The Diagnostic Use of Countertransference in Psychodynamic Practice

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Annalisa Tanzilli and Vittorio Lingiardi

10.1 The Origins of Countertransference

The therapeutic relationship has been shown to be one of the most important mutative factors able to promote good treatment outcomes [1, 2]. Countertransference is a crucial component of the therapeutic relationship, and it is strongly related to multifaceted processes involved in producing the patient's change not only in the context of psychoanalytic/psychodynamic psychotherapies but also, in general, in all approaches of different persuasions [3–5]. Over recent years, it has become increasingly clear to clinicians of various theoretical orientations that recognizing and working through countertransference may help inform a more sensitive diagnostic process, generate accurate and clinically meaningful case formulations, and facilitate planning effective therapeutic interventions [6–10].

Historically, the roots of countertransference must be traced within the confines of classical psychoanalysis. The credit of its discovery is acknowledged to belong to Freud, who first described and discussed this clinical phenomenon in *The Future Prospects of Psycho-Analytic Therapy* at the Second International Nuremberg Congress in 1910 as follows:

> We have become aware of the *counter-transference*, which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it. (…) We have noticed that no psycho-analyst goes further than his own complexes and internal resistances permit; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients. Anyone who fails to produce results in a self-analysis of this kind may at once give up any idea of being able to treat patients by analysis. [11, p. 144–145]

A. Tanzilli · V. Lingiardi (✉)
Department of Dynamic and Clinical Psychology, and Health Studies, Faculty of Medicine and Psychology, SAPIENZA University of Rome, Rome, Italy
e-mail: annalisa.tanzilli@uniroma1.it; vittorio.lingiardi@uniroma1.it

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According to the Freudian perspective, countertransference represents an obstacle to the treatment progress, being the result of the patient's influence on the analyst's unconscious feelings or, in other words, the analyst's transference to the patient [12]. Deriving from the analyst's resistances and unresolved neurotic conflicts originating in early childhood, countertransference reactions create "blind spots" or severe distortions in the clinician's perception of the patient, hindering the treatment; therefore, they have to be eliminated through rigorous psychoanalysis [13]. Freud states:

> [the analyst] must bend his own unconscious like a receptive organ towards the emerging unconscious of the patient, be as the receiver of the telephone to the disc. As the receiver transmutes the electric vibrations induced by the sound-waves back again into sound-waves, so is the physician's unconscious mind able to reconstruct the patient's unconscious, which has directed his associations, for the communications derived from it. [13, p. 115–116]

If the analyst's mind is a powerful and effective tool able to attune to patient and capture the unconscious meanings in his or her communications, countertransference clearly provokes interferences that perturb the therapeutic process. Indeed, the quickly changing, fluctuating, and confusing nature of countertransference reactions severely threatens the analyst's neutrality and may lead him or her to act in antitherapeutic ways.

As is known, neutrality is one of the three structural rules that define the analyst's mental stance in technical or theoretical Freudian writings. The figure of the analyst is compared to that of a surgeon who remains unaffected by his or her emotions. The clinician should serve as a mirror or a "blank screen" to allow the projection of the patient's internal structure. According to Freud's transference theory, indeed, patients displace onto the analyst strong feelings and conflicts associated with significant figures of childhood through unconscious processes, repeating and re-actualizing their dysfunctional patterns of relatedness in therapy [14, 15]. Despite the controversies about the conceptualization of neutrality, which is often misunderstood as the clinician's indifference and detachment [cf., 16], the role of this technique is to promote a deeper understanding of the patient's intrapsychic conflict. Freud highlights the centrality of neutrality to point out that the analyst should reflect the patient's conflicts without conflating them with his or her own emotions and conflicts [17]. In this perspective, it is crucial that the analyst resolves his or her problems and any psychological vulnerabilities that may cause countertransference reactions and impede a neutral attitude toward the patient, irreversibly compromising the therapeutic process [18, 19].

Although Freud's observations on countertransference are not systematized in a more rigorous and accomplished way and his suggestions sometimes seem contradictory, this classical and overly "narrow" perspective, which views this phenomenon as a disturbing factor, predominated for many decades in psychoanalysis with a few exceptions. For example, Sàndor Ferenczi's [20, 21] distances himself from Freudian "orthodoxy" by developing a concept of countertransference as a useful therapeutic tool rather than as an obstacle to the cure. In his theory of

countertransference, he shifts the focus from the patient's individual and intrapsychic dimension to the intersubjective field of the analyst–patient dyad. Ferenczi's ideas and clinical emphasis on mutuality (intimacy) and intersubjectivity in the therapeutic relationship did not have a great response among his contemporaries, but his legacy will influence future generations of analysts, especially by laying the groundwork for the relational turn in psychoanalysis (see later in this chapter) and promoting the radical revision in the theory and technique of countertransference around the 1950s [22].

