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

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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

During the last 20 years, research has emerged showing how emotions experienced by clinicians working with patients that have been diagnosed with personality disorders may help to inform the diagnosis and treatment process. Brody and Farber (1996), as well as McIntyre and Schwartz (1998), demonstrated how patients with *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition; *DSM–IV*; American Psychiatric Association, 1994) Axis II disorders, and particularly Cluster B and borderline patients, elicited more anger and irritation as well as a lower level of likability, empathy, and nurturance than patients with different personality disorders. In addition, these patients tended to be perceived as being more dominant and aggressive than are patients with depressive disorders.

A third study, conducted by Betan, Heim, Zittel-Conklin, and Westen (2005), demonstrated that patients with Cluster A disorders tend to evoke therapists' feelings of being criticized and mistreated, whereas clinicians treating patients with Cluster B disorders often feel overwhelmed, helpless, sexually aroused, and/or disengaged. Finally, patients with Cluster C disorders induce feelings of protectiveness and having a warm connection in their therapists.

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In the same year, Bradley, Heim, and Westen (2005) pointed out how it is possible to empirically differentiate the relationships that patients with personality disorders from different *DSM–IV* Axis II clusters tend to develop with clinicians. In particular, patients with Cluster A disorders tend to not feel a secure engagement with their clinicians, patients with Cluster B disorders tend to develop an angry/entitled or a sexualized relationship, and patients with Cluster C disorders tend to develop an anxious/preoccupied relationship.

A fourth study, conducted by Røssberg, Karterud, Pedersen, and Friis (2007), demonstrated how clinicians' emotional responses to patients with Cluster A and B disorders are generally more negative and troublesome than their emotional responses to patients with Cluster C personality disorders, which are less mixed and less complex. These results dovetail with findings suggesting that overall, clinicians are more comfortable with patients diagnosed with anxious personality disorders than they are with those who are more emotionally dysregulated and show signs of cognitive slippage under stress.

A recent study conducted by Colli, Tanzilli, Dimaggio, and Lingiardi (2014), using the Shedler Westen Assessment Procedure-200 (SWAP-200; Westen & Shedler 1999a) for the diagnosis of personality disorders, demonstrated how different personality styles seem to be associated with specific emotional responses experienced by their therapists. In particular, paranoid and antisocial personality disorders were associated with criticized/mistreated feelings on the part of therapists. Schizoid personality disorder is associated with helpless responses, and schizotypal disorders are associated with disengaged responses. Antisocial personality disorders were connected with feelings of helplessness/inadequacy. Borderline personality disorders were associated with helpless/inadequate, overwhelmed/disorganized, and special/overinvolved emotional reactions. Narcissistic disorder was associated with a disengaged response whereas histrionic disorder showed the opposite pattern, being negatively associated with this kind of emotional reaction. Dependent and obsessive personality disorders were both negatively associated with a disengaged and an overinvolved response. Finally, avoidant personality disorder was associated with a positive emotional reaction, similar to that of a good therapeutic alliance, in addition to a parental/protective emotional response. In general, therapists' negative emotional responses were most strongly associated with a lower (more pathological) level of personality functioning in the patients and with more severe forms of personality pathology.

These studies, although compelling, were based on the *DSM-IV* or Shedler-Westen Assessment Procedure (SWAP; Westen & Shedler, 1999a,1999b; Westen, Shedler, Bradley, & DeFife, 2012) assessment of personality disorders, and so far no studies have been conducted assessing the emotional responses of clinicians working with patients classified using the *Psychodynamic Diagnostic Manual's* (PDM Task Force, 2006) personality disorder diagnoses. Given the PDM's emphasis on understanding the patient's underlying dynamics and expressed behaviors, as well as the broader interpersonal context within which the patient functions (e.g., McWilliams, 2011), further exploration of the links between particular personality styles/disorders and therapist responses may be particularly fruitful.

The PDM is the first complete assessment manual of healthy and pathological functioning that explicitly follows a psychodynamic model, based on the integration of clinical and research evidence. PDM diagnoses are both dimensional and categorical and follow a prototype format, taking into account both implicit and explicit psychological processes and contents. The manual differentiates diagnoses according to the different life stages of patients: adulthood, adolescence, childhood, and infancy. It is worth noting that the next edition of the manual will also have a section focused on the assessment of elderly patients (Lingiardi, McWilliams, Bornstein, Gazzillo, & Gordon, in press). Adult patients are assessed along three axes in the PDM: the P axis for personality organization and patterns, the M axis for the assessment of mental functioning, and the S axis for the assessment of the subjective experiences of symptoms and syndromes.

