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Patient factors predict therapists' emotional countertransference differently depending on whether therapists use transference work in psychodynamic therapy

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Abstract

Objective: Recently, studies have reported systematic relationships between the therapists' emotional response/countertransference (CT) during therapy and a variety of patient characteristics, speaking to the communicative potential of CT. Within an RCT assessing the role of transference work (TW) in psychodynamic therapy, we investigated whether therapist CT was related to patients' pre-treatment interpersonal problems, degree of personality pathology and motivation for psychodynamic therapy. Secondly, we explored if these relationships depended on whether the therapists used TW or not in sessions. **Method:** One hundred outpatients were treated with psychodynamic psychotherapy (with or without TW) for one year. Their therapists' emotional reactions after sessions (CT) were assessed with the Feeling Word Checklist-58 (FWC-58). **Results:** Four subscales of the FWC-58; Inadequate, Confident, Disengaged and Parental feelings were differentially predicted by patient characteristics. Some of the associations depended on treatment condition such that degree of PD pathology was associated with therapists feeling more inadequate in the non-TW-group. Patients' motivation for treatment was associated with less disturbing CT feelings, such as Inadequate and Disengaged CT (the latter especially in the TW group), and feeling more Confident CT. **Conclusion:** Patient factors predict therapists' emotional countertransference differently depending on whether therapists use transference work in psychodynamic therapy. **Trial registration:** [ClinicalTrials.gov identifier: NCT00423462](https://clinicaltrials.gov/ct2/show/study/NCT00423462).

Keywords: countertransference; therapeutic relationship; transference work; Feeling Word Checklist

Clinical and Methodological Significance of this Article:

Recently, several studies have reported systematic relationships between the therapists' emotional response during therapy and a variety of patient characteristics assessed prior to treatment, speaking to the communicative potential of these emotions, which can be used to understand the patient and improve the therapy relationship. In the current study, we found that there was a tendency that increased patient pathology evokes, or is related to, a more negative emotional response in psychotherapists, while patient motivation for change relates to a decrease of these feelings and an increase

of more positive feelings (such as feeling confident). Working with the transference may have had a protective effect against negative CT. Thus, our findings suggest that transference work provides the therapist with a useful tool.

Introduction

Psychotherapy outcome depends to a large extent on relational factors, such as the quality of the therapeutic alliance (Flückiger et al., 2018) and the activation of emotion in the patient (Peluso & Freund,

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2018), as well as in the therapist (e.g., Dahl et al., 2014). In effective therapeutic work, the therapist's facilitative interpersonal skills are foundational (Anderson et al., 2016; Goldberg et al., 2020). To make optimal use of these skills, the therapist needs a fine-tuned apparatus to perceive the overt and covert affective signals of the patient. This capacity forms not only the basis for empathy (Kohut, 1984) but also for grasping the dynamics of the patient's internal relational world and relationship history. According to psychodynamic theory, these dynamics may come forth via the patient's *transference* and can be perceived through a particular awareness of one's own emotional response to the patient, or the therapist's *countertransference* (Gullestad & Killingmo, 2020). Undoubtedly, the therapist's emotions during therapy also reflect the therapist's own feeling states and internal relational dynamics. This was emphasized in Freud's (1912) original definition of countertransference (CT). His idea was that a patient's *transference* might evoke a *counter-transference* reaction in the therapists; a displacement of feelings or expectations stemming from their personal (unresolved) issues onto the patient, which would hinder them in their work. After Freud, various theorists and researchers have taken different stances as to what should be included in a definition of CT. A later definition of CT, the "integrative definition" (Hayes et al., 2018; Gelso & Hayes, 2007) concurs with Freud's classical definition but broadens CT to include reactions to both transference and non-transferential phenomena of the relational matrix. Yet another and even more inclusive definition, later termed the "totalistic definition" (Kernberg, 1965), was first addressed by Heimann (1950) and Little (1951), and implied that countertransference includes the whole range of (conscious and unconscious) emotions, fantasies, and thoughts that therapists experience in their therapeutic work with patients. In this definition, CT is seen to comprise those emotions that predominantly stem from the therapists' own personal material as well those which primarily stem from the patient as a form of "projective communication" (e.g., Bion, 1962), or the emotions that arise as a response to the interpersonal "pull" of the patient (Sandler, 1976). Even if communicating something about the patient, it is now commonly held that the therapist would need a "personal hook" (Gabbard, 1995) for the emotional CT response to materialize, creating a constant challenge for the therapist to sort this out (Ogden, 2004).

Some theorists also propose a distinction between *subjective* and *objective* CT (e.g., Winnicott, 1949), the former being those responses that reflect the particular therapist's own inner world and personal history (specific for one particular therapist), and