Gradually, the conceptualization of countertransference indeed evolves away from the classical position and broadens to encompass all the feelings, thoughts, attitudes, and behaviors clinicians experience in treating patients [23]. Consistent with the so-called "totalistic" approach [24], this clinical dimension becomes a valuable source of knowledge about patients, providing insight into their dysfunctional interpersonal and intrapsychic dynamics in the context of their significant relationships. According to this expanded view, if properly used and managed, countertransference can benefit all of the treatments (of various approaches) rather than hinder them.

10.2 The Rediscovery of Countertransference

In the 1950s, the relevant contributions on countertransference of Donald Winnicott [25], Paula Heimann [23], and Heinrich Racker [26] favor the rediscovery of this phenomenon. Emphasizing the deeper nature of analytic situation that implies the (intersubjective) encounter between two individuals, Heimann [23] proposes evolutionary innovations of countertransference theory that extended its conceptual limits. Consistent with her perspective, all the emotional responses expressed by clinicians toward patient help them shed light on patient's unconscious conflicts and defenses. Heimann [23, p. 82] posits that "often the emotions roused in him are much nearer to the heart of the matter than his reasoning," which suggests that therapists may better understand their patients using their subjectivity and emotional sensitivity. Moreover, she provides a different reformulation of the Freudian technical precepts: "In my view Freud's demand that the analyst must 'recognize and master' his counter-transference does not lead to the conclusion that the countertransference is a disturbing factor and that the analyst should become unfeeling and detached, but that he must use his emotional response as a key to the patient's unconscious" [23, p. 83].

At a similar time, in line with Heimann and, in general, with a broader view of countertransference, Winnicott [25] distinguishes an objective form of this phenomenon reflecting the "normal" therapist's reactions to the patient's personality and behavior from a subjective form; the latter—in accordance with the classical perspective—is based on the analyst's unresolved issues or sensitivities. Borrowing from his experience as a pediatrician, Winnicott focuses on the mother–infant dyad and draws an analogy with the therapist–patient relationship. Thanks to his illuminating clinical observations on the early stages of childhood development and the

environmental failures, the author stresses the developmental relevance of hate in the mother–child relationship. Similarly, he normalizes and universalizes the analyst's negative reactions toward the patients and discusses the hate in countertransference toward severe psychotic patients. According to Winnicott [25], the objective and negative countertransference consists of intense and realistic responses evoked in the analyst by patients with more primitive levels of mental functioning, which in turn were based on the patient's early object experiences (or experiences of significant others).

In line with Heimann and Winnicott, Racker [27] develops the idea of countertransference as the combination of all feelings, thoughts, motivation, and behaviors experienced by the analyst toward the patients and introduces the psychodynamic concepts of concordant and complementary countertransference. Through the observations of the relational dynamics between patient and analyst, the author defines concordant countertransference as the process by which the analyst identifies his ego with the patient's ego and, similarly, with the other parts of the personality (i.e., id and superego). Conversely, following Deutsch's [28] model of identification, complementary countertransference is the result of all the psychological processes by which the analyst's ego identifies with the patient's internal objects.

These two forms of countertransference are highly complex and intimately relate to other relevant and clinically meaningful psychoanalytic constructs. Racker establishes a strong relationship between *empathy* and the first form of countertransference, given that the underlying *concordant identification* is very close to the processes that allows the empathic and positive understanding of patient. Many authors disagree with this point of view and make a firm distinction between these concepts [17]. Contrary to Racker's perspective, they speculate that empathy might refer back to the primary processes of psychic life, and they express concerns on the full correspondence between what goes on in the analyst and what goes on in the patient [cf. 29]. This topic is beyond the scope of this work, but, essentially, these controversies depend on how each author intends to expand the conceptual confines of countertransference (for a deeper discussion, see [19]).

Regarding the *complementary countertransference* (based on this specific kind of identification), Racker [30] also refers to it as the analyst's response by which she or he takes on the role "assigned" to him or her by the patient. For example, a patient projects his introjected father onto the analyst and treats him or her as such. The clinician may identify with the patient's internal object, that is, the introjected father, and experience feelings (e.g., anger, irritation, or resentment) that are consistent to the introjected father. If the clinician is not able to understand what is going on in the relationship with the patients, he or she might act in treatment like the introjected father and repeat an experience "that helped establish the patient's neurosis" [30, p. 138]. The process that Racker describes in this clinical vignette is defined in different ways by many analysts, but it is very close to the view of *projective identification* [31–35], *role responsiveness* [36], or *countertransference enactment* [37, 38].

