49th Congress of International Psychoanalytical Association (IPA)

Teaching psychoanalysis to residents in psychiatry

Vittorio Lingiardi, M.D.
Faculty of Medicine and Psicology,
Sapienza University of Rome, Italy

vittorio.lingiardi@uniroma1.it

Dipartimento
di Psicologia
Dinamica e Clinica

Sapienza
Università di Roma

Something to teach …

Pre-Congress Workshop: Tuesday 21 July
New Psychoanalytic Instruments in the Mental Health Field

Background: In the last two decades, psychoanalysis has lost much of its institutional authority within the mental health field. Yet, the word 'container' and the notion of 'containment' (words that come from the Winnicott and Bion conceptual archive), the concept of 'attachment' (Bowlby) and those of personality structure and mechanisms of defence (Freud) have gained a widespread popularity. This probably happens because these notions seem to capture something which is intuitively perceived as relevant: the constructive function of the psychosocial processes that shape and transform emotion, perception and understanding of patients and professionals alike. The psychoanalytic understanding of these psychosocial processes offers a means to provide real help to colleagues struggling with work in the mental health field.

Today's key words

Personality

Defense Mechanisms

Therapist's Emotional Responses (Countertransference)

"Diagnosis" as a dirty word

For many people, including some therapists, "diagnosis" is a dirty word. We have all seen the misuse of psychodiagnostic formulations: The complex person gets flippantly oversimplified by the interviewer who is anxious about uncertainty; the anguished person gets linguistically distanced by the clinician who cannot bear to feel the pain; the troublesome person gets punished with a pathologizing label. Racism, sexism, heterosexism, classism, and numerous other prejudices can be (and have often been) handily fortified by nosology. Currently in the United States, where insurance companies allot specific numbers of sessions for specific diagnostic categories, often in defiance of a therapist's judgment, the assessment process is especially subject to corruption.

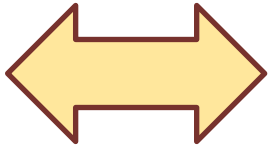
Nancy McWilliams (2011), Psychoanalytic Diagnosis (p. 7)

Two ways of approaching the diagnostic process
- the Jaspersian torment? -
(Karl Jaspers, General Psychopathology, 1913)

NOMOTHETIC PERSPECTIVE:

- A matter of degree
- Categorial
- Descriptive
- Objectevely anchored
- Based on externally observable symptoms

CLINICIANS: Recluctance, mistrust and suspicious toward the ***descriptive psychiatric diagnosis (DSM and ICD)***, based on the ***symptom-behavior oriented approach***.

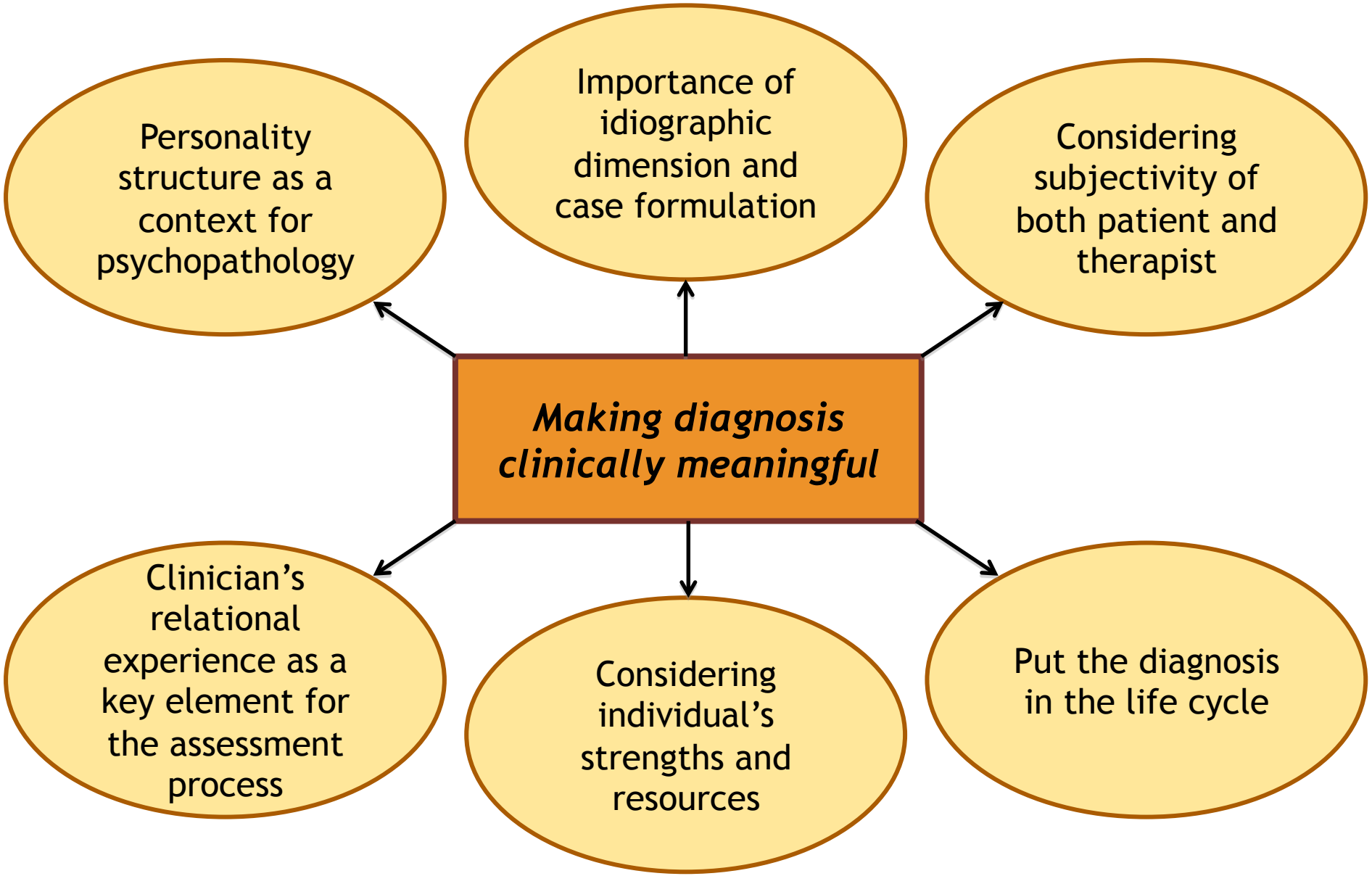


IDEOGRAPHIC PERSPECTIVE:

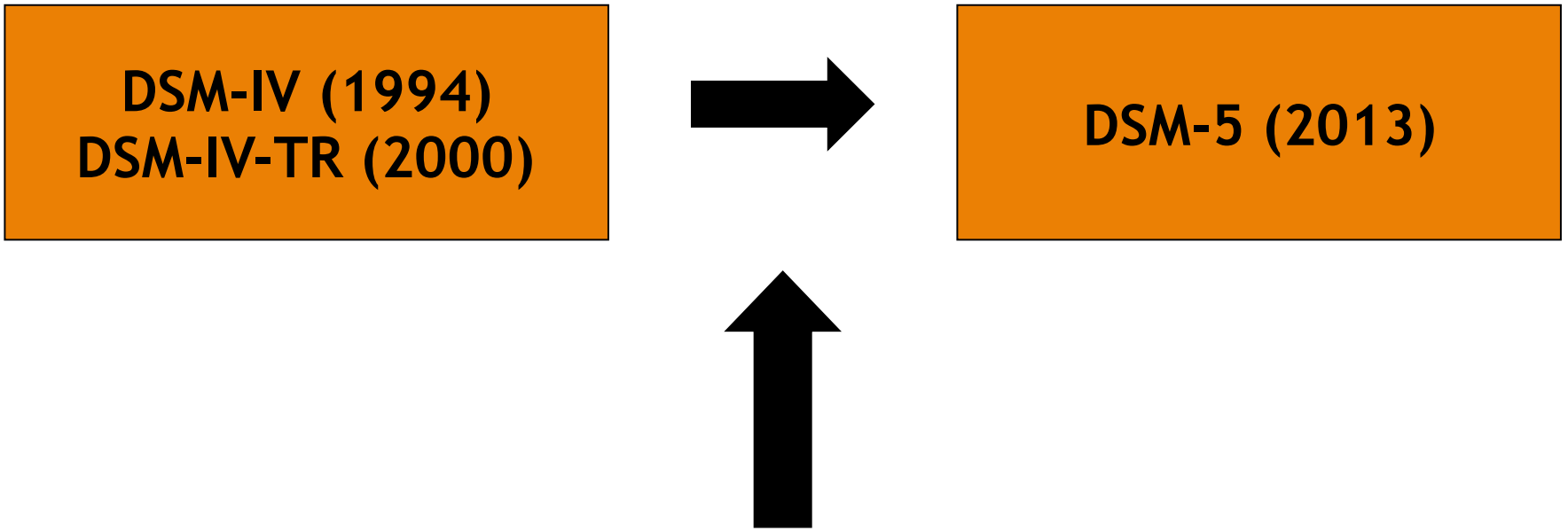
- Dimensional
- Inferential
- Subjectivity
- Contextual
- Biopsychosocial
- Useful for case formulation and treatment indications

RESEARCHERS: Criticism toward the subjectivity attuned ***case formulations*** of therapists, that were substantially idiosyncratic and, hence, unreliable.

Making diagnosis meaningful

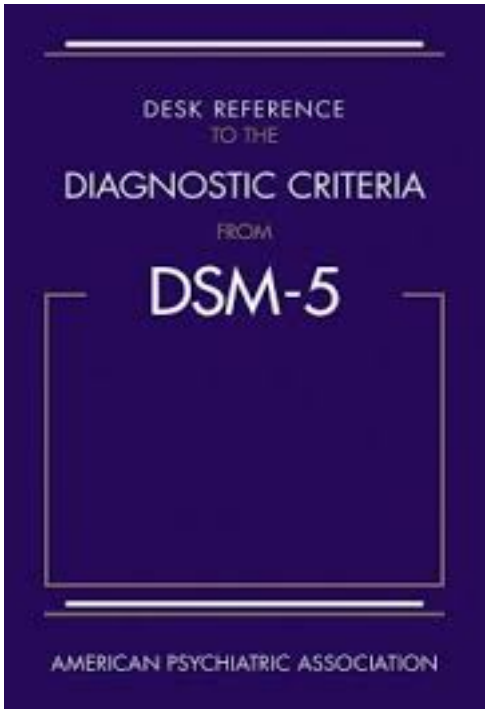


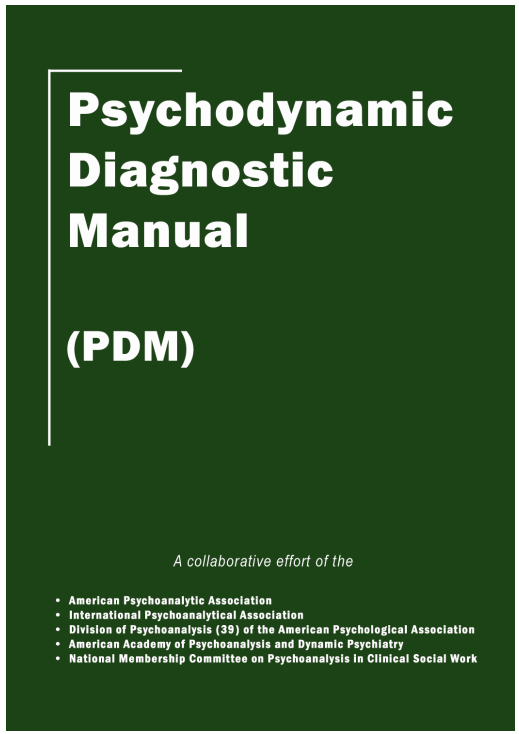
1994-2016


DSM-IV (1994)
DSM-IV-TR (2000)
DSM-5 (2013)
SWAP-200/SWAP-II
(1999, 2003, 2014)
PDM-1 (2006)
PDM-2 (2016)

TOP-DOWN

BOTTOM-UP





As tutors and supervisors of psychotherapists and clinical psychologists, we realize everyday how many young colleagues feel lost in a biomedical diagnostic world and how keenly they feel the lack of a more psychologically articulated diagnostic system.

