several possible reasons:

1. CBT theory and treatment are centred on pathogenic cognitions rather than a personality theory and taxonomy. This leads CBT practitioners to focus on overt symptoms rather than inferred personality dynamics. Educators can still teach CBT while still being loyal to the theoretical underpinnings by introducing the PDM's taxonomy to help prevent ethical and risk management problems. Gordon (2009) found that CBT psychologists had the most favourable reaction to the PDM in the areas that were concrete such as the appreciation of borderline as a personality organization.
2. Personality factors may also be operative in a capacity for CT insight. People attracted to CBT may find the mentalization of personality dynamics difficult. Education helps with mentalization of others, but exceptional mentalization is also a rare talent (Fonagy, 2003). Buckman and Barker (2010) found that preference for PDT was influenced more by training factors, while the preference for CBT was influenced more by personality factors, with the influence of both sets of factors being approximately equal for systemic therapy. Supervision was more influential than the theoretical emphasis of training courses in predicting preferences for psychodynamic and systemic therapies, with the converse pattern found for CBT. Heffler and Sandell (2009) found that the learning style of the average PDT student tended to be a 'feel and watch' style, whereas the CBT student tended have a 'think and do' learning style. PDT practitioners tend to score higher than CBT practitioners on intuition and openness to experience (Topolinski & Hertel, 2007), tolerance and risk taking (Christopher, 2008) as well as tolerance of ambiguity (MacLennan, 2008). Topolinski and Hertel (2007) also found that psychoanalytically oriented therapists indicated higher job satisfaction than behaviourally oriented therapists. This might be partly due to better understanding and managing CT reactions over time.

We therefore suggest that regardless of favoured treatment biases, the addition of CT expectation as a diagnostic tool may alert the practitioner to difficult patients before many objective symptoms are known. The DSM-5 and ICD-10 present with clear descriptive diagnostic criteria but leave out important transference/CT information for differential diagnosis. This exclusion may lead to ignoring or misreading CT feelings to possible high-risk patients. The implications of these findings suggest that clinical training in a taxonomy that considers CT such as the PDM (PDM Task Force, 2006) may be useful in helping to avoid ethical dilemmas regardless of one's level of training or theoretical preference.

The limitations of this study are that we assessed practitioners' CT expectations and not practitioners' actual CT reactions to patients of various diagnostic groups. Although CBT practitioners may not feel as comfortable with terms such as 'transference' and 'CT', they may in actual treatment settings react to the personality triggers of their patients and manage their CT without labelling it as such. Further research is needed in this area. Additionally, future research is needed to help to determine how much of the differences of CT expectations are due to educational factors and how much are due to personality factors.

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