The concept of projective identification has considerably contributed to countertransference's theoretical–clinical (r)evolution. This term is first introduced in

"Notes on some schizoid mechanisms" by Melanie Klein [33], who describes it as results from the patient unconsciously disowning or splitting off certain affects or parts of the self and projecting them into the therapist, exercising their omnipotent control. The therapist unconsciously internalizes these affects and experiences the impulse to act them out; for example, clinician can be the hyperaggressive object that is projected into him or her [22].

According to Klein [33], the projective identification is an unconscious phantasy that plays a pivotal role in structuring the mental life of the child influencing and, in turn, being influenced by the complex relationship between the infant's inner world and the surrounding reality. In other words, in her model of mental functioning, "fantasy is the primary content of unconscious mental processes" [39, p. 82], and the child's inner world is populated with good or bad, total or partial "internal objects," which not only derive from early relational experiences with real human figures, but also are the result, in varying degrees, of his unconscious destructive or constructive fantasies [33].

The Kleinian concept of projective identification essentially refers to an intrapsychic process; thus, the theoretical–clinical framework remains intrinsically related to a monopersonal psychology. Although Klein introduces the concept of the "internal objects" showing a certain interest in the reality, she does not recognize or emphasize the relevance of interpersonal dimension in this mechanism. Overall, her speculation's main focus is always directed on the nature of the phantasmatic processes that characterize the patients' state of mind, and in this perspective, countertransference continues to be read and interpreted in the classical and narrow key as a sign of the analyst's vulnerability that requires further analysis [cf. 40]. It is not surprising that Klein develops a strong argument with Heimann, clarifying her disagreement on the totalistic view of countertransference that would imply the wrong attribution to the patient of the analyst's problems and conflicts.

Looking at the subsequent contributions on projective identification and their implications to the patient–therapist relationship, it is important to discuss the innovative theories of Wilfred Bion [31] and Thomas Ogden [41, 35], who elaborate an interpersonal view of this mechanism reformulating the characteristics and dynamics of countertransference. Bion [42] believes that the projective identification is not only an unconscious phantasy. Consistent with his model of *maternal rêverie* and the *container-contained model* of the mother–infant relationship, the analyst considers the crucial importance of projective identification in the process of a child's growth and learning from experience [31, 43]. According to his theory, the mother should show the ability to contain the infant's unpleasant and intolerable affects, linked to his or her needs' frustration, and to transform these negative emotional experiences into a more tolerable form permitting the infant to reinternalize them as "detoxified" and modified elements.

Ogden [34] develops Bion's conceptualization incorporating the projective identification in his dialectical model of therapist–patient interaction. He considers this process as a complex phenomenon through which (a) specific aspects of the patient's self or internal objects are projectively disavowed by unconsciously displacing it in the clinician (because these aspects threaten to damage the self or, conversely, risk

being attacked by the self's other aggressive and disruptive parties and have to be protected within the therapist); (b) the patient actually exerts an interpersonal pressure to coerce the clinician to experience, unconsciously identify with or behave according with that which has been projected; and (c) the clinician contains and processes the projected contents and, if she or he is capable of "metabolizing" and managing them, allows the reintrojection by the patient in a transformed and more tolerable form [37].

Overall, Bion and Ogden elevate the projective identification to a mental process that allows interpersonal interaction and human communication. The authors recognize that clinicians' exploring and metabolizing of their countertransference experiences from the patients' projective identifications may permit them to integrate aspects of self that originally are intolerable and to develop a more cohesive and stable sense of self. To promote this relevant change in patients, a clinician must resist interpersonal pressures from the patients that, through largely unconscious verbal and nonverbal maneuvers, try to draw the clinician into dysfunctional interactions in which s/he has to play a particular role, provoking the so-called countertransference enactment (for a deeper discussion, see [37, 38, 36]). If appropriately managed, countertransference improves clinical work across a wide array of treatments, reducing detrimental interventions and bridging impasses in the psychotherapy process [5].

10.3 The Relational and Intersubjective Turn of Countertransference

A radical revision of countertransference theory is strongly related to the perspective change in psychoanalysis from a classical monopersonal versus bipersonal approach, which seeks to understand psychological phenomena as products of patient and clinician subjectivities that interact with each other in reciprocal and mutual influence within a dynamic field [e.g., 44–47]. This new metapsychology points out the impact of the clinician and his or her participation on the unfolding of the therapeutic process rejecting the notion of the "blank screen" analyst. Overall, relational and intersubjective analysts question the *myth of the isolated individual mind* [48], which attributes to the individual mind an existence separate from the world of nature and social bonds, denying the dependence on the interpersonal environment and reifying the image of an illusory human self-sufficiency.