the latter being what most therapists would feel in response to a particular patient. Empirically, studies have relied on therapists' self-reports about how they generally feel or respond to a specific patient once or twice during a treatment period (e.g., Tanzilli et al., 2017). Others have asked therapists to report how they feel or respond to a particular patient after each session of a treatment period, reflecting a feeling state in the moment as varying from session to session (e.g., Dahl et al., 2012; Lindqvist et al., 2017). In an approach which combines these, Kiesler (2001) proposed that CT can be studied empirically as the therapist's experiences and actions with a particular client which reflect "deviations from baseline", i.e., when a therapist experiences *more or less* of a feeling state than what is typical for a given therapist. In this conception, CT stems from the therapist him-/herself (their typical way of responding, i.e., subjective CT), but may also vary as a function of the interaction with the patient (objective CT). In line with this thinking, we investigated whether therapist's *atypical* emotional responses after sessions that is, the *deviation from baseline* of feeling after sessions were a function of several pre-treatment patient factors and the therapist's technique. To empirically study potential patient influences on therapist CT, researchers have examined if there are systematic relationships between patient characteristics (types of pathology/clinical diagnoses) and therapists' emotional responses (Putrino et al., 2019). In individual psychotherapy of different theoretical orientations, Lingardi et al. (2015) found associations between patient's symptom severity and therapist emotional response during treatment. In clinical theory, personality pathology, e.g. Borderline Personality Disorder (BPD), is proposed to elicit powerful CT reactions because of the intense, primitive, and often regressive transference typically exhibited by these patients (Breivik et al., 2020; Kernberg, 1984). Indeed, strong associations between therapist CT and patient PD have also been observed in empirical studies. Some of these studies have explored therapists' feelings in relation to clusters of PD disorders (e.g., Røssberg et al., 2007). A few studies have also looked at PD dimensionally in terms of the number of fulfilled PD criteria and CT feelings (e.g., Dahl et al., 2012). One study found that BPD in patients was related to therapists feeling more helpless, overwhelmed and overinvolved (Colli et al., 2014). Moreover, Tanzilli et al. (2017) found that patients' Narcissistic-type PD evoked feelings of anger and annoyance, a sense of being devalued and criticized by the patient, and feelings of helplessness, inadequacy and ultimately disengagement. Again, bringing the clinical,

theoretical, and empirical literature together, therapists seem to report more negative feelings when working with more severely disturbed patients (Tanzilli et al., 2017). In our current study we explored whether patient's PD pathology might give rise to different, i.e., more negative, CT feelings in therapists depending on therapists' use of transference work in psychodynamic therapy.

Another aspect of the patient's relational functioning typically focused on in psychodynamic treatments is the patients' interpersonal problems which affect the therapy process and presumably evoke distinguishable feelings in the therapist. In the current study, the patients' interpersonal problems were measured via the IIP-64 (Horowitz et al., 2000), which is based on the interpersonal theory of personality (Sullivan, 1953) and its operationalization, the interpersonal circumplex (IPC). In this framework, personality is seen as an intrinsically interpersonal product, formed through interactions with significant others, and manifested as mental representations containing the respective needs for *intimacy* and *control* (Sullivan, 1953). These ideas were later operationalized in the IPC (e.g., Leary, 1957) and further developed to measure interpersonal *problems* through the Inventory of Interpersonal Problems—Circumplex (Horowitz et al., 2000). The eight distinct dimensions measured by this inventory (Domineering, Vindictive, Cold, Socially Avoidant, Non-assertive, Exploitable, Overly nurturant, and Intrusive) have shown meaningful relationships to other dimensions of psychopathology (e.g., Pincus & Wright, 2011), as well as demonstrating consistent associations with ratings of the working alliance and the outcome of psychotherapy (e.g., Renner et al., 2012). In accordance with interpersonal theory there are reasons to suggest that the type of interpersonal problem (e.g. of being Intrusive or Vindictive) would represent different “pulls” in the relational matrix, and as such might evoke distinctly different emotional reactions in the therapist.

On the other side of the spectrum, we were also interested in investigating how a resourceful aspect of the patient's pretreatment functioning might affect the therapist's CT. Our chosen variable for this purpose was *motivation for psychodynamic treatment* which was operationalized in terms of a desire for self-understanding and change, and reasonable expectations about what can be achieved in therapy. Variants of this construct (i.e., positive and realistic expectations of change) have been demonstrated to constitute a salient predictor of outcomes across theoretical perspectives (for a summary, see Constantino et al., 2018). It would be expected that motivation is related to less negative and/or more positive CT in therapists.

To sum, in the current study we explored the associations of therapist CT and a range of patient characteristics (degree of PD pathology, interpersonal problems and readiness to change/motivation for psychodynamic therapy), selected on the basis of theory and their known empirical links to psychotherapy process and outcome. We also examined if these relationships were different depending on whether the therapists used transference work (TW) or not in psychodynamic psychotherapy. As a core intervention in psychoanalytic or psychodynamic therapies, TW (i.e., the explicit focus on how the patient might experience the therapy relationship in line with his or her internalized image of self and others) is used to enable a recognition of, and working through of (dysfunctional) relational patterns, to promote a more flexible and healthy way of relating (Gullestad & Killingmo, 2020). Since patients likely are unaware of their transference responses, a key instrument in this kind of work is the therapist's own feelings. One may say that the therapist becomes aware of the patients' relational functioning via his or her CT. Indeed, in psychoanalytic writings aligning with a concept of CT as containing information about the patient's unconscious, CT is considered to be “the royal road to the internal world (or internal object relations) of the patient” (Gullestad & Killingmo, 2020, p. 128). While TW (or working in the here-and-now) gives a therapist access to information about the patient that would otherwise be missed, it might also act as a way of channeling the therapist's own emotions that arise as a response to the patient's emotional ways of relating. In essence, transference work invites patients to bring in their relational history and outside experiences into the ongoing relationship with the therapist. It is thus reasonable to expect that any association between a patient's psychological functioning (i.e. specific interpersonal problems or motivation for change) and therapist CT might differ when working with the transference or not. Posing these questions in our current study, we used data gathered through a dismantling, randomized controlled trial studying the effect of TW in time-limited psychodynamic therapy (see Høglend et al., 2006). All aspects of the psychodynamic treatments were equal, and the therapists were the same in both treatment groups, thus in large part controlling for therapist differences or allegiance in the two conditions. However, half the patients were randomized to psychodynamic therapy with TW and the other half to psychodynamic therapy without an explicit focus on transference. The general findings of this research program showed no mean difference in patient outcome between the two treatment groups. However, patients with a low quality of object

