

Spektor, V., Luu, L. & Gordon, R.M. (2015). The Relationship between Theoretical Orientation and Accuracy of Countertransference Expectations, *Journal of the American Psychoanalytic Association*,

**The Relationship between Theoretical Orientation and Accuracy of Countertransference Expectations<sup>1</sup>**

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Abstract

Various theoretical orientations may represent very different epistemological styles and degrees of insightfulness into subjective states. Gordon (2008) proposed an epistemological dimension from the additive-overt-concrete behavioral/ CBT theories to the dynamic-covert-abstract psychoanalytic theories which values subjectivity and insight, with family systems and humanistic/existential as theoretical midpoints. Based on this epistemological model, a psychodynamic orientation should be the most helpful in using countertransference (CT) to aid in subjective insight for better differential diagnoses, behavioral/CBT the least insightful, with humanistic/existential and family systems being between psychodynamic and behavioral/CBT. The use of countertransference (CT) to help diagnose difficult patients is valuable in risk management and treatment planning (Gordon, 2014). To test this, we asked practitioners who had attended CE ethics and diagnoses workshops, how much they used various theoretical orientations in their clinical work (psychodynamic, CBT, behavioral, family systems and humanistic/existential) (1 = “never or rarely,” 7 = almost always or always). We then asked the participants to complete the Diagnostic Dimensions and Countertransference (DDC) survey. The DDC 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 DDC is projective, asking what the practitioner

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<sup>1</sup> Presented at the American Psychoanalytic Association poster session January 16<sup>th</sup>, 2015 New York.

thinks is common to other practitioners, thereby helping to mitigate defensive responding. The participants were asked to rate “How strong a countertransference?” (1= “None,” 7= “Very Strong”) to the three levels of personality organization (neurotic, borderline and psychotic), which were defined in the workshops.

The accuracy of CT expectations was operationally defined as expecting more CT to psychotic and borderline patients and the least CT to neurotic level patients. Of the 627 attendees, 411 participants turned in all the survey materials- 46% held doctoral degrees, 67% were female, 60% were age 50 or older, and their primary orientations were 26% Psychodynamic, 33% CBT, 6.5% Family Systems, 6.9% Humanistic/Existential, 1.2% Behavioral, 20% Eclectic, and 6.5% Other.

The results confirmed our hypothesis. The more a practitioner used a psychodynamic orientation the more they expected that most practitioners would have CT with psychotic level patients ( $r = .32, p < .01$ ) and borderline level patients ( $r = .29, p < .01$ ). The more a practitioner used a CBT or a behavioral orientation the less accurate they were in CT expectations (CBT: psychotic level  $r = -.14, p < .01$ ; borderline level  $r = -.12, p < .05$ ; behavioral: psychotic level  $r = -.20, p < .01$ ; borderline level  $r = -.19, p < .01$ ).

Humanistic/existential had a significant positive correlation with expected CT for psychotic level patients ( $r = .10, p < .05$ ). Family systems had no significant correlations. There were no significant correlations for the neurotic level with CT expectation across theoretical orientations.

These results support psychodynamic education for all practitioners to aid to making an accurate diagnosis, treatment planning and in risk management with difficult patients.

Does a psychodynamic orientation help practitioners' accuracy with countertransference insight for differential diagnoses better than other theoretical orientations? Certainly, countertransference (CT) insight is important to risk management and treatment success. Thomas' (2005) investigation found that most psychologists who face licensing board complaints needed more awareness of countertransference issues. Similarly, Rossberg, Karterud, Pedersen and Friis (2010) found that symptom change was positively correlated with positive countertransference feelings and negatively correlated with negative countertransference feelings. Thus, and as supported by a recent meta-analysis (Hayes, Gelso, & Hummel, 2011), managing countertransference successfully is related to better therapy outcomes.

More disturbed and acting out patients tend to evoke more negative countertransference (Colli et al., 2013). Colli, Tanzilli, Dimaggio and Lingardi (2013) found that DSM-IV cluster B personality disorders are significantly associated with consistent negative CT than do patients with cluster A and C disorders, and this finding was supported in Liebman & Brunette's (2013) investigation of therapists' reactions to individuals with borderline personality disorder (BPD). Furthermore, Brody and Farber (1996) found that borderline patients evoked the greatest degree of anger and irritation within the practitioner, and schizophrenic patients received the most complex mix of countertransference feelings, along with the highest perceived need for referral in a study of 336 practitioners. Ultimately,

research suggests that CT patterns are systematically related to patients' personality pathology across therapeutic approaches, suggesting that clinicians, regardless of therapeutic orientation, can make diagnostic and therapeutic use of their own responses to the patient (Betan, Heim, Conklin, and Westen, (2005) given adequate insight into their own subjective states (Eagle, 2000).