This new paradigm favors the shift from the classical psychoanalytic model to the intersubjective and relational perspective of therapeutic relationship based on the contributions of many authors such as Stephen Mitchell [49], Lewis Aron [50], and George Atwood and Robert Stolorow [51]. These theorists stress that the analyst's actual behavior influences the patient's transference to the analyst. Hence, the concepts of transference and countertransference are rethought in the light of the intersubjective experience developed in the context of the psychoanalytic relationship. These clinical dimensions continually oscillate between the experiential foreground and background of the transference in concert with perceptions of the

analyst's varying attunement to the patient's emotional states and needs [52]. Thus, transference and countertransference are inextricably linked and jointly co-constructed depending on the mutual interplay of two subjects [50].

Notably, Mitchell [53] recognizes in Ogden's perspective of projective identification an "interpersonalization" of the countertransference concept. Ogden [54] conceives of projective identification as a form of the "analytic third," in which the individual subjectivities of analyst and patient are subjugated to a co-created third subject of analysis. Good analytic work involves a superseding of the subjugating third by means of mutual recognition of analyst and patient as separate subjects and a reappropriation of their (transformed) individual subjectivities [55]. The figure of the analyst or therapist as completely neutral or aloof is no longer appropriate. According to relational and intersubjective perspectives, the analyst is "embedded" within the relational matrix of analytical interactions [49].

10.4 Countertransference and Psychodynamic Diagnosis

The psychodynamic diagnosis aims at promoting an accurate case formulation and fostering patient-tailored treatments. The diagnostic process develops within a relational matrix derived from the encounter and interaction between the subjectivities of patient and clinician. The therapeutic relationship is an essential source of information about the unfolding patient–clinician interaction in the here and now of clinical situations, and psychological and interpersonal characteristics of the patient and the therapist [9, 56].

Notably, according to the post-Freudian contributions reviewed in the previous sections of this chapter [especially, 24, 25, 27], countertransference represents a useful and clinically relevant diagnostic tool to shed light on specific features of patient's personality and mental functioning. Personality disorders are characterized by pervasive and dysfunctional interpersonal styles; thus, personality-disordered patients tend to "reactualize" their relational difficulties in the context of a therapeutic relationship, drawing the clinician into interactions that reflect these enduring and maladaptive schemas of the self, others, and relational interactions [35, 36]. In these terms, therapist's recognition of his or her emotional responses and experiences (i.e., countertransference according to the totalistic view; [24]) is an important vehicle for assessing and understanding patients' personality functioning and their peculiar ways of adapting to environmental contexts.

When considering countertransference as a diagnostic tool, the clinician should always remember to maintain a tension between the idiographic and nomothetic approaches that is inherent in every diagnostic process [57]. Notably, it is crucial to capture the unique and unrepeatable aspects (*idiographic perspective*) that emerge in the here and now of the relational encounter between patient and therapist, and at the same time, the patient's relational patterns that she or he tends to repeat and show in a stable form in all interpersonal situations and that she or he shapes with other similar individuals (*nomothetic perspective*). In other words, examining countertransference reactions toward patients with specific personality disorders by

adopting a nomothetic and idiographic view allows the clinician to identify specific relational models occurring in "coherent and predictable ways" in these patients' treatment, without losing focus on individual relational aspects [58–59].

Not surprisingly, the *Psychodynamic Diagnostic Manual-Second Edition* (PDM-2; [9]) is the first international nosography that "legitimates" the use of the clinician's (but also of the patients') subjectivity in the diagnostic and therapeutic process. Aspiring to be a "taxonomy of people" rather than a "taxonomy of disorders," the PDM-2 offers a theoretical–clinical framework that reflects an individual's full range of functioning—the depth, as well as the surface, of emotional, cognitive, interpersonal, and social patterns. It intends to promote a deeper and accurate knowledge of patient's functioning for case formulation and treatment planning, taking into account individual variations and commonalities.

The diagnostic approach of the PDM-2 is multiaxial and proposes a systematic description of *personality syndromes* (P Axis), including essential characteristics of transference and countertransference patterns that are typical in the treatment of each disorder; profiles of *mental functioning* (including 12 specific capacities, e.g., patterns of relating to others, comprehending and expressing feelings, coping with stress and anxiety, regulating impulses, observing one's own emotions and behaviors, and forming moral judgments) (M Axis); and *symptom patterns* (S Axis), including differences in each individual's personal, subjective experience of psychopathological presentations, as well as the emotional responses and experiences of treating clinicians [cf. 60, 61]. The importance of considering the quality of the therapeutic relationship emphasized by the PDM-2 is supported by some studies showing strong associations between countertransference (or, in this context, therapist emotional responses) and personality pathologies across different treatment approaches [58, 59, 62–68].