relations and more PD did better in the transference group (Høglend et al., 2006, 2008, 2010). The program also collected data on the therapists' feelings after each session using the Feeling Word Checklist (FWC-58; Røssberg et al., 2003). The items of the FWC-58 have shown to be reliably differentiated as four distinct dimensions: Confident, Inadequate, Parental and Disengaged feelings (Dahl et al., 2012). In turn, these factors have been shown to interact with patient pathology in contributing to the long-term effects of treatment (Dahl et al., 2014, 2016, 2017). For example, increased levels of therapists' Inadequate and Disengaged CT were more detrimental for patients when treated with TW, than without TW, particularly so for patients with a history of relational problems. Patients with more relational pathology seem extra vulnerable to their therapist experiencing negative affect when they work explicitly with the therapeutic relationship (Dahl et al., 2016, 2017).

Aims and Research Questions

In this study, we investigated whether there are systematic relationships between patient factors and therapist CT in the TW versus the non-TW condition. Our operational definition of CT shares commonalities with a totalistic definition proposing that CT can communicate something about both the patient and the therapist, but with some important premises to make it viable to empirical scrutiny. When asking therapists to self-report their feeling states we only capture what the therapists become aware of, acknowledge, remember and are willing to report after each session with a patient (see Dahl et al., 2012). Hence, we do not purport to study CT in all its breadth, rather we study one limited aspect, that of the conscious, emotional response which therapists report after each session with a given patient. As mentioned, since every therapist has their own idiosyncratic way of feeling and of reporting their inner states on a questionnaire, to capture therapist emotional CT in this study we aimed to assess a given feeling state when the therapist *deviated* from his or her habitual level of responding (see Kiesler, 2001), that is, their feelings which deviated from their aggregated score across all their patients (i.e., at least those enrolled in the study) and their treatment processes. Hence, we studied the within-person effects of therapist CT, using person-mean centering (Wang & Maxwell, 2015) to disaggregate the variability within therapists in their emotional responses to the FWC-58 after sessions to see if these were differently predicted by our chosen patient variables. First, we investigated if the

three patient variables (1) level of PD pathology (i.e., total number of PD criteria fulfilled in the SCID-II); (2) interpersonal problems (as measured via the IIP-64); and (3) Motivation for psychodynamic psychotherapy, predicted therapist CT responses (i.e., atypical CT responses as reported on the four dimensions of the FWC-58) differently. Secondly, we tested if these relationships were moderated by the use of transference work in sessions (see specific definition of this below), i.e., if the associations between patient characteristics and therapist CT depended on whether patients were treated with psychodynamic therapy with TW or without TW.

Method

Data

Data for this study were collected as part of the clinical trial, "First Experimental Study of Transference" (FEST), which has been described in detail elsewhere (Høglend et al., 2006, 2008). The main objective in the FEST trial was to examine the effects of TW in a one-year psychodynamic treatment. After completion of the pre-treatment assessments, patients were randomized to two groups, either psychodynamic psychotherapy with use of TW or to psychodynamic psychotherapy without TW. The Regional Ethics Committee, Health-region 1, Norway, approved the study protocol of the FEST (FEST307/95). Registration: ClinicalTrials.gov Identifier: NCT00423462. URL: <http://clinicaltrials.gov/ct2/show/NCT00423462?term=FEST&rank=2>.

Participants

Patients. A total of 122 were referred to therapy by primary care physicians, private specialist practitioners, and public outpatient units, and assessed for eligibility by the therapists who also constituted the research team. Patients with psychosis, bipolar illness, organic mental disorder, or substance abuse were excluded from participating in the study. Patients with mental health problems that caused long-term inability to work (>2 years) were also excluded. One hundred patients were found eligible for the main study and were treated as part of it. Written informed consent was obtained from each participant. The patients received 45 min of weekly psychotherapy sessions for up to one year. After 13 patients had started therapy in the project, the research group decided to incorporate a questionnaire on countertransference (i.e., the therapists'

feeling states when working with their patients as measured with the FWC-58). Hence, there are CT data from the therapists working with a total of 87 patients. Their average treatment length was 33 sessions. The mean age of these patients was 37 years old, 59% ($n=51$) of the patients were females. 80% ($n=79$) were employed even if some were on temporary sick leave. There were 72 patients who fulfilled criteria for one or more Axis I diagnosis, of which mood disorders and anxiety disorders were the most frequent. Approximately 47% ($n = 41$) fulfilled the criteria for one or more personality disorders (PD). Number of fulfilled SCID II criteria ranged from 0-35, with a mean of 10.

Therapists. Patients were assigned to one of seven therapists based on availability. These were five men and two female therapists. They had 10–25 years of experience in practicing psychodynamic psychotherapy. Six were psychiatrists and one was a clinical psychologist. Four were fully trained psychoanalysts. This study does not comprise additional therapist characteristics.