Because this paper focuses on the PDM's P Axis, we will describe it in more detail. The P Axis of the PDM asks the clinician to first assess the overall level of the patient's personality organization according to Kernberg's (1984) model (healthy, neurotic, high level borderline, and low level borderline). Second, the clinician is asked to assess the personality disorders most descriptive of the patient's clinical presentation. The disorders taken into account are schizoid, paranoid, psychopathic (passive parasitic and aggressive subtypes), narcissistic (arrogant/entitled and depressive/depleted subtypes), sadistic and sadomasochistic (with an intermediate manifestation, sadomasochistic), masochistic (moral and relational subtypes), depressive (introjective and anaclitic subtypes, with the converse manifestation of hypomanic personality pattern), somatizing, dependent (with a passive-aggressive subtype and with the converse manifestation of a counter dependent pattern), phobic (converse manifestation: counter phobic), anxious, obsessive-compulsive (obsessive and compulsive subtypes), hysterical (inhibited and demonstrative subtypes), and dissociative.

For each level of personality organization, as well as for several personality disorders, the PDM specifies the treatment implications and the potential emotional reactions a therapist may experience. Finally, for all of the principal personality disorders, the manual specifies potential contributing temperament factors, prevalent affects and defense mechanisms, the core tension/preoccupation, associated pathogenic beliefs, and the subtypes of that syndrome, if present.

One of the problems in implementing PDM-based assessments in clinical research studies was the lack of empirical instruments designed to assess the PDM-related constructs. To overcome this limitation, we developed two empirical instruments—the Psychodiagnostic Chart (PDC; Gordon & Bornstein, 2012) and the Psychodynamic Diagnostic Prototypes (PDP; Gazzillo, Lingiardi, & Del Corno, 2012)—to aid clinicians in the assessment of patients according to the PDM dimensions.

The aim of this paper is to explore the relationships between patients' levels of personality organization and the specific personality disorders/patterns of the PDM P Axis with the emotional responses experienced by the therapists working with these patients. Given that there are no previous studies investigating these relationships from an empirical perspective, this preliminary work is intended as an exploratory study.

Method

Clinicians

The sample included 148 clinicians: 87 (58.4%) female, 61 (40.9%) male, and 1 clinician who did not provide gender data. There were 68 clinicians (45.5%) that were 30–40 years old and on

average had 13.7 years of clinical experience after licensing (ranging from 1 to 38 years). Of all of the clinicians, 61 (40.9%) had a dynamic theoretical orientation; 48 (32.2%) an eclectic, but mainly dynamic, orientation; 20 (13.4%) an eclectic, but mainly biological orientation; and 15 (10.1%) a cognitive–behavioral orientation, with the remaining therapists having other orientations. Of our therapists, 131 worked in public settings and 17 in private settings. All clinicians working in public settings were treating their patients with once-weekly psychotherapy sessions. Seven clinicians working in private settings treated their patients three times per week on the couch, seven treated patients two times a week, and three treated once a week. On average, our clinicians were treating their patients for 19 months, (SD = 18.2, ranging from 1 to 72 months), and for this reason we can infer that they knew their patients quite well.

Patients

Of our 148 patients, 82 were female (55%) and 67 (45%) male. Their average age was 36.5 years, ranging from 17 to 75. There were 21 (14.1%) patients in the sample that were conceptualized as having a psychotic personality organization, 81 (54.4%) a borderline personality organization, and 44 (29.5%) a neurotic personality organization. These percentages are similar to those found in a previous study on more than 600 patients from the United States and Italy (Gazzillo et al., 2014).

Using the categorical score of the PDP, the most highly represented personality disorder was the anxious type, (55), followed by depressive (37), dependent (33), narcissistic (30), and hysterical (26); the least represented disorders were hypomanic (6), followed by phobic (5) and counterphobic (2). These data are similar to the frequencies found in a previous broader sample (Gazzillo et al., 2014). The fact that the number of diagnosed personality disorders is higher than the overall number of the patients assessed is due to several patients being diagnosed with more than one personality disorder. All of our patients received at least one diagnosis of a personality disorder because we asked our clinicians to assess one of their patients in treatment for enduring maladaptive patterns of motivation, cognition, emotion, and behavior (i.e., for personality disorders).

