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# Countertransference feelings in one year of individual therapy: An evaluation of the factor structure in the Feeling Word Checklist-58

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**Abstract**
Although countertransference phenomena have been given much attention within psychotherapy theory, single-case studies and clinical anecdotes, empirical research is still conspicuous by its absence. To assess the therapists' emotional reactions, which are understood to be part of the countertransference (CT), we used the Feeling Word Checklist 58 (Røssberg, Hoffart, & Friis, 2003); a self-report questionnaire, comprising 58 feeling words. The aims of the present study were to examine the underlying factor structure and psychometric properties of these factors, and to validate the factors by exploring the relationships between countertransference feelings and the following variables: therapeutic alliance, patient personality pathology, suitability for psychodynamic therapy, interpersonal problems, level of general functioning, and symptoms. Six therapists, who treated 75 patients, with weekly, psychodynamic therapy, over 1 year, completed the checklist after each session. To establish the number of subscales in the checklist, a principal component analysis with promax rotation was conducted. The analysis revealed four clinically meaningful factors named Confident, Inadequate, Parental and Disengaged. The psychometric properties of all subscales proved to be acceptable. Alliance as reported by both patient and therapist showed differential correlations with the subscales. The patients' relational functioning showed stronger correlations with the CT feelings than the patients' symptoms and level of functioning. The four subscales found in the Feeling Word Checklist-58 seem to capture clinically meaningful aspects of the therapeutic dyad, and countertransference feelings are systematically related to different relational variables.

**Keywords:** countertransference; Feeling Word Checklist; therapist feelings; alliance; therapeutic relationship; personality disorder; suitability

In psychodynamic psychotherapy, as well as in other therapy modalities, the relationship between the patient and the therapist is seen as an important tool to improve the patient's mental health. The emotional exchange between persons is an important part of any relationship, and the psychotherapist's emotional reaction is an inescapable aspect of every psychotherapy session.

Freud defined the analysts' emotions and feelings, attitude and behaviour that were not neutral, as the countertransference (CT), which he saw as a result of the analyst's own neurotic conflicts (Freud, 1910). Consequently, CT was seen as a disturbing factor which should be kept out of analysis, and the analysts were encouraged to seek further psychoanalysis to overcome the CT (Freud, 1912). Possibly, this view contributed to the limited clinical discussion and lack of academic scrutiny that characterized CT phenomena for quite a long time. This early definition has later been called the "narrow" definition (Kernberg, 1965) and belonged to the era where psychoanalysis was understood as the analysis of the inner world of the patient, unaffected by the presence of the analyst. Gradually, however, a relational perspective became increasingly dominant in the understanding and description of psychoanalysis. In the 1950s different authors discussed CT and suggested revised definitions closer to experience. In 1949 Winnicott, when describing hate in the CT, understood this feeling as a normal reaction to a boy's destructive behaviour, and labelled this reaction "objective" CT (Winnicott, 1949) as opposed to "subjective" CT. Sullivan (1953) emphasized that the therapists' reaction was a response to the patients' invitation to an interpersonal pattern. Heimann (1950), also stressing the relationship in

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the analytic situation, argued that the totality of what the therapist experiences and feels together with the patient is CT. She argued that the term "counter" implies additional factors than merely the analyst's "transference" and held that the psychotherapist's emotional reaction is the therapist's most important instrument to understand the patient and the relationship between them (Heimann, 1950). Heimann's definition has later been labelled the "totalistic" definition (Kernberg, 1965). This position served to normalize the therapist's feelings, and brought the inner life of the therapist as well as the therapist's contribution to the relationship, into the theoretical and clinical discussions.

Accordingly, there has been a tremendous revision of the construct during the last century. Today CT plays a major part in the clinical and theoretical literature and is not only seen as inevitable, but also as a desirable tool for understanding the patient and the therapeutic relationship. Thousands of papers have been published on the subject, and clinicians from different theoretical positions generally accept the idea that CT can be a useful source of information about the patient, and it is even claimed to be a basis for giving feedback about the patient's impact on others (e.g. "This is why people get angry at you") (Muran & Barber, 2010). In addition, CT is at present seen as a joint creation between therapist and patient, involving conscious and unconscious contributions from both parties (Gabbard, 2001). In other words, the influence of the patient on the therapist's feelings is coloured by the personality, self-image and emotional universe of the therapist (Mitchell & Aron, 1999).