In the pilot phase of this study, the therapists were trained in using a treatment manual of the principles (not step-by-step procedures) for psychodynamic therapy with and without transference work (Høglend, 1990). The therapists practiced for up to four years in order to enable competent provision of treatment with a moderate frequency of transference interpretations (1–3 per session) and treatment without such interpretations, with equal ease and mastery. Each therapist treated 10–17 patients. All the therapists treated patients in both treatment groups.

Treatment. All patients received psychotherapy based on psychodynamic treatment principles, such as focus on affects, exploration of warded off material (defenses), current relationships, past relationship and interpretations of wishes, needs, and motives. A treatment manual (in Norwegian) was published in 1990 (Høglend, 1990). For the transference group, the following specific techniques were prescribed (= quotes from therapy sessions in FEST): (a) the therapist was to address transactions in the patient-therapist relationship (“So here we are today”); (b) the therapist was to encourage exploration of thoughts and feelings about the therapy and therapist (“You miss getting clear advice and feedback from me?”); (c) the therapist was to encourage the patient to discuss how he/she believed the therapist might feel or think about him/her (“How do you think I see you?”); (d) the therapist was to include himself explicitly in interpretive linking of dynamic

elements (conflicts), direct manifestations of transference, allusions to the transference (“Could it be that you are afraid I will get disappointed if you told me that you are getting worse, kind of like you are afraid that your boss will be disappointed?”); and (e) the therapist was to interpret repetitive interpersonal patterns and link these patterns to transactions between the patient and the therapist

(So, coming late to the session with me reminds you of how you felt discredited by your father if you were late, and it sounds like the same happens in relation to your boss, as you told me last week).

In the non-TW group all aspects of the treatment were similar to the transference work group, except the therapists did not explicitly work on the here-and-now relationship between therapist and patient (i.e., did not use interventions such as the ones mentioned above). Treatment fidelity based on ratings from a total of 452 sessions on therapists’ general interpersonal skill, supportive techniques, as well as the specific use of transference work was assessed. Only TW differed significantly between the two groups (Høglend et al., 2006).

Measures

Feeling Word Checklist-58. To assess the therapist’s countertransference, we used the Feeling Word Checklist -58 (FWC-58; Røssberg et al., 2003) which was designed to measure CT in relation to patient work. There are different versions of the FWC, varying in number of items (from 20-58). Some versions use a Likert scale, others a simple “yes/no” to report whether a given feeling is present (see Lindqvist et al., 2017, for a summary of the questionnaire forms). In the current study, we used the FWC-58, which is a 58 item self-report measure in which therapists rate their degree of emotional responses toward a patient on 5-point Likert scales ranging from “nothing” (0) to “very much” (4). In the present study the questionnaire was labeled “Countertransference” and the therapists were asked to rate to what degree they had experienced 58 feeling states (such as helpful, happy, angry, important, empathic, confused, stupid, guilty, inadequate, bored, enthusiastic and so on), in the session they had just had with a given patient. The therapists each filled in on average 387 questionnaires, ranging from 219 to 570, and a mean of 32 questionnaires ($SD = 8.5$) from each patient over the study period. In previous publications (e.g., Dahl et al., 2012), four clinically meaningful factors emerged from principal component analyses of these data. These were termed: (1) Confident (e.g., Attentive, Helpful); (2)

Inadequate (e.g., Insecure, Helpless); (3) Parental (e.g., Affectionate, Important); and (4) Disengaged (e.g., Bored, Tired off). There is still no consensus about which FWC version best captures CT phenomena. Lindqvist et al. (2017) found that all psychometric studies on the FWC have found at least one factor reflecting positive feelings of engagement and interest, and at least one reflecting negative feelings of disengagement and/or frustration. Variants of these, such as the dimensions used in the current study, have in turn shown to demonstrate meaningful associations with long-term patient outcomes (Dahl et al., 2014, 2016, 2017) thus providing evidence for the external and construct validity of the CT dimensions measured via the FWC 58.

Personality disorder criteria (SCID II). The Structured Clinical Interview for DSM-III-R (SCID-II) was used to assess personality disorder (PD) or Axis II diagnoses (Spitzer et al., 1990) in the sample. Each PD is associated with a set of items in SCID-II that assesses different manifestations of a given personality disorder (e.g., Avoidant PD). During the interview each of these items are scored as either “absent”, “sub-threshold”, “true”, or “inadequate information to code.” The fulfilled personality disorder criteria for each patient were summed. As is common practice in several studies (e.g., Solbakken et al., 2012), this dimensional sum score across different types of PD was used to represent *degree of PD pathology*. All therapists had prior training in using SCID-II, but their interrater reliability was not assessed as part of this study. Hence, in order to minimize potential false positive and negative PD diagnoses, the General diagnostic criteria for any personality disorder, the SCID-II interview and all available information about the patients (e.g., data from the clinical history from the in-depth pre-treatment assessment interview, as well as data on education, social functioning and working career) were discussed by the patient’s therapist and at least one other independent clinician in the research group, until consensus about nature and degree of PD pathology was reached. Only two patients in the sample did not fulfill any PD criteria at pre-treatment.