In terms of *DSM–IV* Axis I disorders, 67 had an anxiety disorder, 46 a mood disorder, 25 a somatoform disorder, 8 a psychotic disorder, 5 an impulse control disorder, 4 a sexual disorder, 2 an eating disorder, and 1 an adjustment disorder. Clinicians assigned all of the diagnoses according to the categories of the *DSM–IV–TR* (American Psychiatric Association, 2000), but we should note that these are based on the therapists' evaluations and no independent ratings were conducted to confirm the accuracy of the diagnoses. As with personality disorders, the fact that the number of diagnosed Axis I disorders is higher than the overall number of the patients assessed is due to several patients being diagnosed with more than one Axis I disorder.

Measures

Psychodiagnostic Chart. The PDC (Gordon & Bornstein, 2012) is a quick, easy-to-use clinician report instrument used for assessing patients according to the PDM (PDM Task Force, 2006). Among other relevant psychopathological dimensions, PDC asks the clinician to assess the patient's level of personality organization as well as the seven basic capacities detailed on the PDM P Axis (identity, object relationships, affect tolerance, affect regulation, morality, reality testing, and ego resiliency) using a 10-point Likert scale (1 = *severe*, 10 = *healthy*). The PDC gives a synthetic description of each level of personality organization (healthy, neurotic, borderline, or psychotic) to help the clinician with the assessment procedure.

Overall, the personality organization scale of the PDC shows very good 2-week retest reliability (.92) and good convergent validity, as assessed with the Minnesota Multiphasic Personality Inventory (MMPI-2; Butcher & Williams, 2009), the Karolinska Psychodynamic Profile (KAPP; Weinryb & Rössel, 1991), and the Operationalized Psychodynamic Diagnosis (OPD; Dahlbender, Rudolf, & OPD Task Force, 2006; Zimmermann et al., 2012). Given that in this study we only used the overall personality organization scale of the PDC, we will not describe the other dimensions or their validation data as assessed by this measure (see Gordon & Stoffey, 2014, for a summary of these findings).

Psychodynamic Diagnostic Prototypes. The PDP (Gazzillo et al., 2012) are 19 jargon-free descriptions of the personality patterns/disorders of Axis P of the PDM, along with their converse and intermediate manifestations. Each of these descriptions was taken from the PDM while deleting all references to the published literature and rephrasing sentences in which professional jargon might be problematic (see Figure 1 for an example). To operationalize the theoretical terms, we took inspiration from well-validated empirical instruments such as the SWAP (Westen & Shedler, 1999a,1999b; Westen, Shedler, Bradley, & DeFife, 2012), the Analytic Process Scales (APS; Waldron et al., 2004), and the Defense Mechanisms Rating Scale (DMRS; Perry, 1990).

Each of the PDP prototypes was assessed on a 5-point Likert scale by a treating clinician or by a clinician who knows the patient well (i.e., who has seen him/her for at least 3–5 sessions or has assessed him/her with a systematic interview, such as the Clinical Diagnostic Interview [CDI; Westen & Muderrisoglu, 2003]). The PDP follows a prototype-matching approach to the diagnosis of personality disorders (Spitzer, First, Shedler, Westen, & Skodol, 2008) that enables a dimensional (1–5) and a categorical assessment, with a score of 3 indicating clinically significant traits of the prototype assessed and a score of 4 or 5 implying a categorical diagnosis of the disorder (see Figure 2).

The PDP shows good face validity; the average interrater reliability when categorically implemented (disorder/no disorder) is $\kappa = .61$, ranging from .45 to .75. The average intraclass correlation coefficient (ICC) of the PDP dimensionally assessed is .74, ranging from .63 to .85. The PDP also showed good convergent and discriminant validity with analogous *DSM*[1] disorders, at .62 and .05, respectively, and good convergent validity with measures of antisocial behavior, health problems, and quality of close relationships (for a detailed discussion of evidence on validation of the PDP, see Gazzillo et al., 2012). In this study, we only examined the 11 principal PDP personality disorders.

Therapist Response Questionnaire. The Therapist Response Questionnaire (TRQ; Betan et al., 2005) is a clinician report

[1] Only 10 of the 19 PDP prototypes have an analogous syndrome in *DSM–IV–TR*/*DSM-5*.

Depressive Personality Disorders

Individuals with depressive personalities seem preoccupied regarding goodness or badness of themselves and others, and about aloneness and trust issues. They tend to experience feelings of sadness, boredom, guilt and shame, and show high reactivity to loss and rejection, with strong feelings of emptiness and inadequacy. Individuals who match this prototype tend to feel empty, incomplete, lonely, helpless and weak, and often complain about existential despair, with the feeling that life is empty and meaningless. Perfectionistic and excessively self-critical, they tend to think that there is something essentially bad or inadequate in them, so that people who really get to know them will reject them.