However, the theoretical complexity stemming from psychoanalytic thought embedded in the construct (e.g., the unconscious) and the lack of real theoretical consensus about a definition does not make the simplest foundation for quantitative science. This may partly explain why the empirical literature is limited. In addition, the empirical researchers in the field disagree whether CT should be conceptualized and examined as rooted in the therapist's inner conflicts and vulnerabilities and outside the therapist's conscious awareness (e.g., Friedman & Gelso, 2000; Hayes, Gelso, & Hummel, 2011), as objective feelings and experiences (e.g., Hafkenscheid & Kiesler, 2007), exceptional or deviant feelings (e.g., Holmqvist, 2001), as a prototype that most clinicians agree on (Hofsess & Tracey, 2010) or the totality of all inner experiences (e.g., Betan, Heim, Conklin, & Westen, 2005; Røssberg, Hoffart, & Friis, 2003). The total definition aims at evading the issue of what can and cannot legitimately be called CT. In this paper the therapist's subjective, conscious experience is seen as part of the total CT reaction. Moreover, while aspects of the CT may be out of awareness initially, it may become gradually more conscious as the same patterns in the therapeutic dyad are repeated again and again over time.

In a study examining self-reported CT reactions, a questionnaire designed to assess clinicians' conscious cognitive, affective and behavioural responses was used among a random sample of clinicians from a variety of theoretical orientations (Betan et al., 2005). They concluded that: "CT phenomena can be measured in clinically sophisticated and psychometrically sound ways that tap the complexity of clinicians' conscious reactions toward their patients." In the present study we used a questionnaire designed to capture self-reported feelings. Feelings can be seen as the primary building blocks of a relationship (Horvath, 2009). Working with the patient-therapist relationship is now emphasized in most therapy modalities (Hill & Knox, 2009; Safran & Muran, 2000), and developing a positive relationship should probably be considered the primary task of the therapist in all kinds of therapies, not only dynamic psychotherapy (Beutler, Castonguay, & Follette, 2006). Given that the therapist's feelings affect the development of a relationship, the awareness of one's inner life as a therapist seems central. Hence, we focus on a significant domain within the total CT construct: the feelings of which therapists become aware, acknowledge, remember, and are willing to report after each session.

## The Feeling Word Checklist

This line of empirical work started in 1982 with the first version of the Feeling Word Checklist (FWC) (Whyte, Constantopoulos, & Bevans, 1982). Using 30 emotionally loaded words they examined nurses' countertransference feelings to patients in a psychiatric ward, exploring elements that could explain the variety in feelings reported. In sum, they reported four components that influenced the variation in CT feelings: the professional style (what most nurses felt for most patients), the staff's personal style (what the individual nurse felt for most patients), the diagnostic response to the patient (what most nurses felt toward the same patient), and a unique interaction effect (when one nurse felt deviant from herself, and deviant from the other nurses). Later, Holmqvist and Armelius (1996a) replicated the last three components and reported that the contribution from the staffs' personal style and the unique interaction effect were substantially larger than the diagnostic response. It has also been reported that the diagnostic response explained more of the variance in negative feelings than in positive feelings (Røssberg & Friis, 2003), especially with regard to

feelings of rejection, unhelpfulness, and being controlled (Holmqvist & Armelius, 1996b). Moreover, the diagnostic response varies depending on the staff's self-image and gender (Armelius & Holmqvist, 2003; Holmqvist & Armelius, 2004).

Despite the fact that the CT construct was developed from individual therapy, only one study has used the FWC in individual therapy. A questionnaire consisting of 48 words was used (Holmqvist, 2001; Holmqvist, Hansjons-Gustafsson, & Gustafsson, 2002) and the results confirmed the indication that therapists report feeling words rather consistently. However, they also reported that variations over individual patients and differences between sessions were of importance for explaining the variety in feelings reported. Since only one therapist treats each patient in individual therapy, the unique interaction effect cannot be examined.

The diverse FWCs are assemblies of words based on clinicians' subjective experience of what a CT feeling is. Diverse research groups have developed their own versions based on different clinical settings and therapists' opinions. The reasons given for the different versions of FWC are the wish to include feeling words that experienced therapists have found lacking in other FWCs, and to find stable underlying factors, even if that implies sacrificing the complexity in the feeling words reported. It may be that the therapists use idiosyncratic words describing aspects of more universal experiences. Hence, various authors have looked for underlying factors or subscales in the FWC.