Inventory of interpersonal problems- circumplex version (IIP-64). The IIP-64 (Alden et al., 1990) is a self-report instrument designed to assess interpersonal problems in eight domains (IIP octants): Domineering, Vindictive, Cold, Avoidant, Non-assertive, Exploitable, Overly nurturant and Intrusive. These are situated around the circumplex, with two main dimensions representing the orthogonal axes of

Affiliation and Control. The inventory comprises 64 items that ask about “things you find hard to do with other people” or “things that you do too much” and was administered to the patients before treatment. Each item is rated on a five-point scale ranging from 0 (“not at all”) to 4 (“extremely”). The test-retest reliability, internal consistency and construct validity of the IIP- 64 have been demonstrated to be very good or excellent (see Horowitz et al., 2000). The Cronbach’s alpha at pretreatment was 0.85 in this study. Due to very high correlations (above .70) between neighboring octants around the circumplex in our sample, in line with other studies (Hersoug et al., 2009; Horowitz et al., 2000), we collapsed the Vindictive, Cold and Socially Inhibited octants into one dimension called “IIP Hostile”, and the Nonassertive, Overly Accommodating and Self-sacrificing octants into another dimension called “IIP Over-Friendly”, making two distinct variables.

Motivation. Before randomization, each patient took part in an interview assessing their motivation for psychodynamic therapy adapted from the recommendations of Sifneos (1992) and Malan (1976). At least three clinicians rated the interview using the Motivation Scale (Høglend, 1996). The scale has a range from the very low motivation (1) to very high (8). Several of Sifneos (1972) criteria were used to define motivation, among them (a) Psychological awareness (an awareness that symptoms can be psychological signals or expressions); (b) Desire for self-understanding; (c) Desire for change; and (d) Reasonable expectations about what can be achieved in therapy. Psychological awareness ranged from 1–2 for “no awareness”, 3–4 for “ambivalence about cause of symptoms”, and 5–8 for a “clear psychological explanation of symptoms”. Desire for self-understanding was rated as 1–2 for a “passive expectation of relief”, 3–4 if there was “ambivalence about need for self-understanding”, and 5–8 if there was “clear desire for self-understanding and active attempts to make connections between conflicts, problems, and symptoms”. Desire for change was rated 1–2 if there was “expectation of change by therapist”, 3–4 if there was “ambivalence about need for own activity”, and 5–8 if there was “clear understanding of need to change own attitudes and coping style”. Expectation of change was rated 1–2 if there was “hopelessness or wish for magic cure”, 3–4 if “overly pessimistic/optimistic”, and 5–8 for a “realistic evaluation of problems and change possibilities”. The average scores across raters are used in this study. The mean of the present sample was 5.39 ($SD=.56$) (possible

range is 1–8). The inter-rater reliability for the average score of three independent raters was 0.77 (Marble et al., 2011). Predictive and convergent validity of the motivation scale has been established in previous studies (Barth et al., 1988; Høglend et al., 1992). Studies have shown that motivation /positive expectations have been found to be a strong predictor of outcomes (see Constantino et al., 2018). In our study, motivation showed to be a moderator of outcome: Highly motivated patients showed a better long-term positive effect of transference work compared to those with low motivation (Marble et al., 2011).

Statistical Analyses

Statistical analyses were conducted using SPSS 26 for Windows (IBM SPSS Inc). In line with recommendations from Wang and Maxwell (2015), we used person-mean centering to establish within-person effects, i.e., therapists’ deviation from their own mean or baseline (based on Kiesler’s, 2001 recommendation). We first calculated the mean value for each therapist across all their therapies (10–17 patients s per therapist) on each of the four FWC–58 subscales (Confident, Inadequate, Parental, and Disengaged). We then subtracted this mean from the CT reported in each treatment with a given patient according to this equation:

$$\text{Mean CT_aggr. (across all patients/sessions) -}$$

$$\text{Mean CT_dissaggr. (with one specific patient across treatment sessions of this patient)}$$

Hence, the new CT variables are centered on mean = 0 and a positive CT-value indicates a stronger emotional reaction than what is typical, and a

negative CT-value a weaker reaction that what is typical for the specific therapist. Note that every therapist-patient dyad is represented with one specific therapist CT score (i.e., the deviation of the therapist’s feeling with that patients, which could be small/large; positive/negative).

Next, we assessed whether the four (atypical) emotional CT responses (Inadequate, Parental, Confident; Disengaged) were predicted by the three sets patient variables, entered one by one along with the interaction term IV*Treatment condition, thus assessing if the relationship depended on TW (coded as 1) vs non-TW (coded as 0) in three regression models testing the prediction of each CT dimension. Since the design of the study involved nesting, we first opted for a multilevel modeling approach (MLM) with the patient variables entered at level 1 and therapist’s dyadic response (one CT response for each dyad with a patient) entered at level 2 in a hierarchy using the option Linear Mixed Models (LMM) in SPSS version 26. However, since therapists were few (n=7) there were problems with convergence and since the preliminary results of the LMM procedure were the same as in the standard regression reported below, we opted to report the results of the latter. We also report R² as measure of the models’ explained variability for each CT dimension. Skewness and kurtosis values indicated that all variables were normally distributed.

Results

The idiosyncratic FWC-58 scores are depicted in Table I. The mean values on the CT subscales ranged from lowest mean score (Therapist 1), who scored .07 to the highest mean score (Therapist 3), who scored 2.34, both on the Confident CT subscale. In Table II the descriptives (means, standard

Table I. Therapists’ (1–7) mean value across their treatment periods on each FWC-58 subscale.