Depressive individuals tend to devalue themselves and to idealize others, even the therapist, and interpret their acceptance as evidence that these people have not yet noticed how bad or inadequate they really are. They often internalize negative feelings originally addressed to significant others, and look inward to find the explanation for their painful experiences. When mistreated, rejected or abandoned, they tend to blame themselves, and to attribute their suffering to their own badness.

Depressive people tend to be "good" and to strike others as likeable, even admirable, but rarely are satisfied of themselves. They feel distress and disorganization when facing experiences of loss and separation since their personalities are often organized around themes of relationship, trust, intimacy, warmth, and similar issues. Some of them may be more concerned with issues of value and self-definition, while some others are more concerned with relationships.

Figure 1. PDP description of the depressive personality disorder.

questionnaire designed to assess the emotional responses of therapists to their patients. It consists of 79 items measuring a wide range of thoughts, feelings, and behaviors written in jargon-free language so that clinicians of different theoretical orientations can easily understand the concepts. Each item has to be assessed on a 5-point Likert scale (1 = *not true*; 5 = *very true*). The TRQ items can be synthetized into eight factors/dimensions of the therapist's emotional response to the patient: overwhelmed/disorganized, helpless/inadequate, positive/alliance, special/overinvolved, sexualized, disengaged, parental/protective, and criticized/mistreated.

The *overwhelmed* factor is marked by items describing a desire to avoid the patient, along with strong negative feelings, including dread, repulsion, and resentment. The *helpless* factor includes items describing feelings of inadequacy, incompetence, hopelessness, and anxiety. Items indicating the experience of a positive working alliance and close connection with the patient mark the *positive* factor. The *special* factor includes items describing a sense of the patient as being special, relative to other patients, as well as items describing mild problems in maintaining boundaries, including difficulties in ending sessions on time and feeling overly concerned about the patient. The *sexualized* factor is marked by items describing sexual feelings toward the patient, and the *disengaged* factor includes items describing feeling distracted, withdrawn, or bored. Finally, the *parental* factor includes items describing a desire to protect and nurture the patient, and the *criticized* factor includes items describing feelings of being unappreciated or devalued by the patient.

The TRQ has been used in two previous studies for assessing the emotional reactions of clinicians to the *DSM–IV* clusters of personality disorders (Betan et al., 2005) and the SWAP personality disorder scales (Colli et al., 2014). This is the first study that empirically assesses the emotional reactions of therapists to patients diagnosed according to the PDM Axis P criteria.

Procedure

We contacted clinicians using three different methodologies: through clinical independent practice networks, through postgraduate internships in three Italian Public Mental Health Services, and through several Italian Public Mental Health Services. All of the clinicians that participated in this study did so on a volunteer basis and did not receive any fee for their participation. All were asked to assess one of the patients they were treating for enduring maladaptive patterns of motivation, affect, cognition, and behavior (see Westen & Shedler, 1999a).

1 = no match between the clinical presentation of the patient and the prototype; no categorical diagnosis
2 = low match between the clinical presentation of the patient and the prototype; no categorical diagnosis
3 = moderate match between the clinical presentation of the patient and the prototype; the patient shows some traits of the disorder; no categorical diagnosis
4 = high match between the clinical presentation of the patient and the prototype; the patient has the disorder and a categorical diagnosis can be given
5= very high match between the clinical presentation of the patient and the prototype; the patient is a prototypical case of the disorder and a categorical diagnosis should definitely be given

Figure 2. The assessment format of the PDP.

They had to be treating the chosen patient for at least three sessions, and the patient needed to be at least 18 years old with no acute psychotic symptoms, brain damage, or dependence on psychoactive substances. The clinicians had to assess the patient using study measures within the same week and based on how the patient presented and what emotional reaction was evoked in the therapist at the time of the assessment. They were free to choose the order of the different measures and the patient to be assessed. The clinicians were informed that this study was focused on the assessment of personality and the emotional implications of clinical work with personality disordered patients.

For identifying which emotional responses (TRQ) were most related to the overall level of personality organization (PDC) and to individual PDP personality patterns, we performed a series of "Forward entry" stepwise linear regression models with an inclusion significance level set at $p < .05$. In the first set of analyses, we entered the level of personality organization as the dependent variable and all of the TRQ factors as predictors. In the second set of analyses, we entered the PDP patterns as the dependent variables and the different TRQ factors as predictors. Finally, when a PDP pattern could be predicted by one or more TRQ factors connected to the overall level of personality organization, we performed a partial correlation to see if the emotional reactions of the therapists toward that particular PDP pattern could only be explained by the level of personality organization.