Too often they feel compelled to “choose” between **oversimplified** diagnostic labels and **idiosyncratic**, unreliable and “local” diagnostic languages and procedures.

Moreover, they often miss the dynamic, relational and intersubjective aspects of diagnosing.

In this way, diagnosing – a challenging and thought-provoking process – stops making sense, and it becomes a more routinized, often boring, activity.

Being thrown between the anonymity of rating scales and the challenges of self-referential jargon not only mortifies the clinician's professional identity, but also dims or distorts the practitioner's ability to detect and describe the patient's characteristics and mental functioning.

As a consequence it jeopardizes the clinical relationship.

This is one of the main reasons we needed the PDM.

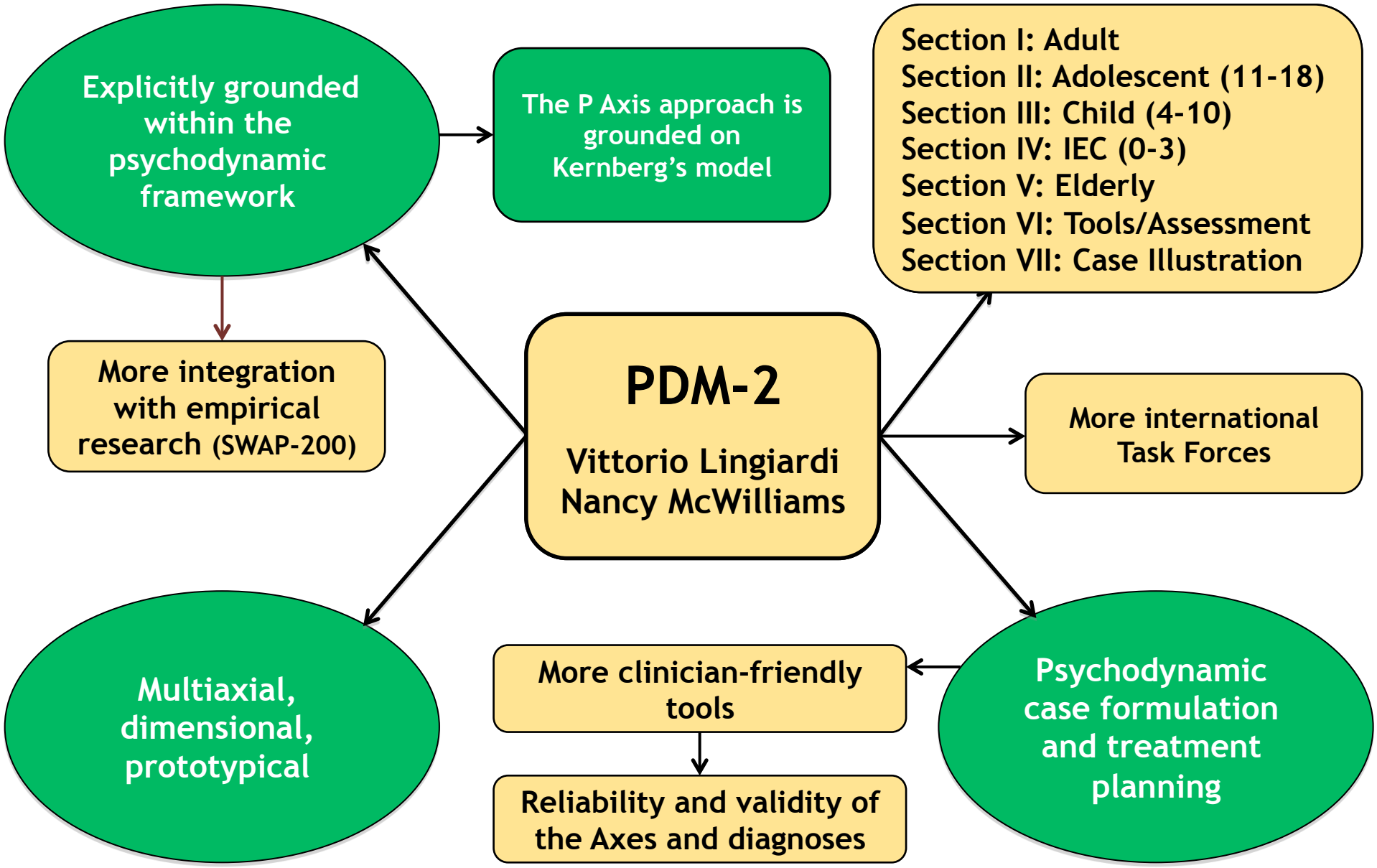
The Psychodynamic Diagnostic Manual (PDM-2)

The PDM aimed to promote integration between **nomothetic** understanding and the **idiographic** knowledge that is useful for individual **case formulation** and the **planning of patient-tailored treatment**

- It **complements** the DSM and ICD efforts to catalogue symptoms and syndromes
- Attempts to characterize an individual's **full range of functioning**, the depth as well as the surface of emotional, cognitive and social patterns
- A "**taxonomy of people**" rather than a "**taxonomy of disorders**" ("**more about who one is than about what disorder one has**")

From the PDM-1 to the PDM-2

"The DSM is a taxonomy of diseases or disorders of function. Ours is a taxonomy of people"
(PDM Task Force, 2006, p. 13)



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2015, Vol. 32, No. 1, 94–115

0736-9735/15/$12.00 http://dx.doi.org/10.1037/a0038546

THE *PSYCHODYNAMIC DIAGNOSTIC MANUAL VERSION 2 (PDM-2)*: *Assessing Patients for Improved Clinical Practice and Research*

Vittorio Lingiardi, MD
Sapienza University of Rome

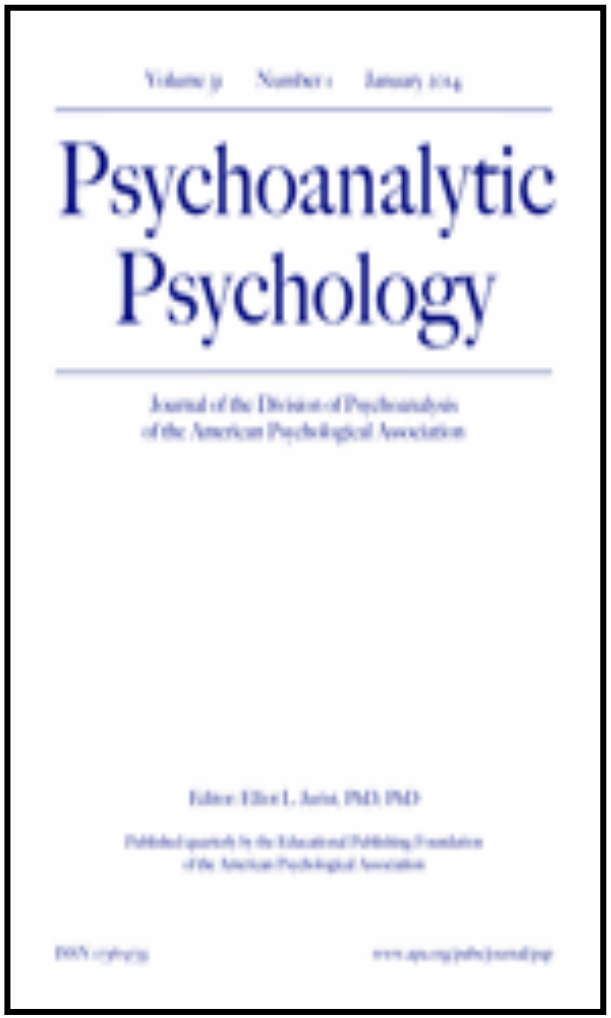
Nancy McWilliams, PhD
Rutgers University

Robert F. Bornstein, PhD
Adelphi University

Francesco Gazzillo, PhD
Sapienza University of Rome

Robert M. Gordon, PhD
Allentown, Pennsylvania

This article reviews the development of the second edition of the *Psychodynamic Diagnostic Manual*, the *PDM-2*. We begin by placing the *PDM* in historical context, describing the structure and goals of the first edition of the manual, and reviewing some initial responses to the *PDM* within the professional community. We then outline 5 guiding principles intended to maximize the clinical utility and



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Routledge
Taylor & Francis Group

The *Psychodynamic Diagnostic Manual (PDM)* and the *PDM*-2: Opportunities to Significantly Affect the Profession

Steven K. Huprich, Ph.D., Nancy McWilliams, Ph.D., Vittorio Lingiardi, M.D.,
Robert F. Bornstein, Ph.D., Francesco Gazzillo, Ph.D.,
and Robert M. Gordon, Ph.D., ABPP

In this article, we discuss the development of the *Psychodynamic Diagnostic Manual* (*PDM*) and its upcoming revision, the *PDM*-2. We describe the processes by which the *PDM*-2 is being developed and highlight important differences across both editions. At the same time, we emphasize the value of assessing internalized experience and how that can be of use toward the diagnostic assessment process.

In 2006, the *Psychodynamic Diagnostic Manual* (*PDM; PDM* Task Force, 2006) was published. The *PDM* was (and is) in many ways a revolutionary document: In contrast to extant diagnostic systems available at that time, the *PDM* was an unabashedly psychodynamic diagnostic system that embraced psychoanalytic concepts, rather than striving for theoretical neutrality, using syndrome descriptions and symptom criteria that incorporate implicit motives, conflicts, defenses, wishes, fantasies, and other dynamic processes, and drawing upon a wealth of empirical research

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PERSPECTIVE

The Psychodynamic Diagnostic Manual – 2nd edition (PDM-2)

VITTORIO LINGIARDI[1], NANCY MCWILLIAMS[2]