Research in the field to date is still limited, but the findings are clinically meaningful and empirically robust. Overall, evidence shows that patients with cluster A and B personality disorders tend to evoke more negative therapist reactions than cluster C patients, and that cluster B patients elicit more intense and heterogeneous feelings in their therapists [58, 65, 66]. Moreover, among cluster B disorders, borderline patients seem to arouse stronger and more mixed reactions in clinicians [69–72].

A relevant and comprehensive study [59] has examined the relationships between therapist's responses (evaluated using the Therapist Response Questionnaire; [58, 72]) and all the patients' personality disorders (assessed using the Shedler–Westen Assessment Procedure-200; [73–75]). Research has found that specific countertransference configurations reflect particular patterns of relatedness that are ubiquitous in the patient's life [cf. 37, 76]. For example, schizoid patients tend to elicit a sense of helpless and inadequate in therapists. Clinicians report difficulties establishing a comfortable relationship with, being more attuned with, and developing a sense of intimate connections with a schizoid patient who show a pervasive pattern of detachment from social relationships and have a very restricted range of expression of emotions in interpersonal contexts [77]. Patients with antisocial personality

disorder tend to provoke countertransference reactions combining anger and irritation, which are strongly related to their reckless disregard for others, the lack the empathy and tendency to manipulate and lie without remorse, as well as insensibility and callous unemotional traits [9, 74]. Notably, borderline patients may "pull" therapists to experience countertransference reactions characterized by strong feelings of anxiety, concern, and frustration in therapy. Clinicians treating these patients report feeling incompetent or inadequate and experiencing a sense of confusion in sessions. These reactions likely reflect the patients' fragmented and incoherent sense of self and others; severe difficulties regulating emotions and impulses and developing and maintaining stable, intimate relationships; prevalent use of primitive defense mechanisms, such as splitting and projective identification; and some problems in reality testing [e.g., 78]. Conversely, clinicians report protective and positive feelings toward avoidant patients, perhaps experiencing a wish to repair some deficiencies or failures in their patients' relationships with parents or significant others [9, 74].

Another recent study [79; see also 80] has examined clinician emotional responses in psychotherapy with patients presenting with narcissistic personality disorder (NPD), one of the most common and challenging clinical syndromes to treat. This empirical investigation has indicated that NPD was positively associated with hostile, criticized, helpless, and disengaged countertransference, and negatively associated with a positive response to the patient. Clinicians treating NPD patients experience intense feelings of being unappreciated, denigrated, and belittled, as well as rage and resentment due to the contemptuous and devaluing attitudes expressed by these patients or their manipulative and defiant behaviors [81, 82]. These therapists' reactions may be related to the most common defensive strategy of narcissistic patients who devalue others (including therapists) to protect their grandiosity and deny feelings of inadequacy associated with difficulties in regulating their vacillating self-esteem [76, 83]. Moreover, these patients are difficult to engage in a therapeutic relationship characterized by reciprocity, trust, and close connection, evoking frustration and disengagement in clinicians [84]. Thus, clinicians' understanding of their own countertransference reactions to NPD patients and of the quality of mutual collaboration and connection with them is helpful when making a thorough and accurate diagnosis and planning individualized interventions or treatments.

Overall, research in this field seems to show that, despite the uniqueness of each patient–therapist dyad, distinct dimensions of countertransference are associated with specific personality disorders in a clinically meaningful and systematically predictable manner. In other words, all patients can not only stimulate *idiosyncratic countertransference responses* in clinicians (that borrow from the clinician's personal dynamics and are based on his or her life history, personality and psychological functioning, anxieties, and unresolved conflicts) but they also evoke *average expected countertransference reactions*, which likely resemble the typical responses activated in significant others in the patient's life, similar to Winnicott's concept of "objective countertransference."

10.5 Conclusion

Countertransference has evolved from a narrow conceptualization of obstacle to therapeutic progress and become a ubiquitous, pervasive, and potentially useful phenomenon for practitioners of various backgrounds and experiences, in all therapeutic situations and settings. It reflects a broad spectrum of clinicians' emotional and interpersonal experiences with patients and is intrinsically linked to the complex combination of the therapist's own dynamics, responses evoked by the patient, and the interaction of patient and therapist.

The clinical and empirical literature seems to support the view that countertransference responses is a useful source of knowledge for better understanding the patients' psychological functioning, and in particular all the relational dynamics that tend to repeat in significant relationships of their life, which are strongly associated with their relatively stable patterns of thinking, feeling, behaving, and regulating emotions and impulses.