When the stepwise regression analyses resulted in a model with more than one TRQ factor as a predictor, for the sake of clarity, we focused our attention on the two largest predictor factors, although all significant variables are presented in Table 2 and in the *Results* section of this paper. In this way, we gain in specificity and in the ability to differentiate characteristic emotional reactions connected with the different disorders.

Results

Overall, across the patients' levels of personality organization and the specific personality styles/disorders, the strongest TRQ emotional responses reported by our clinicians were the positive and the parental ($M = 2.30$ and 2.26, SD 0.7 and 0.8, respectively), as could be expected on the basis of the collaborative and caregiving/caretaking nature of the therapeutic relationship. The weakest emotional reaction overall was the sexualized one ($M = 1.19$, $SD = 0.4$). Because every clinician assessed only one patient, our study was not affected by therapist effects (several patients nested within treatment by a single therapist; see Table 1.

Therapists' Emotional Reactions in Relation to Patients' Overall Level of Personality Organization

The TRQ dimensions most predictive of the overall level of personality organization were the helplessness (negative), positive, and overwhelmed (negative) dimensions ($R = .46$; $R^2 = .21$; standardized $\beta = -18, 25, -21$; $F = 12.5$; $p < .0001$). In other words, the more pathological the patient's overall personality functioning, the more the therapists tended to feel helpless, overwhelmed, and less able to develop a good alliance with the patient.

Table 1
Means and Standard Deviations of the Personality Dimensions Assessed With the PDC and PDP and of the TRQ Factors

PDC, PDP, and TRQ Dimensions	Mean	*SD*
Overall level of personality organization (PDC)	5.48	1.61
PDP personality disorders		
Schizoid	1.53	0.80
Paranoid	1.81	1.06
Psychopathic	1.61	1.03
Narcissistic	2.30	1.20
Sadistic	1.45	0.84
Masochistic	2.06	1.01
Depressive	2.61	1.12
Somatizing	2.00	1.15
Dependent	2.39	1.18
Phobic	1.46	0.75
Anxious	2.57	1.41
Obsessive-compulsive	2.10	1.15
Hysterical	2.09	1.21
Dissociative	1.55	0.88
TRQ factors		
Criticized	1.53	0.62
Helpless	1.66	0.66
Positive	2.26	0.69
Parental	2.30	0.82
Overwhelmed	1.43	0.62
Special	1.54	0.66
Sexualized	1.19	0.45
Disengaged	1.79	0.82

Note. PDC Likert scale is 1 (*severe*) to 10 (*healthy*), PDP Likert scale is 1 (*no match*) to 5 (*prototypic*), and TRQ Likert scale is 1 (*not true*) to 5 (*very true*). PDC = Psychodiagnostic Chart; PDP = Personality Diagnostic Prototype; TRQ = Therapist Response Questionnaire.

Therapist Emotional Responses in Relation to Specific PDP Disorders

As shown in Table 2, the depressive and anxious personality disorders could be predicted by a parental and disengaged response of the therapist ($R = .30$, $R^2 = .09$, standardized $\beta = .24$ and .19 for the depressive disorder and $R = .45$, $R^2 = .21$, standardized $\beta = .36$ and .29 for the anxious disorder; $p = 001$ and $p < .0001$, respectively), whereas the phobic disorder was predicted only with a parental response ($R = .22$, $R^2 = .05$, standardized $\beta = .22$; $p = .008$). Narcissistic disorder was predicted by a parental and hostile/criticized emotional reaction ($R = .44$, $R^2 = .19$, standardized $\beta = .30$ and .25, respectively; $p < .0001$).

Dissociative disorder was predicted by a helpless and parental ($R = .37$, $R^2 = .14$, standardized $\beta = .28$ and .18; $p < .0001$) response in the treating clinicians, whereas dependent disorder was predicted by a disengaged and parental ($R = .39$, $R^2 = .15$, standardized $\beta = .33$ and .22; $p < .0001$) response, and somatizing disorder by a disengaged reaction ($R = .30$, $R^2 = .09$, standardized $\beta = .30$; $p < .0001$). Given that the therapists' helpless response was one of the strongest predictors of the overall level of personality organization, it is worth noting that a correlation between dissociative disorder and this emotional response was still significant when the overall level of personality organization was controlled (partial $r = .20$, $p = .02$).