## Underlying Factors in the Feeling Word Checklists

The studies on dimensionality in FWCs have not yet reached agreement regarding underlying factors. Holmqvist and Armelius (1994) ran the first principal component analysis on the FWC-30 (Whyte et al., 1982), which revealed seven interpretable bipolar factors (Holmqvist & Armelius, 1994). Later, a Japanese version of FWC-30 yielded five unipolar subscales (Katsuki, Goto, Takagi, Ozdemir, & Someya, 2006). A study using FWC containing 36 words found two bipolar and one unipolar factor (Hoffart & Friis, 2000). The FWC used in the present study is based on a revision of the FWC-30 by Røssberg et al. (2003), who added 28 words, thus creating the FWC-58. When they examined the underlying structure in the FWC-58, again seven factors were found. This study found the factors to be unipolar and named them Important, Confident, Rejected, On Guard, Bored, Overwhelmed, and Inadequate.

Only one study has examined the factor structure of FWCs used in individual therapy: The FWC the FWC-30 was expanded with 18 words; hence, the FWC-48 (Holmqvist, 2001). The best fit for the data were four unipolar subscales named Positive, Negative, Distant, and Dejected (Holmqvist et al., 2002).

In sum, the different research groups have found a variety of factors underlying the FWCs, varying from three to seven; either bipolar, unipolar, or a mixture of both types of factors. The reasons behind this variation in numbers of factors within FWCs may be that each study uses its own FWC. As a result, the numbers of words vary, and the checklists either include (Røssberg et al., 2003) or do not include (Holmqvist & Armelius, 1996) Likert scales. In addition, the studies involve different patient groups; e.g., borderline and psychotic patients (Holmqvist & Armelius, 1996), anxiety patients (Hoffart & Friis, 2000), or large heterogeneous patient groups (Røssberg et al., 2003). The different versions of the FWC have not yet been compared and we are still uncertain as to which questionnaire captures or represents CT feelings in the best manner.

## Associations Between Feeling Word Checklists and Patient Characteristics

Associations between the FWCs and patient variables are especially studied by examining staff feelings when working with inpatients. The patients' recurrent evocative styles have been reported to contribute most to staff feelings of being helpful (Holmqvist & Armelius, 1996b). In a day treatment program for PD patients, several correlations between therapists' feelings and patients' self-reported symptoms at the start of treatment were revealed; for example higher levels of symptoms were related to lower levels of negative CT, especially therapists' feelings of being rejected (Røssberg, Karterud, Pedersen & Friis, 2010). In addition, patients with aggressive and suicidal behavior explained more of the variance in negative feelings than in positive (Røssberg & Friis, 2003). Borderline patients evoked fewer relaxed and more aggressive feelings in staff, in contrast to patients with psychoses (Holmqvist, 2000). Staff's feelings differed between personality disorder clusters, where cluster A, the odd or eccentric disorders (Paranoid PD, Schizoid PD, Schizotypal PD), + cluster B, the dramatic, emotional or erratic disorders (Antisocial PD, Borderline PD, Histrionic PD, Narcissistic PD), evoked more negative and less positive CT feelings than cluster C, the anxious or fearful disorders (Avoidant PD, Dependent PD, Obsessive-compulsive PD) (Røssberg, Karterud, Pedersen, & Friis, 2007; Thylstrup & Hesse, 2008). Feelings are also reported to vary

more in relation to patients with cluster A + B than toward those with cluster C (Røssberg et al., 2007). The amount of personality disorder criteria is reported to relate to therapists' feelings of insecurity, but not to interest or anger (Hoffart, Hedley, Thornes, Larsen, & Friis, 2006). It has also been reported that the patients' self-image affected the staff's feelings more than the patients diagnoses (Holmqvist, 1998). From individual therapy only one finding with regard to patient characteristic is reported, namely that the patients' interpersonal patterns as measured with CCRT (Luborsky & Crits-Christoph, 1990) before therapy affected the therapist feelings, but that the associations were scattered and small (Holmqvist et al., 2002).