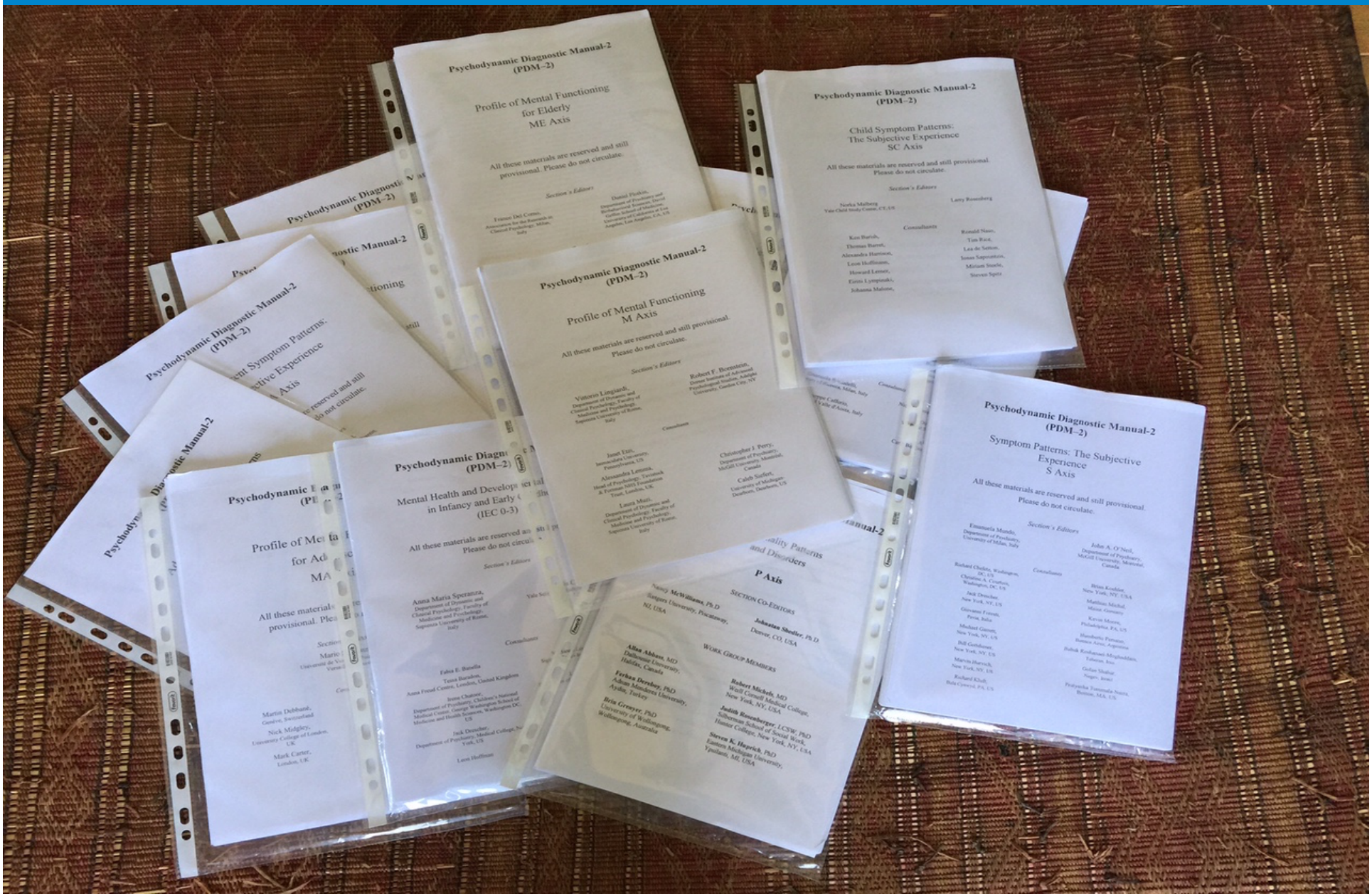
[1]Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Rome, Italy; [2]Graduate School of Applied and Professional Psychology, Rutgers University, Piscataway, NJ

For decades many clinicians, especially psychodynamic and humanistic therapists, have resisted thinking about their patients in terms of categorical diagnoses. In the current era, they find themselves having to choose between reluctantly "accepting" the DSM diagnostic labels, "denying" them, or developing alternatives more consistent with the dimensional, inferential, contextual, biopsychosocial diagnostic formulations characteristic of psychoanalytic and humanistic approaches. The Psychodynamic Diagnostic Manual (PDM) (1) reflects an effort to articulate a psychodynamically oriented diagnosis that bridges the gap between clinical complexity and the need for empirical and method-

focuses on the psychological health and distress of a particular person. Several psychoanalytical groups joined together to create PDM as a complement to the descriptive systems of DSM-5 and ICD-10. Like DSM-5, PDM includes dimensions that cut across diagnostic categories, along with a thorough account of personality patterns and disorders. PDM uses the DSM diagnostic categories but includes accounts of the internal experience of a person presenting for treatment" (6, pp. 243-244).

Addressing the discomfort many clinicians have with categorical diagnosis (7), the PDM provided an alternative framework that attempts to "characterize an individual's full range

Coming soon


Psychodynamic Diagnostic Manual-2
(PDM–2)
Profile of Mental Functioning
for Elderly
ME Axis
All these materials are reserved and still
provisional. Please do not circulate.
Psychodynamic Diagnostic Manual-2
(PDM–2)
Child Symptom Patterns:
The Subjective Experience
SC Axis
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Psychodynamic Diagnostic Manual-2
(PDM–2)
Profile of Mental Functioning
M Axis
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Psychodynamic Diagnostic Manual-2
(PDM–2)
Symptom Patterns: The Subjective
Experience
S Axis
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Psychodynamic Diagnostic Manual-2
(PDM–2)
Mental Health and Developmental Disorders
in Infancy and Early Childhood
(IEC 0-3)
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P Axis
Section Co-Editors
Work Group Members

Adult's P Axis - PDM-2

The major organizing principles of the P-Axis are:

1) **level** of personality organization,

2) personality ***style*** or **pattern** or **disorder**.

The former is a spectrum describing severity of personality dysfunction that ranges from healthy, through neurotic and borderline, to psychotic levels of personality organization.

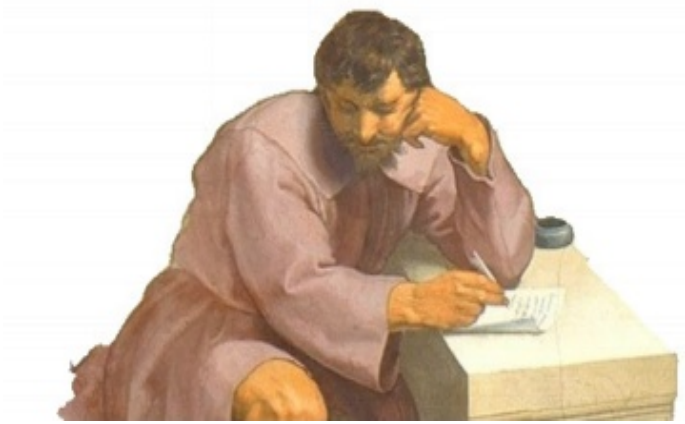
The latter represents clinically-familiar personality styles or types that cross-cut level of personality organization. The concept of personality style does not inherently connote either health or pathology, but rather core psychological themes and organizing principles.

Personality as a diathesis for psychopathology

Relationship between personality and psychopathology

"If we want to understand symptoms, we have to know something about the person who hosts them"
(Westen, Gabbard, Blagov, 2006)

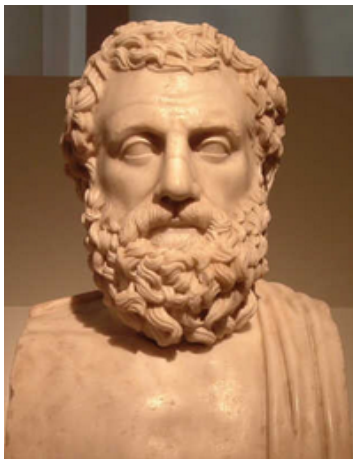
Back to the future → Although this insight is very exciting, it seems eerily familiar… Originally, Freud formulated a theory of psychopathology based on a ***model of discrete syndromes***. Then, he came to believe that he could not understand his patients' symptoms in isolation from what came to be called their ***character*** or ***personality***.



“Character is destiny.”
(Heraclitus)

“You can't sum up people.”
(Virginia Woolf)

"Don't tell me what type of disease the patient has, tell me what type of patient has the disease!”
(Sir William Osler … and also Hippocrates)



Adult's M Axis Functions - PDM-2

1. Cognitive and affective processes

- Capacity for regulation, attention, and learning
- Capacity for affective experience, communication and understanding
- **Capacity for mentalization and reflective functioning**

2. Identity and relationships

- Capacity for differentiation and integration (**identity**)
- Capacity for relationships and intimacy
- **Self-esteem regulation** and **quality** of internal experience

3. Defense mechanism and coping

- **Impulse control and regulation**
- Defensive functioning
- **Adaptation, resiliency and strength**

4. Self-awareness and self-direction

- Self-observing capacities (psychological mindedness),
- Capacity to construct and use internal standards and ideals
- **Meaning and purpose**

Adult's S Axis - PDM-2

PDM's S Axis mostly refers to the **symptom descriptions** of the DSM and of the ICD.

The intent is to elaborate on the **patient's subjective experience** of the symptom pattern.

→ *People belonging to the same diagnostic category, and with similar symptom lists, may still vary widely in their subjective experience.*

Individual subjectivity is depicted in terms of ***"affective patterns"***, ***"mental content"***, accompanying ***"somatic states"***, and associated ***"relationship patterns"***.

More attention to ***therapists' emotional responses/countertransference***.

The S Axis is placed third in our overall diagnostic profile because **symptoms are better understood in the context of the patient's overall personality structure and profile of mental functioning.**

APsaA Statement on the DSM-5

The DSM-5, published by our colleague organization the American Psychiatric Association, has been met with both praise and criticism. Like its predecessors, this fifth edition of the Diagnostic and Statistical Manual will be widely used in the mental health field to classify mental disorders according to diagnoses based on descriptive criteria. There is a place in the field for classifying patients based on descriptions of symptoms, illness course, and other objective facts. However, as psychoanalysts, we know that each patient is unique. No two people with depression, bereavement, anxiety or any other mental illness or disorder will have the same potentials, needs for treatment or responses to efforts to help.

Whether or not one finds great value in the descriptive diagnostic nomenclature exemplified by the DSM-5, psychoanalytic diagnostic assessment is an essential complementary assessment pathway which aims to provide an understanding of each person in depth as a unique and complex individual and should be part of a thorough assessment of every patient.

Even for psychiatric disorders with a strong biological basis, psychological factors contribute to the onset, worsening, and expression of illness. Psychological factors also influence how every patient engages in treatment; the quality of the therapeutic alliance has been shown to be the strongest predictor of outcome for illness in all modalities. [1]

For information about a diagnostic framework that describes both the deeper and surface levels of symptom patterns, as well as of an individual's personality, emotional and social functioning, mental health professionals are referred to the *Psychodynamic Diagnostic Manual*, published conjointly by the American Psychoanalytic Association, International Psychoanalytic Association, Division of Psychoanalysis (39) of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the American Association for Psychoanalysis in Clinical Social Work.