Sadistic disorder was predicted by an overwhelmed response and a disengaged response ($R = .52$, $R^2 = .27$, standardized $\beta = .45$ and .19; $p < .0001$), and the masochistic disorder by an

Table 2
Stepwise Regression Model of TRQ Factors Predicting Different PDP Diagnoses

PDP Disorders and TRQ Factors		R	R^2	Standardized β	F Change (Model)	p
Paranoid						
Helpless		.34	.11	.34	18.93	.000
Psychopathic						
Overwhelmed		.43	.19	.43	32.76	.000
Narcissistic						
Step	1	.37	.14		23.03	.000
Parental				.37		
Step	2	.44	.19		17.21	.000
Parental				.30		
Criticized				.25		
Sadistic						
Step	1	.49	.24		44.57	.000
Overwhelmed				.49		
Step	2	.52	.27		26.59	.000
Overwhelmed				.45		
Disengaged				.19		
Masochistic						
Step	1	.48	.23		44.37	.000
Overwhelmed				.48		
Step	2	.54	.29		29.59	.000
Overwhelmed				.45		
Disengaged				.24		
Step	3	.58	.34		24.20	.000
Overwhelmed				.34		
Disengaged				.26		
Parental				.24		
Step	4	.60	.35		19.58	.000
Overwhelmed				.24		
Disengaged				.23		
Parental				.23		
Criticized				.18		
Depressive						
Step	1	.23	.05		8.06	.005
Parental				.23		
Step	2	.30	.09		7.18	.001
Parental				.24		
Disengaged				.19		
Somatizing/Disengaged		.30	.09	.30	14.85	.000
Dependent						
Step	1	.33	.11		17.43	.000
Disengaged				.33		
Step	2	.39	.15		13.03	.000
Disengaged				.33		
Parental				.22		
Phobic						
Parental		.22	.05	.22	7.201	.008
Anxious						
Step	1	.35	.12		20.00	.000
Parental				.35		
Step	2	.45	.21		18.77	.000
Parental				.36		
Disengaged				.29		
Hysterical						
Step	1	.43	.19		33.58	.000
Overwhelmed				.43		
Step	2	.48	.23		21.42	.000
Overwhelmed				.40		
Sexual				.21		
Step	3	.50	.25		16.11	.000
Overwhelmed				.38		
Sexual				.27		
Positive				−.17		
Dissociative						
Step	1	.33	.11		17.33	.000
Helpless				.33		
Step	2	.37	.14		11.57	.000
Helpless				.28		
Parental				.18		

Note. PDP = Personality Diagnostic Prototype; TRQ = Therapist Response Questionnaire.

overwhelmed, disengaged, parental, and hostile/criticized response ($R = .60$, $R^2 = .35$, standardized $\beta = .24, .23, .23, .18$; $p < .0001$). Histrionic disorder was predicted by an overwhelmed, sexualized, and positive (in reverse) response ($R = .50$, $R^2 = .25$, standardized $\beta = .38, .27, -.17$; $p < .0001$), and the psychopathic by an overwhelmed response ($R = .43$, $R^2 = .19$ standardized $\beta = .43$; $p < .0001$). Even controlling for overall level of personality organization, the sadistic, masochistic, and psychopathic patterns continued to be significantly correlated with the overwhelmed TRQ factor (partial $r = .41, .47$, and $.32$, respectively, $p < .0001$). The same was true for the hysterical pattern (partial $r = .35$, $p < .0001$). In contrast, when controlling for the overall level of personality organization, the hysterical personality disorder no longer showed a significant connection with the positive TRQ factor (partial $r = .04$; $p = .752$).

Finally, paranoid disorder was predicted by a helpless reaction ($R = 34$, $R^2 = .11$, standardized $\beta = .34$; $p < .0001$) in the treating clinicians. However, when controlling for the overall level of personality organization, this correlation becomes not significant (partial $r = .08$; $p = .346$). No specific emotional reaction was found to be predictive of the schizoid and the obsessive-compulsive patterns (all $p > .05$).

Discussion

These are the first empirical data examining the emotional reactions experienced by therapists while treating patients whose personality disorders are assessed with the PDM classification. The PDM descriptions of personality disorders, although in some cases similar to the DSM, International Classification of Diseases, and SWAP descriptions, are generally more centered on inner psychological dynamics than on their explicit features. Moreover, some of the PDM personality disorders are not accounted for at all by the DSM, ICD, or SWAP nosologies (for example, see sadistic personality disorder). In other cases, their descriptions are quite different from the descriptions of those disorders that, in other diagnostic systems, have the same labels. Given that the PDM gives explicit indications about the countertransference reactions expected with most of the P Axis personality disorders, this is the first empirical study that can support or disconfirm the PDM indications.