References

1. Norcross JC, Lambert MJ. Psychotherapy relationships that work III. Psychotherapy (Chic). 2018;55(4):303–15. https://doi.org/10.1037/pst0000193.
2. Wampold BE. How important are the common factors in psychotherapy? An update World Psychiatry. 2015;14(3):270–7. https://doi.org/10.1002/wps.20238.
3. Gabbard GO. Countertransference: the emerging common ground. Int J Psychoanal. 1995;76(3):475–85.
4. Gabbard GO, Westen D. Rethinking therapeutic action. Int J Psychoanal. 2003;84(4):823–41. https://doi.org/10.1516/0020757037682846O5.
5. Hayes JA, Gelso CJ, Goldberg S, Kivlighan DM. Countertransference management and effective psychotherapy: meta-analytic findings. Psychotherapy (Chic). 2018;55(4):496–507. https://doi.org/10.1037/pst0000189.
6. Bateman AW, Fonagy P. Mentalization based treatment for borderline personality disorder: a practical guide. Oxford, UK: Oxford University Press; 2006.
7. Beck AT, Davis DD, Freeman A. Cognitive therapy of personality disorders. 2nd ed. New York, NY: Guilford Press; 2004.
8. Gabbard GO, editor. Textbook of psychotherapeutic treatments. Washington, DC: American Psychiatric Publishing; 2009a.
9. Lingiardi V, McWilliams N, editors. Psychodynamic diagnostic manual, 2nd ed. (PDM-2). New York, NY: Guilford Press; 2017.
10. Yeomans FE, Clarkin JF, Kernberg OF. Transference focused psychotherapy for borderline personality disorder: a clinical guide. Washington, DC: American Psychiatric Publishing; 2015.
11. Freud S. The future prospects of psychoanalytic therapy. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 11. London, UK: Hogarth Press; 1910. p. 139–51.
12. Laplanche J, Pontalis JB. Vocabulaire de la psychanalyse. Paris: Les Presses Universitaire de France; 1967.
13. Freud S. Recommendations to physicians practicing psychoanalysis. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 12. London, UK: Hogarth Press; 1912b. p. 111–20.
14. Freud S. The dynamics of transference. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 12. London, UK: Hogarth Press; 1912a. p. 97–108.

15. Freud S. Introductory lectures on psychoanalysis: part III. General theory of neurosis. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 16. London, UK: Hogarth Press; 1917. p. 243–436.
16. Hoffer A. Toward a definition of psychoanalytic neutrality. J Am Psychoanal Assoc. 1985;33(4):771–95. https://doi.org/10.1177/000306518503300402.
17. Eagle MN. From classical to contemporary psychoanalysis: a critique and integration. New York, NY: Routledge; 2011.
18. Epstein L, Feiner AH. Countertransference: the therapist's contribution to treatment. Contemp Psychoanal. 1979;15(4):489–513. https://doi.org/10.1080/00107530.1979.10745593.
19. Etchegoyen RH. The fundamentals of psychoanalytic technique. London: Karnac Books; 1986.
20. Ferenczi SL. On the technique of psychoanalysis. In: Richman J, editor. Further contributions to the theory and technique of psychoanalysis. Karnac: London, UK; 1919. p. 177–89.
21. Ferenczi S. Child-analysis in the analysis of adults. Int J Psychoanal. 1931;12:468–82.
22. Gelso CJ, Hayes JA. Countertransference and the therapist's inner experience: perils and possibilities. Mahwah, NJ: Erlbaum; 2007.
23. Heimann P. On counter-transference. Int J Psychoanal. 1950;31:81–4.
24. Kernberg O. Notes on counter-transference. J Am Psychoanal Assoc. 1965;13(1):38–56. https://doi.org/10.1177/000306516501300102.
25. Winnicott DW. Hate in the countertransference. Int J Psychoanal. 1949;30:69–75.
26. Racker H. A contribution to the problem of counter-transference. Int J Psychoanal. 1953;34(4):313–24.
27. Racker H. The meanings and uses of countertransference. Psychoanal Q. 1957;26(3):303–57. https://doi.org/10.1080/21674086.1957.11926061.
28. Deutsch H. Occult processes occurring during psychoanalysis. In: Devereux G, editor. Psychoanalysis and the occult. New York, NY: International University Press; 1926. p. 133–46.
29. Sandler J. On communication from patient to analyst: not everything is projective identification. Int J Psychoanal. 1993;74(6):1097–107.
30. Racker H. Transference and countertransference. London, UK: Hogarth Press; 1968.
31. Bion WR. Learning from experience. London: William Heinemann; 1962.
32. Joseph B. In: Feldman M, Spillius EB, editors. Psychic equilibrium and psychic change: selected papers of Betty Joseph. London, UK: Taylor & Frances/Routledge; 1989.
33. Klein M. Notes on some schizoid mechanisms. J Psychother Pract Res. 1996;5(2):164–79.
34. Ogden TH. Projective identification and psychotherapeutic technique. New York, NY: Jason Aronson; 1982.
35. Ogden TH. The analytic third: working with intersubjective clinical facts. Int J Psychoanal. 1994;75:3–19.
36. Sandler J. Countertransference and role-responsiveness. Int Rev Psychoanal. 1976;3(1):43–7.
37. Gabbard GO. A contemporary psychoanalytic model of countertransference. J Clin Psychol. 2001;57(8):983–91. https://doi.org/10.1002/jclp.1065.
38. Jacobs TJ. On countertransference enactments. J Am Psychoanal Assoc. 1986;34(2):289–307. https://doi.org/10.1177/000306518603400203.
39. Isaacs S. The nature and function of phantasy. Int J Psychoanal. 1948;29:73–97.
40. Klein M. The psychoanalytic play technique. Am J Orthopsychiatry. 1955;25(2):223–37.
41. Ogden TH. On projective identification. Int J Psychoanal. 1979;60(3):357–73.
42. Bion WR. Development of schizophrenic thought. Int J Psychoanal. 1956;37:344–6.
43. Bion WR. Attention and interpretation. London: Tavistock Publications; 1970.
44. Baranger M, Baranger W. Insight in the analytic situation. In: Litman RE, editor. Psychoanalysis in the Americas. New York, NY: International Universities Press; 1966. p. 56–72.
45. Gill MM. Psychoanalysis in transition: a personal view. Hillsdale, NJ: Analytic Press; 1994.
46. Langs R. The bipersonal field. New York, NY: Jason Aronson; 1976.
47. Sullivan HS. The interpersonal theory of psychiatry. New York, NY: WW Norton & Co; 1953.
48. Stolorow R, Atwood G, Brandchaft B, editors. The intersubjective perspective. Northvale, NJ: Jason Aronson; 1994.