## The Aims of the Present Study

The scientific merit of the different versions of the FWCs is unclear. The FWC with 58 items has been applied to inpatients settings before (Røssberg et al., 2003, 2007, 2010), but not yet to individual therapy. Hence, we wanted to evaluate its underlying factor structure and psychometric properties when used in this context. Furthermore, for the purpose of validating and evaluating the factors found in the present study, we will explore the relationship between the factors and the patient-therapist relationship (alliance) as well as a variety of patient characteristics.

First, the therapeutic alliance is seen as an essential and important component of the psychotherapeutic relationship (Horvath, 2005; Meissner, 2006) and an empirically supported factor regarding outcome (Norcross, 2011). Therefore, we are interested in whether and how therapeutic alliance as measured by both therapist and patient correlates with therapist-reported feelings.

Second, we are curious as to what extent the CT factors co-vary in a systematic way with somewhat differing patient characteristics that we interpret as primarily relational, and hence will affect CT feelings differentially:

(a) The patients' personality pathology: A consistent finding is that patients with one PD often show a high degree of comorbidity with other PDs (Critchfield & Benjamin, 2006), hence the patients' problems are not so clear cut as discrete categories indicate (Widiger & Lowe, 2008). Additional criteria, independent of specific PD disorder, have an effect on the level of quality of life and dysfunction in a perfect linear fashion (Cramer, Torgersen, & Kringlen, 2006; Torgersen, 2005). In line with the view that cumulative scores of criteria for PD represent the data better than categorical scores (Hersoug, Monsen, Havik, & Høglend, 2002), we have chosen to use number of PD criteria as a measure of personality pathology.
(b) Therapists' evaluation of the patients' suitability for psychodynamic therapy: Level of motivation for change, psychological mindedness, as well as the quality of object relations have been shown to be the best predictors for good outcome in psychodynamic therapy (Valbak, 2004).
(c) Patients' self-reported level of interpersonal problems: Heightened levels of feelings such as cold, vindictive and dominant are found to be especially resistant to change (Crits-Christoph, Gibbons, Narducci, Schamberer, & Gallop, 2005; Horowitz, Rosenberg, & Bartholomew, 1993; Lorentzen & Høglend, 2004; Vinnars, Thormählen, Gallop, Norén, & Barber, 2009). These problems have also been found to correlate with therapists reporting an elevated level of negative feelings and fewer positive feelings towards the patients in a day treatment program (Røssberg, Karterud, Pedersen, & Friis, 2008).

Finally, we want to explore the relationship between CT factors and patient characteristics which are not direct measures of relational problems, and consequently might shape the therapists' CT feelings to a lesser extent:

(d) We will examine whether the pretreatment level of global functioning have an impact on average CT feelings. Global Assessment of Functioning captures both severity of psychopathology and social functioning.
(e) Self reported symptoms: Relations between patients' self-reported symptoms and staff feelings have been reported in in-patient settings (Røssberg et al., 2010), hence we would like to examine this in individual therapy.

As we understand the CT feelings from a relational perspective, we would expect the factors in the FWC-58 to show a stronger correlation with interpersonal variables than with level of symptoms. To our knowledge, this has not been studied empirically before.

## Research Questions

More specifically, the present study examined the following research questions:

1. How many clinically meaningful subscales do the items in FWC-58 constitute and what are their psychometric properties?

2. What are the relationships between the subscales and alliance as reported by both therapists and patients?
3. What is the relationship between the FWC-58 subscales and the following patient characteristics: (a) number of personality disorder criteria; SCID II, (b) suitability for psychodynamic psychotherapy, (c) level of interpersonal problems (IIP-C), (d) Global Assessment of Functioning (GAF) and (e) self-reported symptoms (SCL-90).
4. Is the relationship between the CT subscales and measures of relational problems stronger than the relationship with other measures of symptoms and psychopathology?



## Method

Data for this study were collected as part of the First Experimental Study of Transference (FEST), which has been described previously in detail (Høglend et al., 2006, 2008; Johansson et al., 2010). The Regional Ethics Committee, Health-region 1, Norway, approved the study protocol. The main objective in FEST was to examine the effects of transference interpretations in a 1-year manualized psychodynamic treatment program. Hence, after completion of the pre-treatment ratings patients were consecutively randomized to two groups, either dynamic psychotherapy with low to moderate use of transference work or dynamic psychotherapy without transference work. However, the randomization is not a variable in the present study when evaluating the factor structure in the FWC-58.