From a phenomenological perspective, the parental response of clinicians working with anxious and depressive patients is generally experienced as a desire to help and care for them. However, we also found that clinicians experience feelings of disengagement with these patients, feelings that can be partly explained by the chronic nature of the anxious and sad feelings experienced by people with these disorders. These data seem not to support the PDM hypothesis that anxious patterns tend to stir up overwhelmed reactions in the treating clinicians (PDM Task Force, 2006, p. 57).

The parental reaction experienced in clinical work with phobic patients is consistent with the tendency of these patients to attribute a protective power to idealized parental figures and to seek help from them for painful feelings, as described in the PDM (PDM Task Force, 2006, p. 54) and in the PDP. Along similar lines, therapists of phobic patients react with a parental/protective attitude toward them. It is worth noting that the recent study by Colli et al. (2014) also identified a strong parental reaction toward avoidant/phobic patients.

The parental and criticized reactions experienced by clinicians treating narcissistic patients are consistent with the expected reactions associated with the narcissistic patterns described in the PDM (PDM Task Force, 2006, p. 39) and may be linked to two of their basic defense mechanisms: idealization and devaluation (Kernberg, 1984; Kohut, 1971; McWilliams, 1994; Perry, 1990). It is also possible that the parental reaction appeared as the first predictor of the narcissistic pattern in our study because of the high rate of depressed/depleted narcissistic patients (in contrast with arrogant/entitled ones) in our sample. In fact, of the 30 patients in our study who received a full diagnosis of narcissistic personality disorder according to the PDP, 24 had a depressed/depleted subtype (i.e., tended to behave ingratiatingly, seeking people to idealize, were easily wounded, and felt chronic envy of others seen as in a superior position; see PDM Task Force, 2006, p. 40). However, these data contrast with the association found between narcissistic personality disorder and the disengaged factor in the study by Colli et al. (2014). This difference could also be partly due to differences in the descriptions of the narcissistic patterns presented in the PDM and in the SWAP scales' typology, in which the SWAP-200 narcissistic scale primarily describes the arrogant type of this disorder. In future research, we will examine whether there is a specific association between depressed/depleted narcissism and a parental reaction as well as whether there is an association between arrogant/entitled narcissism and a criticized reaction.

Likewise, the helpless reaction to the paranoid patterns could be understood as a complementary response (Racker, 1968) to unacknowledged feelings of anger and fear, typical of paranoid patients, and is in line with the findings reported by Colli et al. (2014). The helpless and parental emotional reactions connected to the dissociative patterns are substantially in line with the emotional reactions described by Davies and Frawley (1994) as well as the descriptions noted in the PDM (PDM Task Force, 2006, p. 63).

The disengaged and parental responses associated with the dependent patterns described in the PDM (PDM Task Force, 2006, p. 51) seem to represent reactions similar to those experienced by the clinicians with anxious and depressive patients, but with dependent patients the first predictor in our data was the disengaged factor, confirming that clinicians working with these patients often feel burdened by their persistent and intense needs and react to them with withdrawal (see Bornstein, 2007 for a discussion of this dynamic). In turn, the parental reaction may represent a caring response to these needs that is more sympathetic with the patients' feelings. The somatizing patients also seem to evoke a disengaged reaction that might be interpreted as a consequence of the frustration in line with the difficulties these patients encounter in exploring or understanding the psychological aspects of their problems (PDM Task Force, 2006, p. 50).

The findings suggesting that the sadistic and masochistic personality patterns are connected with the same overwhelmed and disengaged reaction are of particular interest because of the lack of empirical data about therapists' emotional responses associated with these disorders. The overwhelmed response, which was also found to be the best predictor of the psychopathic pattern, could be understood at least in part as the clinician's reaction to the disorienting situation of being in a relationship with a person who presents as help-seeking and cooperative in the therapeutic enterprise while, in fact, seeming to associate a caretaking/caregiving relationship with humiliation, harm, suffering, and manipulation

(Gazzillo, 2012). The PDM (PDM Task Force, 2006 p. 41, 43) explicitly refers to feelings associated with the TRQ overwhelmed factor, such as visceral disturbance, uneasiness, and intimidation, as pathognomonic reactions to sadistic patterns, whereas it connects the masochistic patterns with therapists' feelings of first exhibiting a parental response, and then having a hostile reaction, which appear only in our third and fourth models of regression. In this context, the disengaged component of the therapist's emotional responses could be understood as an avoidance resulting from feeling overwhelmed.