49. Mitchell SA. Relational concepts in psychoanalysis: an integration. Harvard University Press; 1988.
50. Aron L. A meeting of minds: mutuality in psychoanalysis. Hillsdale: The Analytic Press; 1996.
51. Atwood G, Stolorow R. Structures of subjectivity: explorations in psychoanalytic phenomenology. Hillsdale, NJ: The Analytic Press; 1984.
52. Stolorow R, Atwood G. Contexts of being: the intersubjective foundations of psychological life. Hillsdale, NJ: The Analytic Press; 1992. p. 1992.
53. Mitchell SA. Interaction in the Kleinian and interpersonal traditions. Contemp Psychoanal. 1995;31(1):65–91. https://doi.org/10.1080/00107530.1995.10746896.
54. Ogden TH. Reverie and interpretation. Psychoanal Q. 1997;66(4):567–95. https://doi.org/10.1080/21674086.1997.11927546.
55. Ogden TH. This art of psychoanalysis. Dreaming undreamt dreams and interrupted cries. Int J Psychoanal. 2004;85:857–77. https://doi.org/10.1516/0020757041557575.
56. Lingiardi V, Holmqvist R, Safran JD. Relational turn and psychotherapy research. Contemp Psychoanal. 2016;52(2):275–312. https://doi.org/10.1080/00107530.2015.1137177.
57. Lingiardi V, McWilliams N. Introduction to the special issue on the Psychodynamic Diagnostic Manual, 2nd Edition (PDM-2). The PDM: yesterday, today, tomorrow. Psychoanal Psychol. 2018;35(3):289–93. https://doi.org/10.1037/pap0000188.
58. Betan E, Heim AK, Zittel Conklin C, Westen D. Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. Am J Psychiatry. 2005;162(5):890–8. https://doi.org/10.1176/appi.ajp.162.5.890.
59. Colli A, Tanzilli A, Dimaggio G, Lingiardi V. Patient personality and therapist response: an empirical investigation. Am J Psychiatry. 2014;171(1):102–8. https://doi.org/10.1176/appi.ajp.2013.13020224.
60. Hilsenroth MJ, Katz M, Tanzilli A. Psychotherapy research and the Psychodynamic Diagnostic Manual (PDM–2). Psychoanal Psychol. 2018;35(3):320–7. https://doi.org/10.1037/pap0000207.
61. Tanzilli A, Majorana M, Fonzi L, Pallagrosi M, Picardi A, Coccanari De Fornari MA, Biondi M, Lingiardi V. Relational variables in short-term psychodynamic psychotherapy: an effectiveness study. Res Psychother. 2018;21(3):327. https://doi.org/10.4081/ripppo.2018.327.
62. Dahl HJ, Høglend P, Ulberg R, Amlo S, Gabbard GO, Perry JC, et al. Does therapists' disengaged feelings influence the effect of transference work? A study on countertransference. Clin Psychol Psychother. 2017;24(2):462–74. https://doi.org/10.1002/cpp.2015.
63. Dahl H-S, Røssberg J, Bøgwald K, Gabbard G, Høglend P. Countertransference feelings in one year of individual therapy: an evaluation of the factor structure in the Feeling Word Checklist-58. Psychother Res. 2012;22(1):12–25. https://doi.org/10.1080/10503307.2011.622312.
64. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Assessing clinician's subjective experience during interaction with patients. Psychopathology. 2014;47(2):111–8. https://doi.org/10.1159/000351589.
65. Pallagrosi M, Fonzi L, Picardi A, Biondi M. Association between Clinician's Subjective Experience during Patient Evaluation and Psychiatric Diagnosis. Psychopathology. 2016;49(2):83–94. https://doi.org/10.1159/000444506.
66. Røssberg JI, Karterud S, Pedersen G, Friis S. An empirical study of countertransference reactions toward patients with personality disorders. Compr Psychiatry. 2007;48(3):225–30. https://doi.org/10.1016/j.comppsych.2007.02.002.
67. Tanzilli A, Gualco I, Baiocco R, Lingiardi V. Clinician reactions when working with adolescent patients: the therapist response questionnaire for adolescents. J Pers Assess. 2020;102(5):616–27. https://doi.org/10.1080/00223891.2019.1674318.
68. Tanzilli A, Lingiardi V, Hilsenroth M. Patient SWAP-200 personality dimensions and FFM traits: do they predict therapist responses? Personal Disord. 2018;9(3):250–62. https://doi.org/10.1037/per0000260.
69. Brody EM, Farber BA. The effects of therapist experience and patient diagnosis on countertransference. Psychotherapy. 1996;33(3):372–80. https://doi.org/10.1037/0033-3204.33.3.372.