Although countertransference awareness is important to patient care, the knowledge and capacities for this self-awareness may vary according to practitioners' theoretical orientation. Gordon (2008) proposed an epistemological dimension from the additive-overt-concrete behavioral/ CBT theories to the dynamic-covert-abstract psychoanalytic theories which values subjectivity and insight, with family systems and humanistic/existential as theoretical midpoints. Family systems theory is dynamic but overt and concrete with no theory of personality, given that the emphasis is on systems within the family rather than individual characteristics (Gurman & Kniskern, 2014). Humanistic/existential has a theory of personality, which has covert elements, and abstract constructs, but it is not a dynamic developmental model of the interaction of the psychological constructs at various levels of consciousness (Schneider & Krug, 2010).

Based on Gordon's (2008) epistemological model, a psychodynamic orientation should be the most helpful in using CT to aid in subjective insight for better differential diagnoses, behavioral/CBT the least insightful, with humanistic/existential and family systems being in the middle. Supporting this idea, Gordon et al (2014) found that therapists practicing psychodynamic therapy (PDT) had significantly greater CT expectations in the differential diagnoses between neurotic and borderline-level pathologies than both CBT and "Other" practitioners. Furthermore, many studies have shown that PDT practitioners tend to

score higher than CBT practitioners on intuition and openness to experience (Topolinska & Guido, 2007), tolerance and risk taking (Christopher, 2008), , abstract thinking (Gordon, 2009), as well as tolerance of ambiguity (MacLennan, 2008) and affect (Heffler, & Sandell, 2009;).

In light with the above findings, the present study was guided by the following hypothesis: accuracy of expected CT would be highest for psychodynamic practitioners and lowest for behavioral/CBT Practitioners, with humanistic/existential and family systems being between psychodynamic and behavioral/CBT. Accuracy of CT was operationalized as greater expected CT for borderline and psychotic patients.

## **Method**

### **Instruments:**

**Demographic Survey.** Participants reported their gender, age, education and primary theoretical orientation. We also asked how much they used (psychodynamic, CBT, behavioral, family systems, humanistic/existential) in their clinical work (1 = “never or rarely” 7 = almost always or always”).

### **Diagnostic Dimensions and Countertransference (DDC).**

The DDC, an ad hoc face valid survey, 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,” 7= “Very Strong.” The survey lists the three levels of personality organization (neurotic, borderline and psychotic). The DDC is projective,

asking what the practitioner thinks is common to other practitioners, thereby helping to mitigate defensive responding.

### **Participants**

The final sample included 411 participants. Of these, 46% held doctoral degrees, 67% were female, and 60% were age 50 or older. Practitioners' primary orientations were 26% Psychodynamic, 33% CBT, 6.5% Family Systems, 6.9% Humanistic/Existential, 1.2% Behavioral, 20% Eclectic, and 6.5% Other.

### **Procedure**

Participation was voluntary and participants were not aware of the hypotheses of the investigation other than that the investigators wanted help in understanding diagnostic and ethical issues. We asked practitioners who had attended CE ethics and diagnoses workshops how much they used various theoretical orientations in their clinical work (psychodynamic, CBT, behavioral, family systems and humanistic/existential) (1 = "never or rarely," 7 = almost always or always). We then asked the participants to complete the Diagnostic Dimensions and Countertransference (DDC) survey. The participants were asked to rate "How strong a countertransference?" (1= "None," 7= "Very Strong") to the three levels of personality organization (neurotic, borderline and psychotic), which were defined in the workshop. The accuracy of CT expectations was operationally defined as expecting more CT to psychotic and borderline patients and the least CT to neurotic level patients.

The IRB of Chestnut Hill College determined that this project adequately protects the welfare, rights, and privacy of human subjects.

### **Results**

The results supported our hypothesis. The more practitioner used a psychodynamic orientation the more they expected that most practitioners would have CT with psychotic ( $r = .32, p < .01$ ) and borderline level patients ( $r = .29, p < .01$ ). The more a practitioner used a CBT or a behavioral orientation the less accurate they were in CT expectations (CBT: psychotic level  $r = -.14, p < .01$ ; borderline level  $r = -.12, p < .05$ ; behavioral: psychotic level  $r = -.20, p < .01$ ; borderline level  $r = -.19, p < .01$ ). Humanistic/existential had a significant positive correlation with expected CT for psychotic level patients only ( $r = .10, p < .05$ ). Family systems had no significant correlations with expected CT for patients of borderline or psychotic personality organization. There were no significant correlations for the neurotic level with CT expectation across theoretical orientations. These results support psychodynamic education for all practitioners to aid to making an accurate diagnosis, treatment planning and in risk management with difficult patients.

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