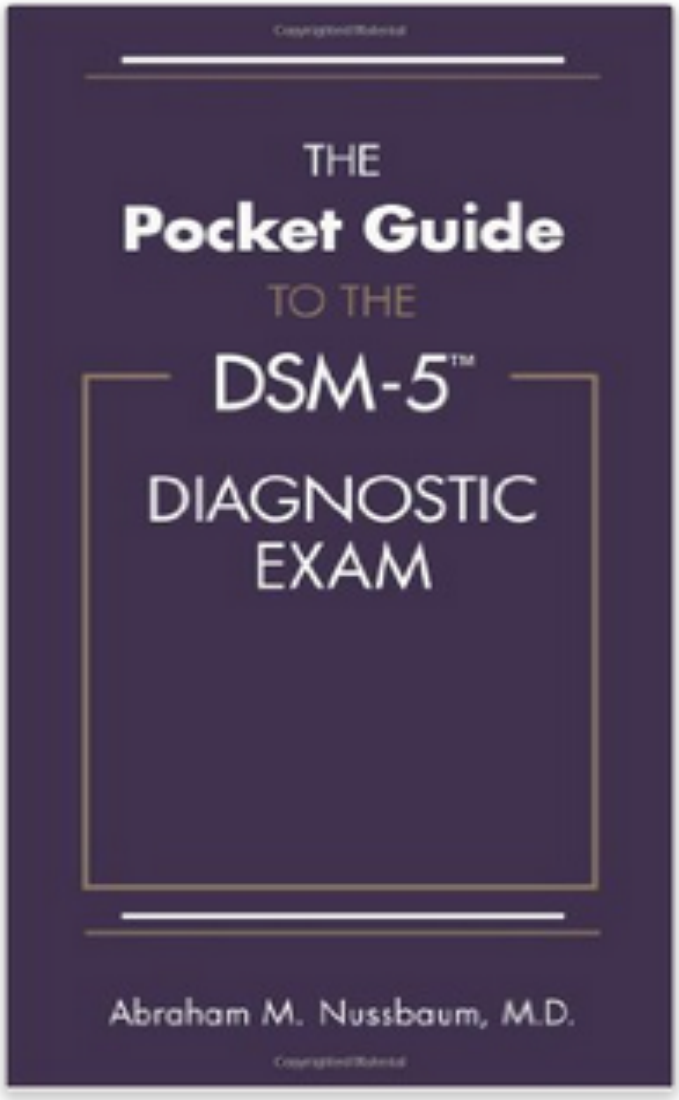
[1] Krupnick JL, Slotsky SM, Simmens S, et al The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. J. Consulti Clin Psychol 64:532-539, 1996

Pocket Guide to the DSM-5 Diagnostic Exam
(Nussbaum, 2013)

ICD-10 is focused on public health, **whereas the Psychodynamic Diagnostic Manual (PDM) focuses on the psychological health and distress of a particular person.**

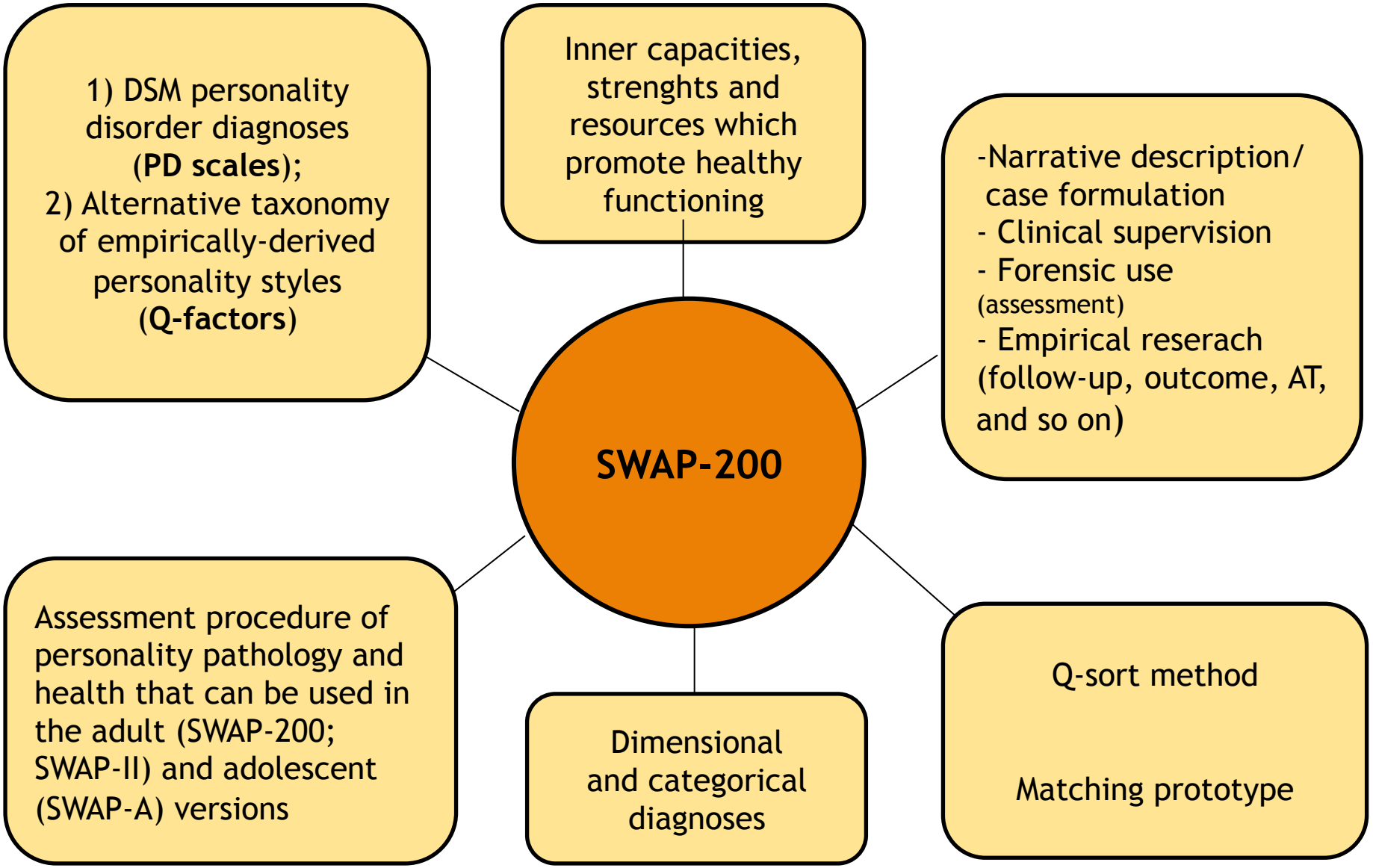
Several psychoanalytical groups joined together to create PDM as a complement to the descriptive systems of DSM-5 and ICD-10. Like DSM-5, PDM includes dimensions that cut across diagnostic categories, along with a thorough account of personality patterns and disorders. PDM uses the DSM diagnostic categories but **includes accounts of the internal experience of a person presenting for treatment.**

(pp. 243–244)

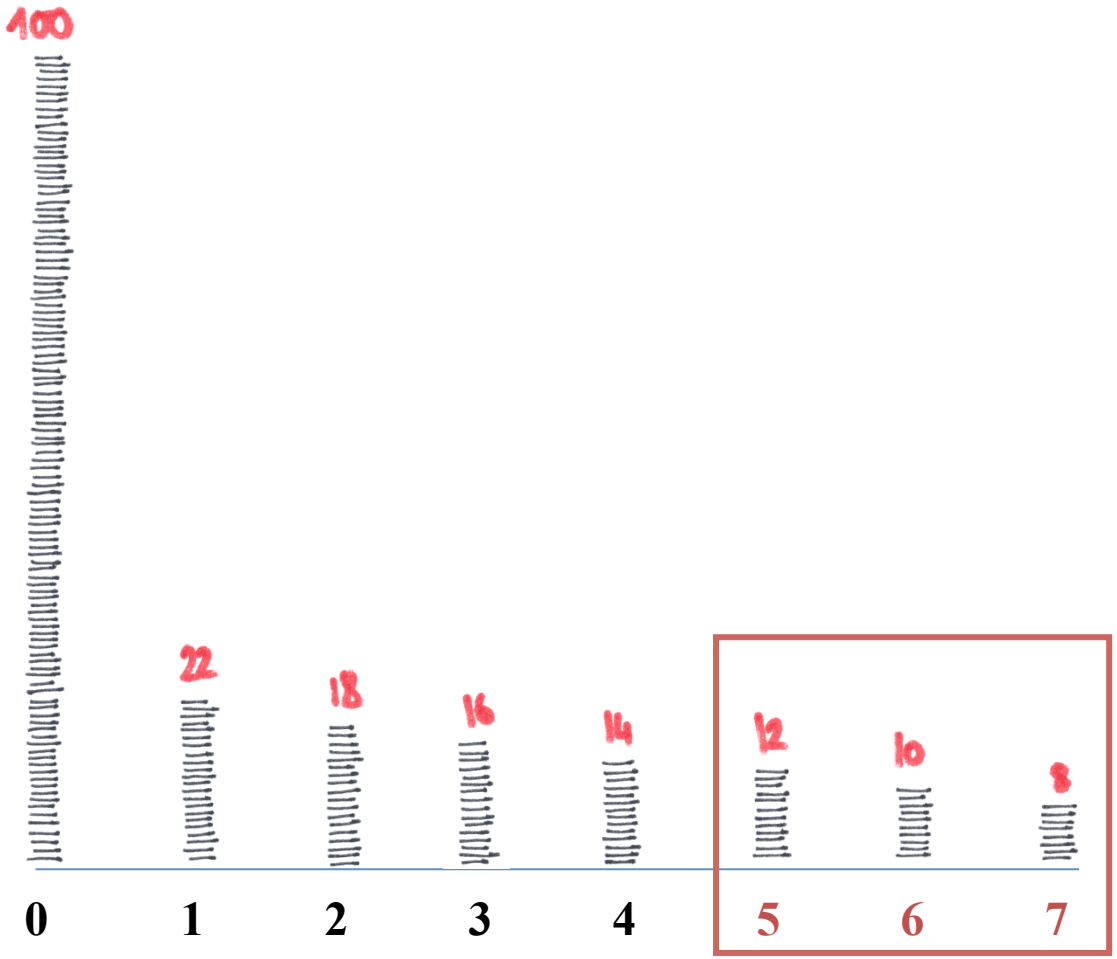


Shedler-Westen Assessment Procedure

(SWAP; Westen, Shedler, 1999a, 1999b; Shedler, Westen, 2004, 2007)



The SWAP-200 is based on a ***Q-sort method***, which requires clinicians to assign each score a specified number of times (i.e., there is a "fixed distribution" of scores). Clinicians or raters do rank statements into 8 categories from those that are more descriptive (assigned a value of 7) to those that are not descriptive (assigned a value of 0).



Items of SWAP: Some examples

The SWAP is an assessment instrument of 200 items designed to provide clinicians of all theoretical orientations a **standard "vocabulary"** for case description. Items was developed to *organize clinical observations* and inferences about a patient's personality and to provide an in-depth portrait of a patient's psychological functioning. They are written in straightforward, experience-based language.

Item 14. Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors.

Item 29. Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions.

Item 59. Is empathic; is sensitive and responsive to other peoples' needs and feelings.

Item 74. Expresses emotion in exaggerated and theatrical ways.

Item 76. Manages to elicit in others feelings similar to those s/he is experiencing (e.g., when angry, acts in such a way as to provoke anger in others; when anxious, acts in such a way as to induce anxiety in others).

The evaluation of patient's changes during and at the end of the treatment

Understanding the changes arising from psychotherapy is an important area of empirical investigations in the field of ***outcome research*** focused on treatment efficacy.

Outcome research complements other forms of psychotherapy research associated with understanding therapy process, identifying what works best for whom, and determining what specific interventions are the active ingredients in facilitating specific psychological changes.

Traditionally, outcome research has focused on symptoms: treatments are expected to reduce symptoms and suffering in individuals seeking therapy for psychopathology.

Psychodynamic psychotherapies and psychoanalyses seek to facilitate other changes or improvements relating to: ***patients' personality pathology, defensive functioning, interpersonal functioning, coping abilities, self-understanding and sense of self-coherence*** (e.g., Høglend et al., 2008; Kuutmann, Hilsenroth, 2012; Lingiardi et al., 2006, 2010; Perry et al., 2012; Shedler, 2010).