Therapist	Confident CT Mean (SD)	Inadequate CT Mean (SD)	Parental CT Mean (SD)	Disengaged CT Mean (SD)
1 (n = 16)	.07 (.08)	.12 (.08)	.25 (.23)	1.9 (.45)
2 (n = 13)	.25 (.08)	.21 (.17)	.08 (.08)	.89 (.42)
3 (n = 12)	2.34 (.34)	1.11 (.04)	.72 (.38)	2.16 (.27)
4 (n = 12)	.19 (.07)	.04 (.06)	.11 (.06)	.11 (.08)
5 (n = 7)	.32 (.23)	.05 (.04)	.03 (.02)	.16 (.14)
6 (n = 15)	.82 (.41)	.25 (.19)	.35 (.23)	.54 (.41)
7 (n = 14)	.19 (.23)	.10 (.07)	.12 (.11)	.24 (.17)
Overall (n=87)	.59 (.78)	.27 (.39)	.26 (.29)	.93 (.84)

Note: n in this case means number of observations/patients per therapist.
CT = Countertransference feelings on the FWC-58.

Table II. Descriptives of the independent variables/patient characteristics.

	Mean	SD	1	2	3	4
1 PDCrit	9.85	7.27	–			
2 IIP Hostile	.77	.59	.40**	–		
3 IIP Over-Friendly	1.64	.77	.24*	.27**	–	
4 Motivation	5.42	.61	–.37**	–.41**	–.12	–

Note: number of SCID-II criteria. IIP Hostile = Vindictive + Cold + Socially Inhibited subscales of the IIP-64/3; IIP Overly-Friendly = Nonassertive + Overly Accommodating + Self-sacrificing subscales of the IIP-64/2. Motivation = Motivation for psychodynamic therapy, as assessed in a pre-treatment interview. **Correlation is significant at the 0.01 level (2-tailed). *Correlation is significant at the 0.05 level (2-tailed)

deviations and intercorrelations) of the independent patient variables (PD criteria; IIP Hostile; IIP Over-friendly; and Motivation for psychodynamic psychotherapy) can be found. These statistics (descriptives of IVs) show that while several of the constructs are significantly related, their intercorrelations never exceed .40, indicating that we study distinctly different constructs.

We examined how the patient variables predicted therapist CT response in the two treatment groups using linear regression analyses. Note that we first tested the regression equations using multilevel modeling (MLM) in Linear Mixed Models (LMM; SPSS) since our data were nested (i.e., patients were nested within therapists). However, problems with convergence made the results unstable and thus we report findings of the standard regression analyses. Note also that since we use person-mean centering, every therapist-patient-dyad has a unique CT score, and the therapist CT is already disaggregated at the individual patient level.

We then performed a series of 12 regression analyses to examine the effects of the patient characteristics and their interaction with treatment condition in one model for every patient IV for each of the four CT subscales. The findings indicated that there were notable differences in the dynamics taking place between patient characteristics and therapist CT depending on treatment condition. There was also differences between relationships of patient IVs and therapist CT depending on type of CT in the sample. Lastly, the level of explained variability (R^2) varied greatly.

First, PD had an overall positive association with Inadequate CT (Stand. B = .58, p = .000) and a significant interaction between the level of patients' PD pathology and treatment condition, to the effect that when patients with more criteria fulfilled on the SCID II were treated without TW, their therapists

reported more Inadequate CT (Stand. B = -.43, p = .039). The R^2 of this model was .23. Increased Motivation was associated with less Inadequate CT (Stand. B = -.35 p = .017), while more IIP Hostile was related to feeling more Inadequate (Stand. B = .53, p = .002).

Second, more interpersonal problems of hostility (IIP Hostile) was associated with less Confident CT (Stand. B = -.46, p = .007). Motivation was positively related to Confident CT in both groups (Stand. B = .40, p = .009). There was no significant interaction between patient variables and Confident CT. R^2 of the models predicting Confident CT ranged from .04 to .23.

Third, there was a significant interaction between patient Motivation and Disengaged CT, to the effect that therapists experienced feeling more Disengaged if patients were less motivated in the TW condition (Stand. B = .37 p = .017, R^2 = .18.). Other than this effect, none of the patient variables were related to Disengaged CT.

In regards to Parental CT, only IIP Hostile showed a (negative) association (Stand. B = -.35, p = .048, R^2 = .09) and the models explained little variance in this dimension CT. See Table III for all findings of the regression analyses.

Discussion

Patients' relational behaviors in psychotherapy can give rise to distinct emotional responses in the therapist. These feelings can be challenging, even disturbing, but they may provide useful information about the internal dynamics of the patient (Gullestad & Killingmo, 2020; Sandler, 1976). Indeed, several recent empirical investigations (e.g., Breivik et al., 2020; Colli et al., 2014; Lingardi et al., 2015; Putrino et al., 2019; Tanzilli et al., 2017) have revealed systematic patterns of associations between patients' pre-treatment functioning and therapists' feelings reported after therapy sessions, suggesting that, to some extent, therapists' in-session feelings mirror the patient's internal psychological experiences (Putrino et al., 2019). The relationship between therapists' emotional states and the patients' psychological functioning may also depend on the therapist's use of therapeutic methods and types of intervention. To our knowledge, this is the first empirical study on whether patients' characteristics predict therapists' emotional countertransference differently depending on a specific therapeutic intervention, in this case, on transference work (i.e., working in the here-and-now/immediate therapy relationship) in a randomized trial of psychodynamic psychotherapy (Høglend et al., 2008). Specifically, we explored

Table III. Therapist's emotional countertransference: Patient variables and treatment condition as predictors.