70. McIntyre SM, Schwartz RC. Therapists' differential countertransference reactions toward clients with major depression or borderline personality disorder. J Clin Psychol. 1998;54(7):923–31. https://doi.org/10.1002/(sici)1097-4679(199811)54:7<923::aid-jclp6>3.0.co;2-f.
71. Schwartz RC, Smith SD, Chopko B. Psychotherapists' countertransference reactions toward clients with antisocial personality disorder and schizophrenia: an empirical test of theory. Am J Psychother. 2007;61(4):375–93. https://doi.org/10.1176/appi.psychotherapy.2007.61.4.375.
72. Tanzilli A, Colli A, Del Corno F, Lingiardi V. Factor structure, reliability, and validity of the Therapist Response Questionnaire. Personal Disord. 2016;7(2):147–58. https://doi.org/10.1037/per0000146.
73. Shedler J, Westen D, Lingiardi V. The evaluation of personality with the SWAP-200. Milan, Italy: Raffaello Cortina Publisher; 2014.
74. Westen D, Shedler J. Revising and assessing axis II, Part I: developing a clinically and empirically valid assessment method. Am J Psychiatry. 1999;156(2):258–72. https://doi.org/10.1176/ajp.156.2.258.
75. Westen D, Shedler J. Revising and assessing axis II, Part II: toward an empirically based and clinically useful classification of personality disorders. Am J Psychiatry. 1999;156(2):273–85. https://doi.org/10.1176/ajp.156.2.273.
76. Gabbard GO. Transference and countertransference: developments in the treatment of narcissistic personality disorder. Psychiatr Ann. 2009;39(3):129–36. https://doi.org/10.1037/pst0000111.
77. McWilliams N. Psychoanalytic diagnosis: understanding personality structure in the clinical process. 2nd ed. New York, NY: Guilford Press; 2011.
78. Kernberg OF. Severe personality disorders: psychotherapeutic strategies. New Haven, CT: Yale University Press; 1984.
79. Tanzilli A, Muzi L, Ronningstam E, Lingiardi V. Countertransference when working with narcissistic personality disorder: an empirical investigation. Psychotherapy (Chic). 2017;54(2):184–94. https://doi.org/10.1037/pst0000111.
80. Tanzilli A, Gualco I. Clinician emotional responses and therapeutic alliance when treating adolescent patients with narcissistic personality disorder subtypes: a clinically meaningful empirical investigation. J Personal Disord. 2020;34(Suppl):42–62. https://doi.org/10.1521/pedi.2020.34.supp.42.
81. Gabbard GO, Crisp H. Narcissism and its discontents: diagnostic dilemmas and treatment strategies with narcissistic patients. Washington, DC: American Psychological Association; 2018.
82. Ogrodniczuk JS, Kealy D. Interpersonal problems of narcissistic patients. In: Ogrodniczuk JS, editor. Understanding and treating pathological narcissism. Washington, DC: American Psychological Association; 2013. p. 113–27.
83. Ogrodniczuk JS, editor. Understanding and treating pathological narcissism. Washington, DC: American Psychological Association; 2013.
84. Ronningstam E. Alliance building and narcissistic personality disorder. J Clin Psychol. 2012;68(8):943–53. https://doi.org/10.1002/jclp.21898.