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CLINICAL CASE APPLICATIONS

Assessing Personality Change in Psychotherapy With the SWAP–200: A Case Study

Vittorio Lingiardi
Faculty of Psychology
University "La Sapienza"
Rome, Italy

Jonathan Shedler
Graduate School of Professional Psychology
University of Denver

Francesco Gazzillo
Faculty of Psychology
University "La Sapienza"
Rome, Italy

Many studies document the efficacy of psychotherapy for acute syndromes such as depression, but less is known about personality change in patients treated for personality pathology. The Shedler–Westen Assessment Procedure (SWAP–200; Westen & Shedler, 1999a, 1999b) is an assessment tool that measures a broad spectrum of personality constructs and is designed to bridge the gap between the clinical and empirical traditions in personality assessment. In this article, we demonstrate the use of the SWAP–200 as a measure of change in a case study of a patient diagnosed with borderline personality disorder. We collected assessment data at the start of treatment and after 2 years of psychotherapy. The findings illustrate the personality processes targeted in intensive psychotherapy for borderline personality.

The case of Melania

Figure below shows Melania's personality profile at the start of treatment and again after 2 years of psychotherapy.

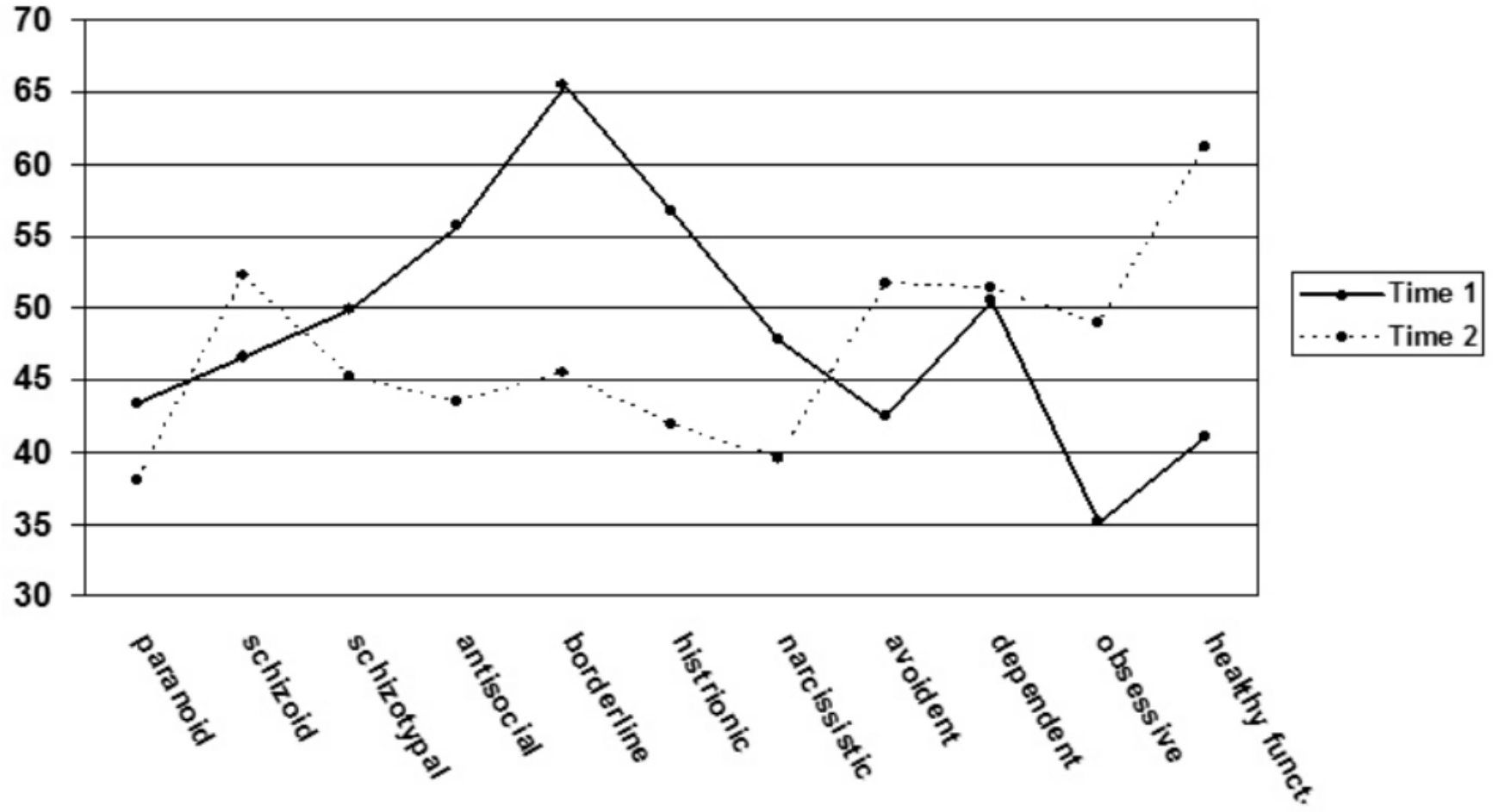


FIGURE 1 Melania's personality disorder profiles at Time 1 and Time 2.

Melania: case formulation (1)

Melania experiences depression and dysphoria. She tends to feel unhappy, depressed, or despondent, appears to find little or no pleasure or satisfaction in life's activities, feels life is without meaning, and tends to feel like an outcast or outsider. She tends to feel guilty and to feel inadequate, inferior, or a failure. Her behavior is often self-defeating and self-destructive. She appears inhibited about pursuing goals or successes, is insufficiently concerned with meeting her own needs, and seems not to feel entitled to get or ask for things she deserves. She appears to want to "punish" herself by creating situations that lead to unhappiness or actively avoiding opportunities for pleasure and gratification. Specific self-destructive tendencies include getting drawn into and remaining in relationships in which she is emotionally or physically abused, abusing illicit drugs, and acting impulsively and without regard for consequences. She shows little concern for consequences in general.

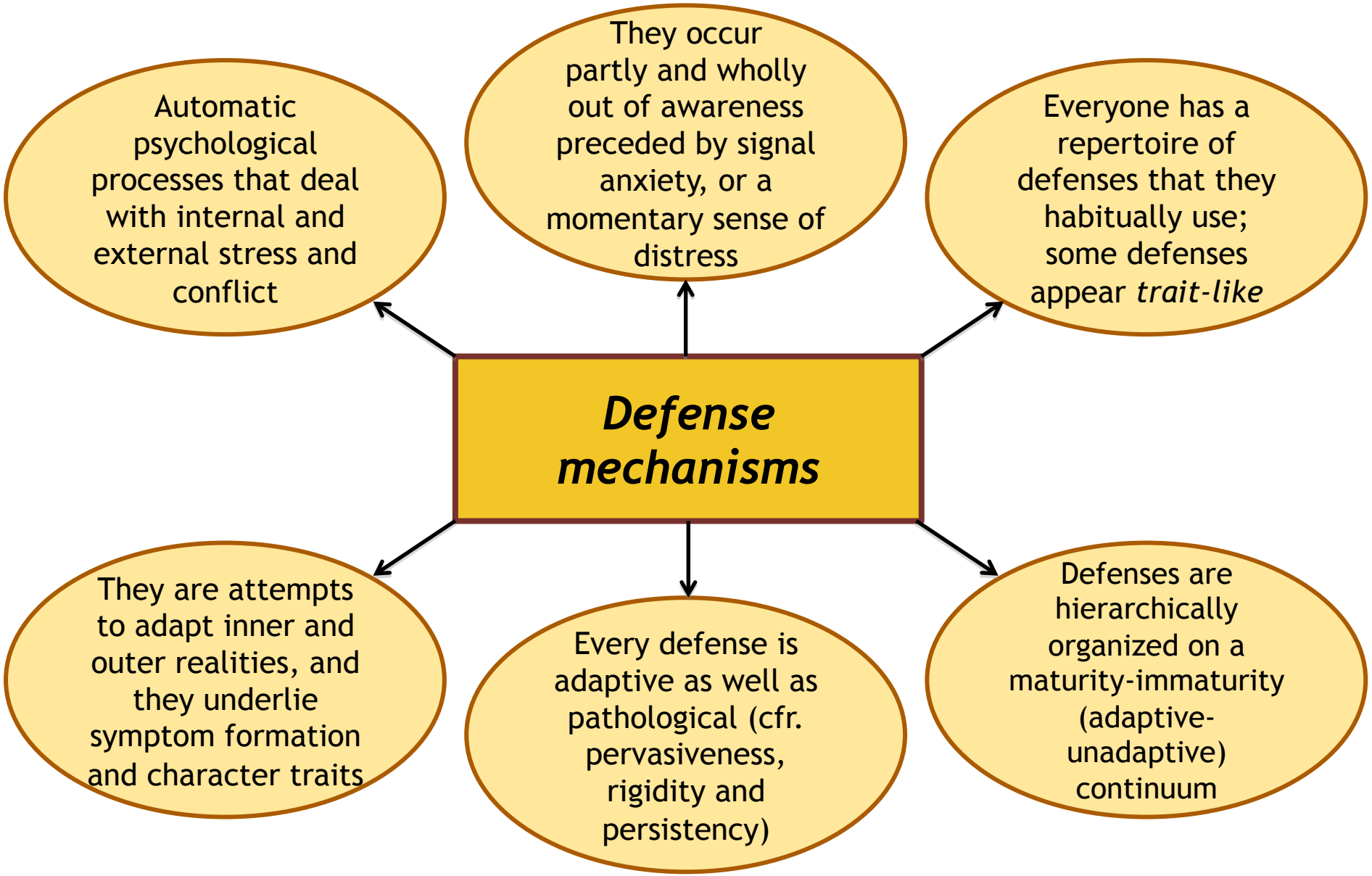
Melania shows many personality traits associated specifically with borderline PD. Her relationships are unstable, chaotic, and rapidly changing. She has little empathy and seems unable to understand or respond to others' needs and feelings unless they coincide with her own. Moreover, she tends to confuse her own thoughts, feelings, and personality traits with those of others, and she often acts in such a way as to elicit her own feelings in other people (for example, provoking anger when she herself is angry, or inducing anxiety in others when she herself is anxious).

Melania: case formulation (2)

Melania expresses contradictory feelings without being disturbed by the inconsistency, and she seems to have little need to reconcile or resolve contradictory ideas. She is prone to see certain others as "all bad," losing the capacity to perceive any positive qualities they may have. She lacks a stable image of who she is or would like to become (e.g., her attitudes, values, goals, and feelings about self are unstable and changing), and she tends to feel empty. Affect regulation is poor: She tends to become irrational when strong emotions are stirred up and shows a noticeable decline from her customary level of functioning. She also seems unable to soothe or comfort herself when distressed and requires the involvement of another person to help her regulate affect. Both her living arrangements and her work life tend to be chaotic and unstable.

Finally, Melania's attitudes toward men and sexuality are problematic and conflictual. She tends to be hostile toward members of the opposite sex (whether consciously or unconsciously), and she associates sexual activity with danger (e.g., injury, punishment). She appears afraid of commitment to a long-term love relationship, instead choosing partners who are inappropriate in terms of age, status (e.g., social, economic, intellectual), or other factors.