Countertransference		R^2	St. β	F	p	
Inadequate CT						
Model 1	Whole model	.23		7.75		
	Treatment condition		.50		.004	
	PD criteria		.58		.000	
Model 2	PD*Treatment		-.43		.039	
	Whole model	.20		3.88		
	Treatment condition		.65		.014	
	IIP Hostile		.53		.002	
	IIP Over-Friendly		-.02		.892	
	IIP Hostile*Treatment		-.40		.088	
Model 3	IIP Over-Friendly*Treatment		.25		.377	
	Whole model	.25		9.28		
	Treatment condition		.22		.026	
	Motivation		-.35		.017	
	Motivation*Treatment		.10		.510	
Confident CT						
Model 1	Whole model	.04		1.01		
	Treatment condition		-.06		.737	
	PDCriteria		-.27		.111	
	PD*Treatment		.19		.421	
Model 2	Whole model	.18		3.42		
	Treatment condition		-.27		.307	
	IIP Hostile		-.46		.007	
	IIP Over-Friendly		.055		.732	
	IIP Hostile*Treatment		.092		.693	
Model 3	IIP Over-Friendly*Treatment		.40		.154	
	Whole model	.23		8.10		
	Treatment condition		.12		.237	
	Motivation		.40		.009	
Model 3	Motivation*Treatment		-.10		.503	
	Disengaged CT					
	Model 1	Whole model	.02		.53	
Treatment condition			.18		.347	
PDCriteria			.20		.234	
PD*Treatment			-.23		.324	
Model 2	Whole model	.12		1.99		
	Treatment condition		.32		.236	
	IIP Hostile		.30		.089	
	IIP Over-Friendly		.29		.086	
	IIP Hostile*Treatment		-.10		.684	
Model 3	IIP Over-Friendly*Treatment		-.33		.263	
	Whole model	.18		6.08		
	Treatment condition		-.01		.897	
	Motivation		-.07		.655	
Model 3	Motivation*Treatment		.37		.017	
	Parental CT					
	Model 1	Whole model	.02		.617	
Treatment condition			-.11		.584	
PDCriteria			-.05		.770	
PD*Treatment			.24		.299	
Model 2	Whole model	.09		1.59		
	Treatment condition		-.19		.491	
	IIP Hostile		-.35		.048	
	IIP Over-Friendly		-.06		.728	
	IIP Hostile*Treatment		.08		.748	
Model 3	IIP Over-Friendly*Treatment		.24		.413	
	Whole model	.06		1.81		
	Treatment condition		.07		.517	
	Motivation		.16		.319	
Model 3	Motivation*Treatment		-.10		.544	

Note: Treatment condition: Transference work and non-transference work. PD criteria = number of SCID-II criteria. IIP Hostile = Vindictive + Cold + Socially Inhibited subscales of the IIP-64/3; IIP Overly-Friendly = Nonassertive + Overly Accommodating + Self-sacrificing subscales of the IIP-64/3. Motivation = Motivation for psychodynamic therapy, as assessed in a pre-treatment interview. Bold = p -value is significant at the 0.01 or 0.05 levels.

whether emotional countertransference, which deviated from the therapists' baseline, in a group of experienced psychodynamic therapists were differentially affected by the patients' level of personality pathology, type of interpersonal problems, and motivation for change, depending on whether the therapists explicitly focused on TW or not. TW in this sense is intended to enable the patient and therapist to become more aware of the distinction between what is real (i.e., the therapist's contribution) and what is influenced by the patient's past experience (Høglend & Gabbard, 2012), thus involving the *therapist as a person* to a greater extent than when TW is not used. Hence, as argued before, it is plausible that TW affects the relationship between patients' pathology and the therapist's emotional response in sessions. In fact, our findings indicate that this is true; there were some important differences in the dynamics taking place between patient characteristics and therapist CT depending on treatment condition. When patients had more PD pathology, their therapists generally felt more Inadequate CT (i.e., experienced more than their usual level of inadequate feelings), especially when they were treated without TW. This model explained a sizable proportion of the variation in therapist Inadequate CT. This finding is reminiscent of prior findings by Colli et al. (2014) and Tanzilli et al. (2017) that therapists experience more disturbing CT when working with patients who suffer from various PDs. However, working with the transference may have had a protective effect against negative CT. In turn, this may partly explain why TW seems to be more productive for patients with personality pathology, a finding which was previously noted in the current research program (Høglend et al., 2008, 2010). Our findings suggest that transference work provides the therapist with a useful tool too. We may assume that if a therapist feels devalued by a patient and uses this feeling as basis for linking it to the here-and-now, e.g., in a transference interpretation, then the feeling is somehow altered by the therapeutic intervention, thus, attenuating the association between patient PD and the response of the therapist. It is noteworthy that increased PD, often representing more intense dysphoric affect and more primitive defenses (see Kernberg, 1984), increased the therapists' feelings of helplessness and inadequacy, even for this group of highly experienced psychodynamic therapists/psychoanalysts who had long term training, personal therapy and professional experience to draw from. These feelings are indeed described as typical states evoked in therapists when working with personality disorder patients, e.g. BPD (Colli et al., 2014), while more narcissistic problems evoke a sense of being devalued and criticized (Tanzilli et al., 2017).