Hysterical personality styles were also connected to an overwhelmed reaction in the therapist, along with increased sexualized feelings. Our tentative understanding is that the overwhelmed reaction to these patients' clinical presentations could be read as a concordant reaction to their dysregulated affects (Westen & Shedler, 1999b). The sexualized reaction that seems specific to these patients has often been interpreted as a concordant reaction to the sexualized self-presentation in patients diagnosed with these disorders (Kernberg, 1992; McWilliams, 1994). However, it is worth noting that many of the PDP and TRQ mean scores only have a mean of 1 (i.e., *none*) to 2 (*low*); therefore, they represent only limited presence at the overall group level (see Table 1).

Conclusions

In general, these data, along with data from previous studies on the same subject reviewed in the introduction, seem to support the idea that clinicians can use their emotional reactions as an aid for understanding the personality styles of their patients (see also Eagle, 2000, for a discussion of this issue). The fact that the clinicians' emotional reactions identified in this study to many of the personality disorders are in line with those described in the PDM and identified in previous studies seems to suggest that the different personality styles of the patients may have a specific emotional impact on the clinicians, at least in part independent from clinicians' personalities.

Moreover, these findings suggest that although the positive TRQ factor (i.e., the therapeutic alliance) is connected to a general capacity of good-enough personality functioning, most of the other TRQ factors—in particular the overwhelmed and helpless ones—seem to be reactions to pathological personality functioning. More specifically, the criticized reaction is associated with angry and devaluing dynamics in treated patients and in the therapeutic relationship, the overwhelmed response with patients' perceived difficulties in regulating emotions and in clearly asking for help in a caregiving/caretaking relationship, and the sexualized response to sexual dynamics perceived in the patients or in the therapeutic relationship. In this context, the parental response could be interpreted as a complementary response to the patient's asking for help from a therapist who is experienced as a parental/idealized figure and the helpless reaction as a concordant response to patients' feelings of frightened helplessness.

Limitations and Future Research

The first limitation of this study is the fact the same rater, the treating clinician, was responsible for using all three of the assessment tools: the PDC and PDP (for the assessment of personality organization and personality disorders) as well as the TRQ (for the assessment of therapist emotional reaction). This is a source of potential bias because it could be argued that clinicians' diagnostic prejudices are reflected in personality diagnoses and in their emotional responses to the patients. To deal with this possible objection, in future studies we will ask to assess the personality of our patients using a rater other than the treating clinician. However, the advantage of having the treating clinician act as personality assessor of the patient is that patients are rated by practitioners who know the person being assessed quite well (in this study, the clinicians had been treating the patients for an average of 19 months). For this reason, in future studies it could be useful to average the treating clinician and an independent rater's assessment of the same patient and use these average scores as the variable to be predicted on the basis of the clinicians' emotional reactions.

The second limitation of this study is that we were not able to differentiate, in a more fine-grained way, the emotional reactions connected to the different subtypes of several PDM/PDP disorders, such as the arrogant versus the depressed subtype of narcissistic personality disorder and the moral versus relational subtype of the masochistic disorder. To overcome this limitation, we are widening the PDP descriptions of these subtypes so that in future studies we will have different autonomous descriptions of each subtype to correlate with the different emotional responses of the therapist.

A third limitation of this study to be overcome by future research is the evolution of therapists' emotion responses to the different personality disorders during the course of treatment. In other words, we need to test the hypothesis that the emotional reaction of a therapist to a patient with a personality disorder depends not only on the clinical presentation of the patient but it also evolves over the course of treatment in response to the therapeutic intervention and to the patients' evolution. Such a methodology not only has the advantage of exploring variations in therapists' countertransference responses over the course of treatment, but it may also help illuminate situational and dispositional variables (e.g., patients' defense styles, frequency of therapist-patient sessions, depth of elaboration, and therapeutic alliance—for example, see Lingiardi, Colli, Gentile, & Tanzilli, 2011) that moderate the therapists' emotional responses during therapy.

A fourth limitation is the fact that we did not assess the degree to which the comorbid disorders of our patients (e.g., mood disorders) could directly or indirectly influence the emotional reactions of our clinicians. In other words, it is possible that the clinicians' emotional responses to the patients were at least partly due to the comorbid disorders that the patients exhibited in addition to the patients' personality disorders. In future studies, we will try to verify this hypothesis.

Finally, in future research we will ask clinicians with different backgrounds (psychiatrists, psychologists, social workers, and so on) and different theoretical orientations (dynamic, cognitive, humanistic, etc.), to assess the same patients so that we will be able to explore if these, and other factors, may influence clinicians' emotional reactions toward their patients.

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