Defense mechanisms



DMRS hierarchy of defense categories, levels, and individual defense mechanisms

I. MATURE
***7 High Adaptive Level (Mature)*:** Affiliation, Altruism, Anticipation, Humor, Self-assertion, Self-observation, Sublimation, Suppression
II.NEUROTIC
6 Obsessional Level: Intellectualization, Isolation of Affect, Undoing
5 Other Neurotic Level: (a) Repression, Dissociation, (b) Reaction Formation, Displacement
III. IMMATURE
4 Minor Image-distorting Level (Narcissistic): Devaluation of Self or Object Images, Idealization of Self or Object Images, Omnipotence
3 Disavowal Level: Denial, Projection, Rationalization + Autistic Fantasy
2 Major Image-distorting Level (Borderline): Splitting of Others' Images, Splitting of Self-Images, Projective Identification
1 Action Level: Acting Out, Hypochondriasis, Passive-Aggression
IV. PSYCHOTIC
0 Defensive Dysregulation Level (Psychotic): Psychotic Denial, Distortion, Delusional Projection, concretization, Autistic Withdrawal, Fragmentation

Defense Mechanisms Rating Scale
(DMRS; Perry, 1991)

The **DMRS** is a valid and reliable **observer-rated method** that can be applied to the audio or video recording or the written transcriptions of various forms of interviews or of therapy sessions

30 individual defenses

7 levels of defensive functioning

Overall defensive functioning score (ODF)
obtained from the average of all weighted level of defensive functioning scores

Psychoanalytic Psychology
2010, Vol. 27, No. 2, 190–218

0736-9735/10/$12.00 DOI: 10.1037/a0019418

AN EMPIRICALLY SUPPORTED PSYCHOANALYSIS

The Case of Giovanna

Vittorio Lingiardi, MD and
Francesco Gazzillo, PhD
Sapienza University of Rome

Sherwood Waldron Jr., MD
New York Psychoanalytic Institute and
Mt. Sinai School of Medicine

Psychoanalysts have long relied on the case study method to support the validity of their theoretical hypotheses and clinical techniques and the efficacy of their treatments. However, limitations of the case study method have become increasingly salient as the medical-scientific community and policymakers have increasingly emphasized the need for empirical data. This article describes the progression of an analysis from the perspective of both the treating analyst and an independent research team using empirical methods to study verbatim session transcripts. Empirical measures include the *Shedler-Westen Assessment Procedure-200* (Westen & Shedler, 1999a, b; Shedler & Westen, 2006), the *Defense Mechanism Rating Scale* (Perry, 1990a) and the *Analytic Process Scales* (Waldron, Scharf, Crouse, Firestein, & Burton, 2004, and Waldron, Scharf, Hurst, et al., 2004). The article illustrates one way in which clinical and

The case of Giovanna

Beginning of the therapy:

- obsessional traits (T = 55.01) in PD terms,
- externalizing-hostile (T = 57.5), paranoid (T = 56.6), obsessional traits (T = 55.4) in Q-factor terms.
- High functioning score = T = 49.34.

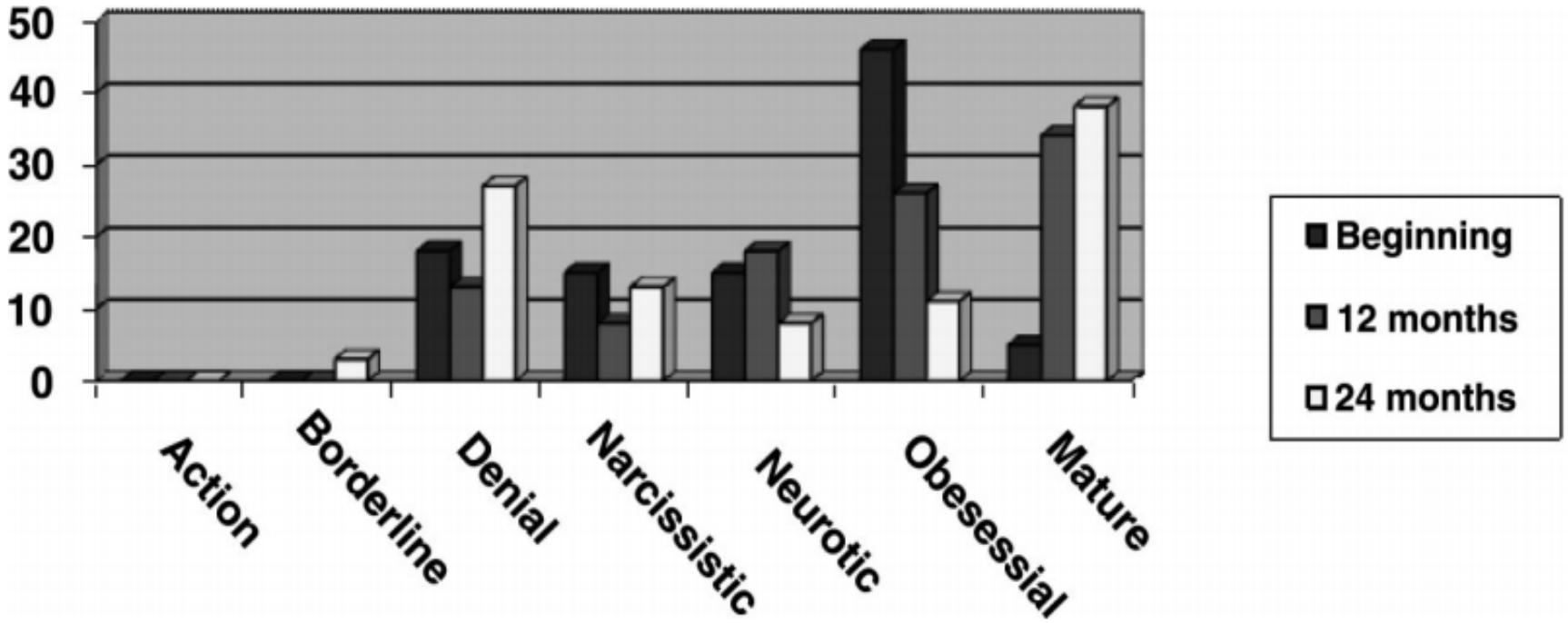


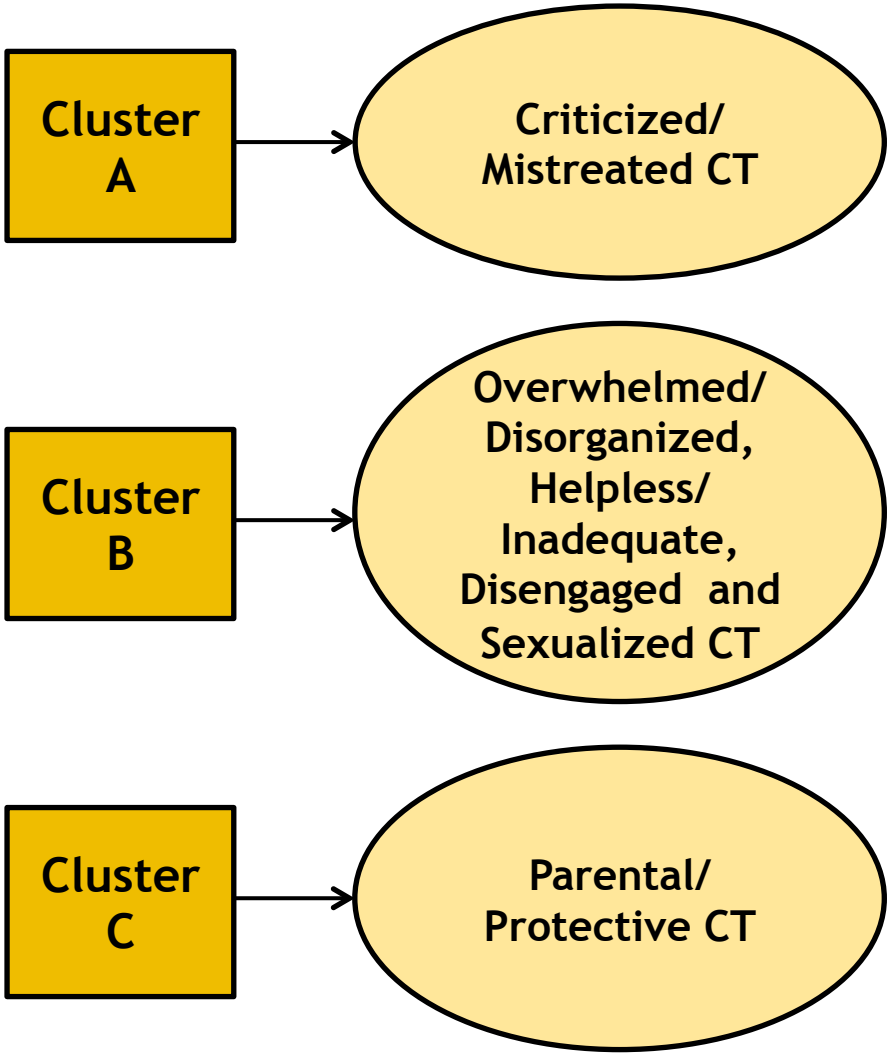
Figure 1. Changes in defensive functioning by year of psychoanalysis

Therapist Emotional Response: A *clinically relevant* source of diagnostic and therapeutic information

A therapist's emotional response to a patient
can be viewed as a source of valuable
diagnostic and therapeutic information,
as well as plays a crucial role
in the psychotherapy process and outcome
across different forms of psychopathology
and various therapeutic approaches

Therapists' Emotional Responses and Patients' Personality Pathology

Betan, Heim, Zittel Conklin, Westen (2005)



Article

Countertransference Phenomena and Personality Pathology in Clinical Practice: An Empirical Investigation

Ephi Betan, Ph.D.

Amy Kegley Heim, Ph.D.

Carolyn Zittel Conklin, Ph.D.

Drew Westen, Ph.D.

Objective: This study provides initial data on the reliability and factor structure of a measure of countertransference processes in clinical practice and examines the relation between these processes and patients' personality pathology.

Method: A national random sample of 181 psychiatrists and clinical psychologists in North America each completed a battery of instruments on a randomly selected patient in their care, including measures of axis II symptoms and the Countertransference Questionnaire, an instrument designed to assess clinicians' cognitive, affective, and behavioral responses in interacting with a particular patient.

Results: Factor analysis of the Countertransference Questionnaire yielded eight clinically and conceptually coherent factors that were independent of clinicians' theoretical orientation: 1) overwhelmed/disorganized, 2) helpless/inadequate, 3) positive, 4) special/overinvolved, 5) sexualized, 6) disengaged, 7) parental/protective, and 8) criticized/mistreated. The eight factors were associated in predictable ways with axis II pathology. An aggregated portrait of countertransference responses with narcissistic personality disorder patients provided a clinically rich, empirically based description that strongly resembled theoretical and clinical accounts.

Conclusions: Countertransference phenomena can be measured in clinically sophisticated and psychometrically sound ways that tap the complexity of clinicians' reactions toward their patients. Countertransference 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.

(Am J Psychiatry 2005; 162:890–898)

Freud first introduced the concept of countertransference in 1910, noting that the patient's influence on the analyst's unconscious feelings can interfere with treatment. This early and relatively narrow view of countertransference as an impediment to treatment prevailed in the psychoanalytic literature for several decades. Over time, however, theorists broadened the concept, recognizing that the clinician's reactions to the patient (conscious and unconscious) can be a source of information about the patient's internal world and that the therapist acts in accordance with a role that is part of a relationship paradigm the patient unconsciously re-creates with the therapist. Wachtel (11, 12) proposed the similar concept of cyclical psychodynamics, by which patients' fears, wishes, expectations, and behaviors often create self-fulfilling prophecies.