We do not know if therapists in the studies of Colli and Tanzilli and co-workers actively used the here-and-now with their patients, but our findings suggest to us that it may be a viable strategy. We also observed that more hostility in patients, as assessed with the collapsed Cold/Vindictive/ Socially Inhibited IIP-64 subscales, was related to therapists feeling less confident after sessions. This pattern of interpersonal problems in patients might also come forward in the form of devaluing the therapist and being less willing to accept the therapist's interventions, and so the finding is not surprising given the negative complementarity hypothesis of interpersonal dynamics in psychotherapy (e.g., Kiesler & Watkins, 1989) and prior findings by Colli et al. (2014) and Tanzilli et al. (2017) who reported similar patterns.

Another finding in the current study was that a more resourceful aspect of the patient's psychology, namely their *motivation for treatment* (i.e., a healthy expectation and desire for change and self-understanding) was inversely related to therapists feeling Disengaged and Inadequate and positively related to feeling Confident. Patients with a stronger motivation to engage in therapy and make psychological connections are likely more open to therapeutic interventions that connect earlier relations with the here-and-now, creating a fruitful and collaborative climate where the therapist also feels a sense of mastery and engagement. Moreover, when working with the transference, therapists felt less Disengaged CT if patients had been assessed to have more motivation. These findings imply that when one is instructed to focus explicitly on the here-and-now with a patient who is generally more motivated for working psychodynamically, this seems to protect the therapist from feeling Disengaged. Together these findings are not surprising. What is fascinating, however, is that the relational dynamics regarding the two participants' inner feelings actually are observable at this level, underscoring the mutual, reciprocal nature of the therapy relationship and therapist CT (Ogden, 2004).

Overall, we see what might be a tendency that increased patient pathology evokes, or is related to, a more negative CT response while Motivation relates to a decrease of these feelings and an increase of more positive feelings (such as feeling Confident). These findings fit well with the conclusion of Colli and co-workers (2014) that the more PD pathology of the patient, the stronger the CT of the therapist. We could add; especially when therapists do not work with the transference or the relational dynamics going on in the patient-therapist relationship.

As discussed above, therapists' emotions arising as part of their engaging with patients can have numerous sources, such as the therapist's own personal life

and relational history (Tishby & Vered, 2011), current mood and influences of their own emotional burdens (Nissen-Lie et al., 2013), as well as constitute an intelligible reaction to patients' emotional disturbances or interpersonal behaviors, as demonstrated in previous research (e.g., Colli et al., 2014; Lingardi et al., 2015). Therapists' emotional responses after sessions likely stem from all these sources, to varying degrees and proportions at any given time, and are always the therapist's own responsibility (Ogden, 2004). No therapist or clinical writer would argue that therapists' emotions arising in therapeutic work must stem from one source only. Rather, different writers may take different approaches as to which emotions should be defined as *countertransference*, and which should not. Our view is that CT can tell us something about the patient and something about the therapist, or more precisely, the dynamics taking place between the two, as our findings demonstrate. The attention in this current research is the part of the therapists' emotional reactions that are systematically linked to the patient's pre-treatment pathology and resources, rather than those that stem from vulnerable aspects of the therapists' own relationship history or current life situation, which might be re-termed as the therapist's own *transference* (Gullestad & Killingmo, 2020). These issues need to be dealt with and we believe personal therapy presents one viable vehicle for this important work, but the issues may not be solved once and for all. Rather, they might be evoked from time to time and require ongoing self-assessment and supervision (e.g. Heinonen & Nissen-Lie, 2020).

The findings of the current study may prove relevant to clinical supervisors and practitioners. Therapists' emotional reactions to patients, especially when deviating from their typical level, may provide them with cues as to what (unconsciously) goes on in the patient. Tentatively, our findings provide some evidence for what Freud (1912) proclaimed about the unconscious communications between the patient and the analyst, when he said that (the analyst):

must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient, (...), so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious. (pp. 115–116)

Limitations

This study is part of an RCT on psychodynamic therapy with and without and transference work, which was conducted with scientific rigor and with careful control of the experimental manipulation,

training of the therapists, and assessment of patients (see Høglend et al., 2006). The same therapists were used in each condition so we controlled for their inherent tendencies when assessing the interplay between patient factors and treatment group in relation to therapist CT as well as to their allegiance for or against TW. However, the therapists do not represent a wide variety of therapists since they were only seven in number, and all of them had received extensive training and had many years of professional experience. Thus, they may be viewed as a less than an optimally heterogeneous group in order for our findings to generalize to therapists with other backgrounds and persuasions and in other types of settings. The therapists did not receive formal supervision in this project, but they met regularly to discuss the processes of the cases that were included in the study. This fact and the fact that they filled out questionnaires regarding their immediate CT after sessions might have increased their awareness of their inner states, consolidating their reactions, making the findings less generalizable to therapists who do not fill out forms and do not get the same opportunity to consolidate their emotional response.

Note that the design does not permit us to draw conclusions about causality, nor ruling out a number of unknown third variables. We may not determine that the patient characteristics *caused* the therapists to feel certain ways—even if the patient variables were all measured prior to treatment; only that the two were related. Nonetheless, the relationships shed light on intricate associations between the patient and the therapist that may be used to understand more about the relational dynamics in psychotherapy.

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