Although the clinical literature on countertransference is rich and rapidly expanding, the corresponding empiri-

Therapists' Emotional Responses and Patients' Personality Disorders
Colli, Tanzilli, Dimaggio, Lingiardi (2014)

Article

Patient Personality and Therapist Response: An Empirical Investigation

Antonello Colli, Ph.D.

Annalisa Tanzilli, Ph.D.

Giancarlo Dimaggio, M.D.

Vittorio Lingiardi, M.D.

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

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

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

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

(Am J Psychiatry 2014; 171:102–108)

Therapists' Emotional Responses and Patients' Personality Disorders

Colli, Tanzilli, Dimaggio, Lingiardi (2014)

SWAP-200	Therapists' Emotional Responses (TRQ)							
	Criticized Mistrea-ted	Helpless/ Inade-quate	Positive	Parental/ Prote-ctive	Overwhel-med/ Disorgani-zed	Special/ Overinvol-ved	Sexualized	Disengaged
Paranoid	0.24***							
Schizoid		0.14*						
Schizotypal								0.39***
Antisocial	0.31***							
Borderline		0.36***			0.51***	0.22***		
Histrionic								-0.27***
Narcissistic								0.16*
Avoidant			0.16*	0.28***		0.18*		
Dependent		0.14*		0.27***		0.19**		-0.16*
Obsessive						-0.16*		

Therapists' Emotional Responses and Patients' Personality Pathology

➡ Although every clinician and every therapeutic dyad is distinct, the significant correlations between the countertransference factors and personality disorder suggest that ***therapists' emotional responses can occur in coherent and predictable patterns.***

➡ Patients not only elicit idiosyncratic responses from particular clinicians (based on the clinician's history and the interaction of the patient's and the clinician's dynamics) but also elicit what we might call ***average expectable countertransference responses,*** which likely resemble responses by other significant people in the patient's life.

Psychotherapy, 2015

Psychotherapy

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Clinicians' Emotional Responses and *Psychodynamic Diagnostic Manual* Adult Personality Disorders: A Clinically Relevant Empirical Investigation

Francesco Gazzillo and Vittorio Lingiardi
Sapienza University of Rome

Franco Del Corno
Milan, Italy

Federica Genova
Sapienza University of Rome

Robert F. Bornstein
Derner Institute, Adelphi University

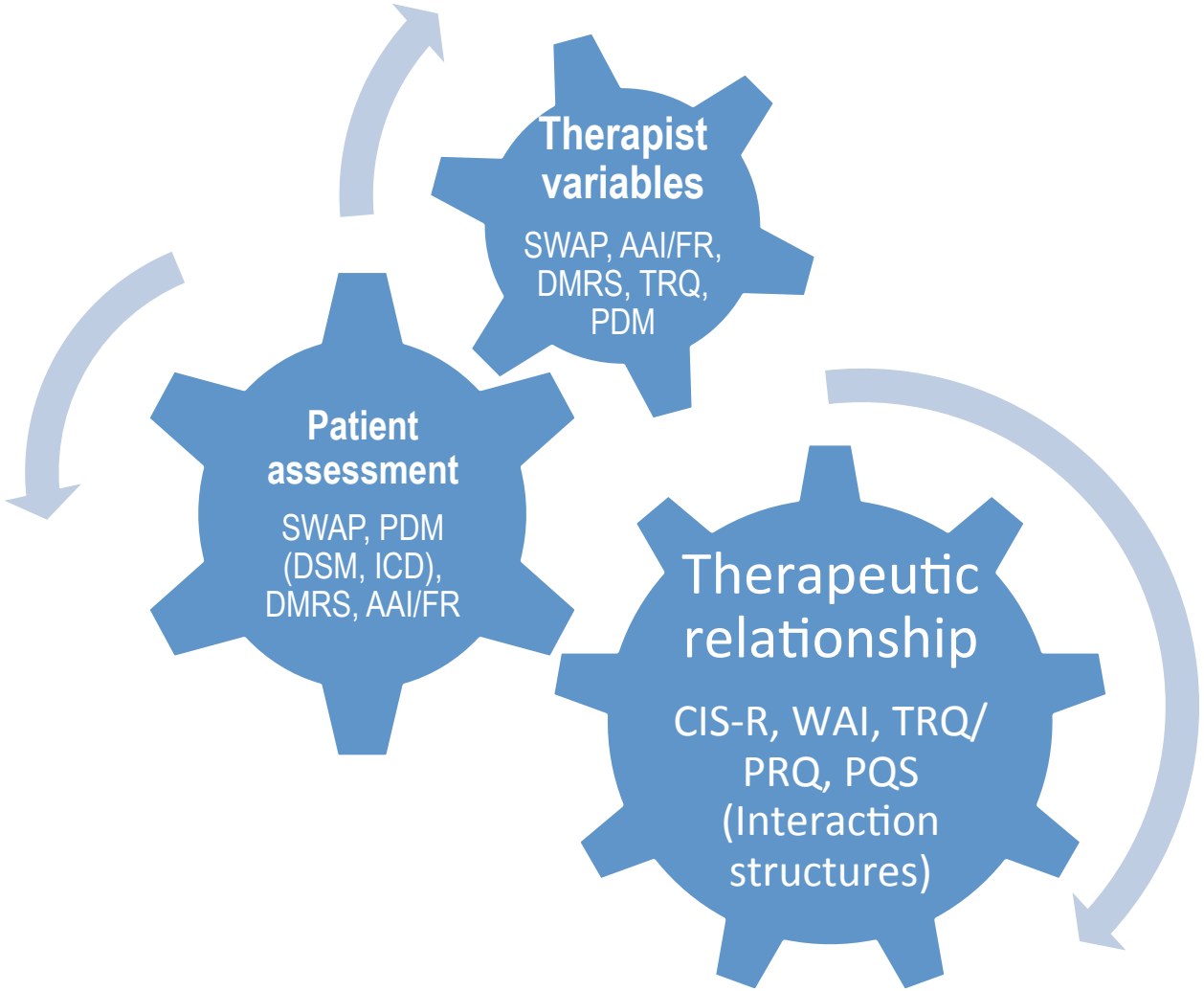
Robert M. Gordon
Allentown, Pennsylvania

Nancy McWilliams
Graduate School for Applied and Professional Psychology, Rutgers University

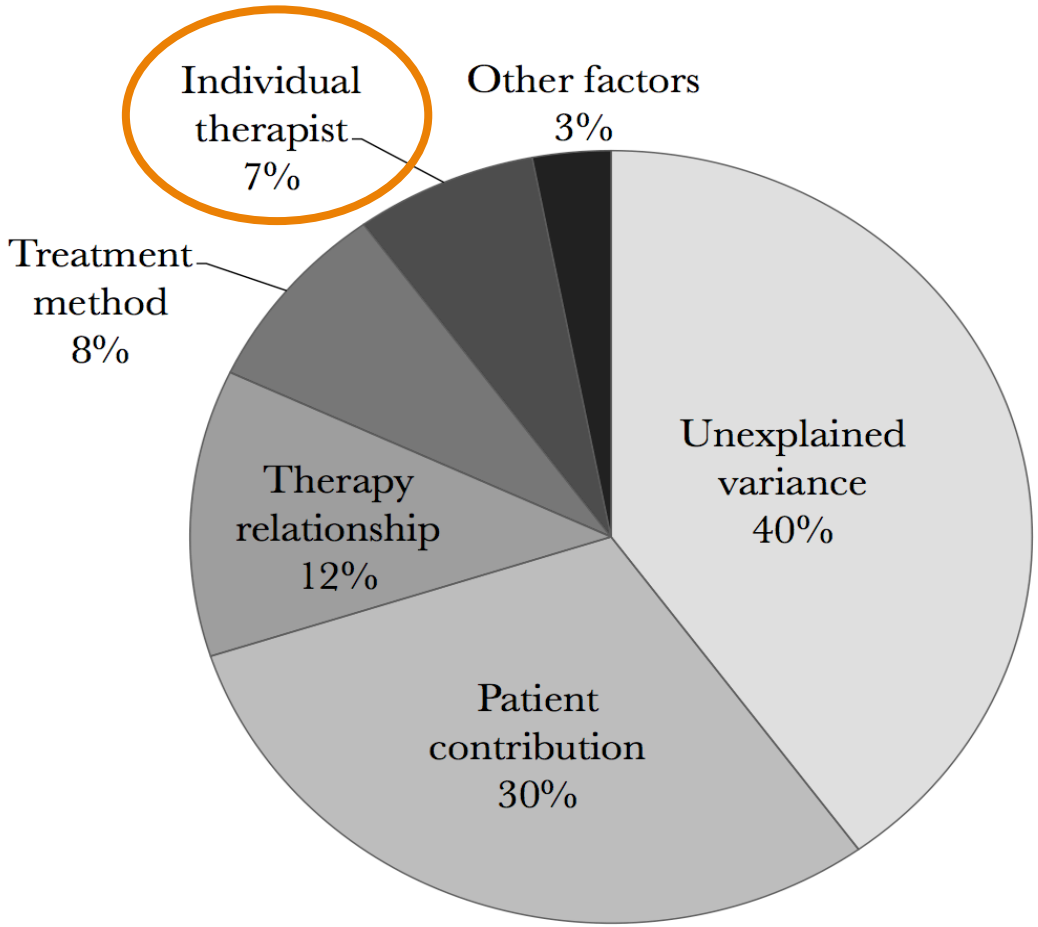
The aim of this study is to explore the relationship between level of personality organization and type of personality disorder as assessed with the categories in the *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006) and the emotional responses of treating clinicians. We asked 148 Italian clinicians to assess 1 of their adult patients in treatment for personality disorders with the Psychodiagnostic Chart (PDC; Gordon & Bornstein, 2012) and the Personality Diagnostic Prototype (PDP; Gazzillo, Lingiardi, & Del Corno, 2012) and to complete the Therapist Response Questionnaire (TRQ; Betan, Heim, Zittel-Conklin, & Westen, 2005). The patients' level of overall personality pathology was positively associated with helpless and overwhelmed responses in clinicians and negatively associated with positive emotional responses. 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 disorder 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 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. Clinical implications of these findings were discussed.

Keywords: personality assessment, PDM, PDC, PDP, therapists' emotional responses, countertransference

A new frontier for clinical research: From the patient assessment to the therapist characteristics



…What about therapist?
Therapists' effects on psychotherapy outcome



% of Total Psychotherapy Outcome Variance Attributable to Therapeutic Factors (Norcross, 2011)

Therapists' variables

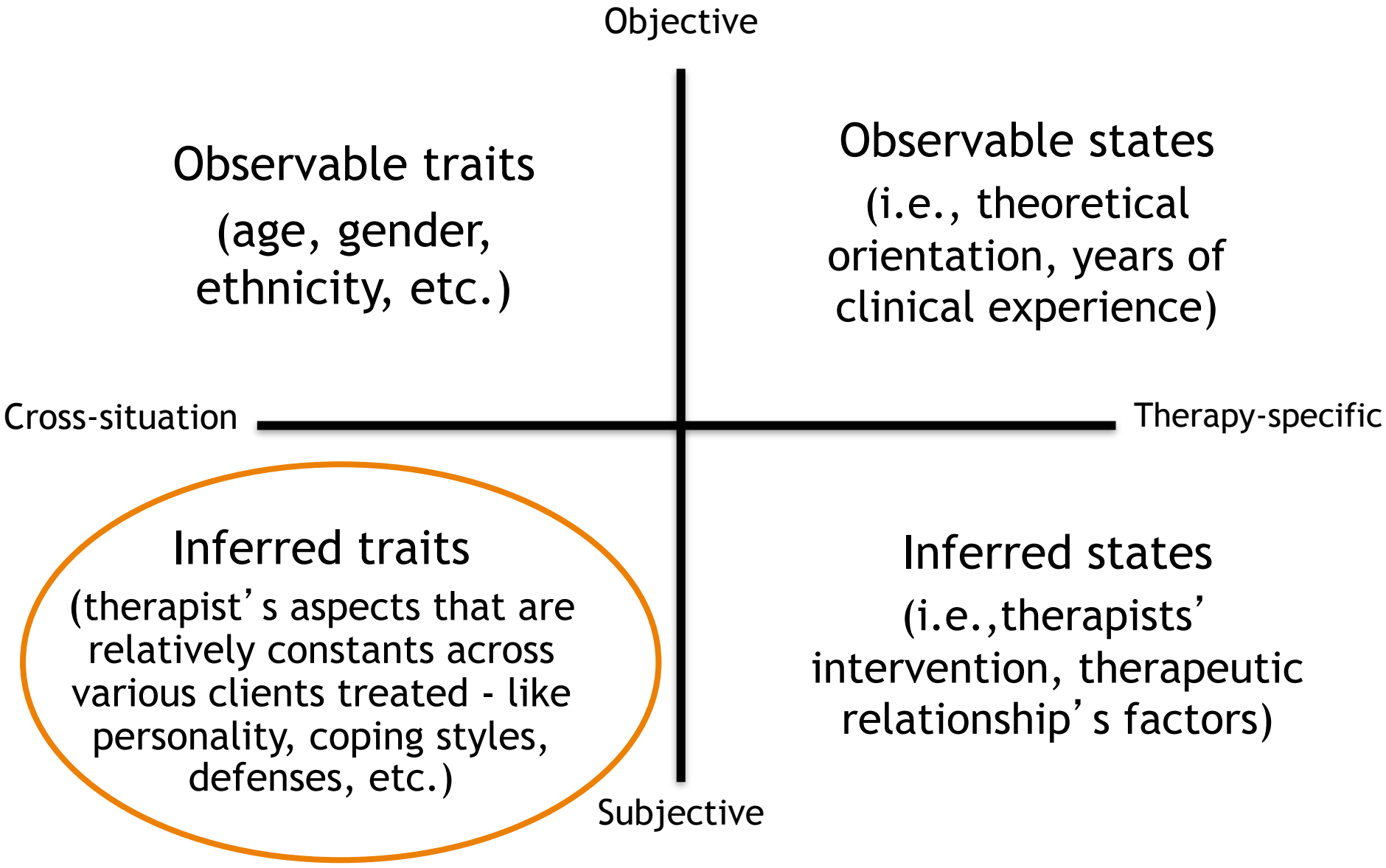
«Very closely related to such implicit factors is the indefiniable effect of the therapist' personality. Though long recognized, this effect still presents an ***unresolved problem***»

(Rosenzweig, 1936)

«An ignored but critical factor» (Wampold, Imel, 2015)

The empirical literature is limited and still in its infancy

Understanding the therapists' influence on psychotherapy process and outcome (Beutler et al., 2004)



Research Project

DIPARTIMENTO
DI PSICOLOGIA
DINAMICA E CLINICA
CATTEDRA DI VALUTAZIONE
CLINICA E DIAGNOSI
SAPIENZA
UNIVERSITÀ DI ROMA

UNIVERSITY OF
COPENHAGEN

Attachment and Personality of psychodynamic therapists: Influence on therapeutic relationship

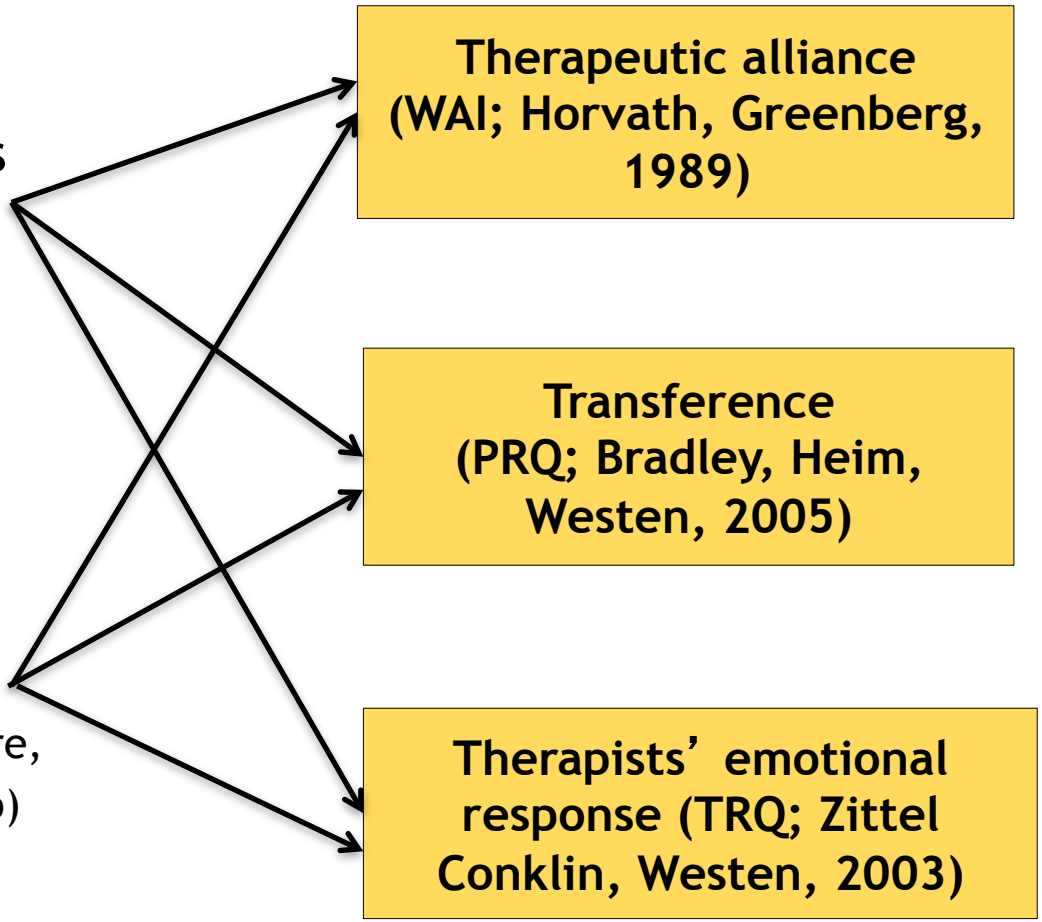
Lingiardi, V., Muzi, L. (Sapienza University, Rome)
Talia, A. (University of Copenhagen)

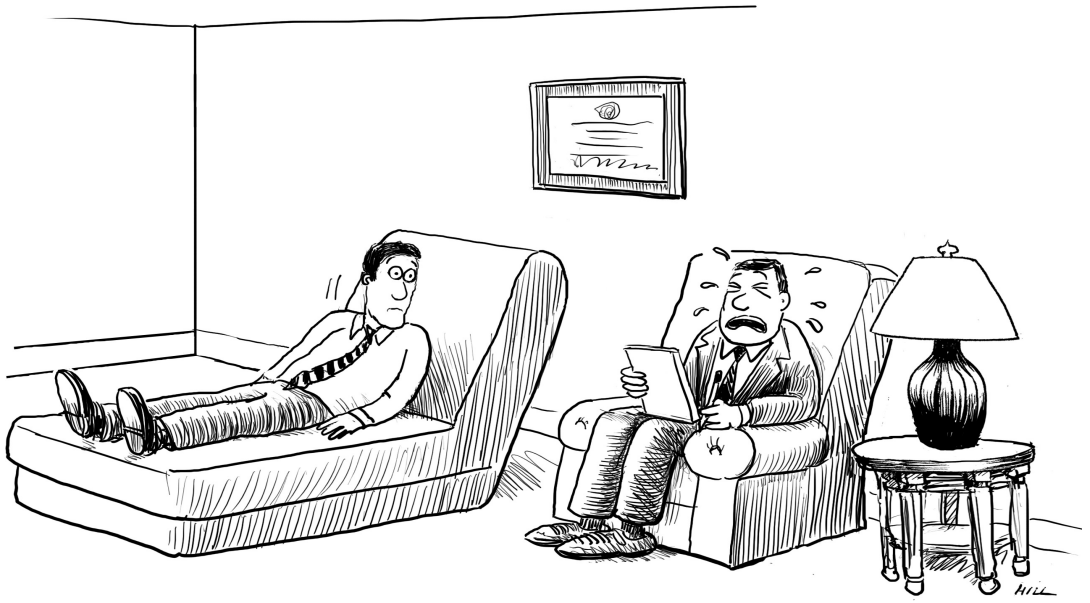
Research Project

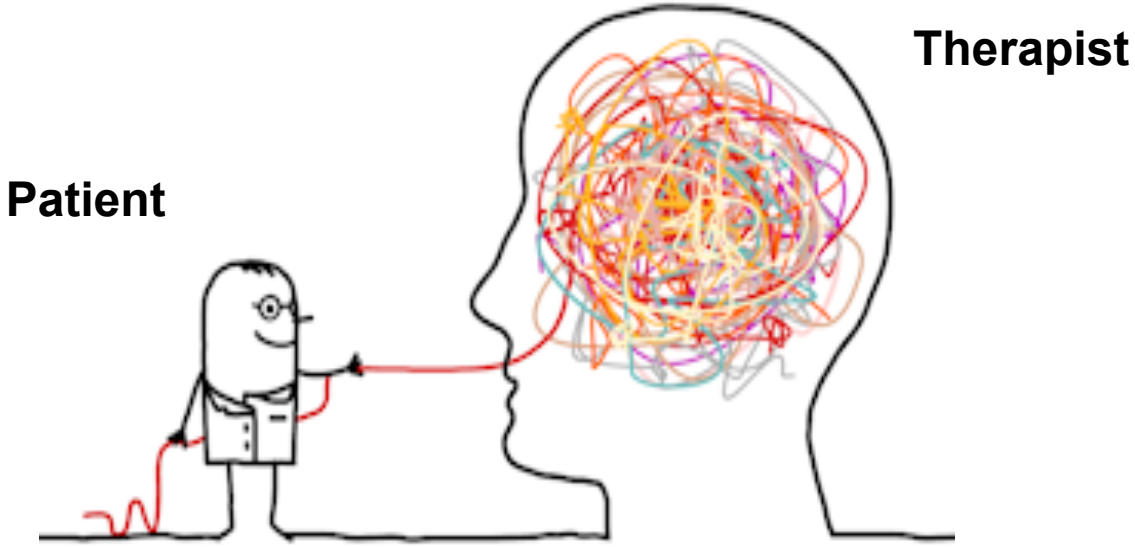
1. Empirically grounded description of a sample of novice dynamic therapists in terms of attachment patterns and personality → unexplored field

2. Secure vs insecure therapists
   (Adult Attachment Interview; George et al., 1998)

3. High vs Low Personality Functioning
   (Shedler-Westen Assessment Procedure, SWAP-200; Westen, Shedler, 1999a, b)






Therapist
Patient