### Participants

**Therapists.** Patients were assigned to one of seven therapists based on availability, all of whom had 10–25 years of experience in practising psychodynamic psychotherapy. In the pilot phase of this study, the therapists were trained in using a treatment manual of principles, not step-by-step procedures for psychodynamic therapy (Høglend, 1990). The therapists practised for up to 4 years in order to enable 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 groups. The study does not comprise additional data on the therapists. No differences between the therapists with regard to effectiveness could be detected (Høglend et al., 2006). However, this study did not have sufficient power to detect small to moderate differences in effectiveness between therapists.

One therapist used the FWC-58 differently from the rest of the therapists. This therapist's mean score on all the words, ($M = 1.4$, $SD = .14$) were 8 *SD* above the other therapists' mean score ($M = 0.24$, $SD = .14$). The extreme cases were either to be removed from the file or changed by statistical procedure to less extreme values (Tabachnick & Fidell, 2007). As all cases were extreme outliers, it is likely that the therapist used the questionnaire in such a different manner that transforming the data would not be appropriate, hence we decided to remove the therapist's data from further analysis.

Consequently, six therapists, four men and two female, were included of whom five were psychiatrists and one was a clinical psychologist. Four were fully trained psychoanalysts.

**Patients.** From 1993 to 2001, 122 patients were referred for therapy by primary care physicians, private specialist practitioners and public outpatient departments. These patients sought psychotherapy due to depressive disorders, anxiety disorders, personality disorders and interpersonal problems. The research therapists assessed the patients for eligibility. Patients with psychosis, bipolar illness, organic mental disorder or substance abuse were excluded. Patients with mental health problems that caused long-term inability to work (>2 years) were also excluded. Written informed consent was obtained from each of the 100 participants who were included in the main study. The patients underwent 45 min sessions, weekly, for up to 1 year. All sessions were audio recorded.

After 13 patients had started therapy, the research group decided to incorporate a questionnaire on countertransference in the study. Hence, there are CT data from the therapists working with 87 patients, but 12 of these patients were removed from the data, due to the excluded therapist.In conclusion, 75 patients were included in the statistical analyses: Their mean age was 37 years old, 46 patients were females and 60% were employed. There were 89% who fulfilled criteria for one or more Axis I diagnosis, of whom 34 had depressive disorders, 13 had anxiety disorders, and 7 had both. Approximately 50% ($n = 37$) fulfilled the criteria for one or more personality disorders (PD), mainly in cluster C and PD NOS.

### Treatment Conditions

All patients received psychotherapy based on a treatment manual (Høglend, 1990) including general psychodynamic treatment principles such as

focus on affects, exploration of warded off material, current relationships, past relationship and interpretations of wishes, needs, and motives. Since the treatment was exploratory, rather than supportive, the therapists mostly abstained from giving advice, praise, or reassurance.

## Measures

**Feeling Word Checklist-58.** We aim to capture the therapist's countertransference feelings with the use of the FWC-58 (Røssberg et al., 2003). This is a modified version of the original FWC-30 (Wythe et al., 1982), where 28 words were added; 23 words were feelings that experienced therapists found were lacking and five words were taken from the PANAS scale (Watson, Clark & Tellegen, 1988) for greater variability. The FWC-58 is a 58-item self-report measure in which therapists rate their emotional responses toward the patient on 5-point Likert scales ranging from "nothing" (0) to "very much" (4). In the present study the questionnaire was labelled "Countertransference" and the respondent was asked to rate to what degree they had experienced 58 feeling states such as helpful, happy, angry, important, empathic, confused, stupid, guilt, bored, enthusiastic, etc. FWC-58 takes about 5 min to complete and was administered after each session. The therapists have 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 psychotherapy period.

**Alliance measures.** The patients filled in the Working Alliance Inventory – short version (WAI) (Horvath and Greenberg, 1989) in session seven. The WAI is a 12-item questionnaire and patients are asked to judge on a Likert scale from "never" (1) to "always" (7) three different aspects of the patient's relationship to the therapist; bond, task and goal. In addition to WAI, we used the Help and Understanding Scale (HUS) (Bøgwald, 2002) reported by both patients and therapists. HUS captures mainly the bond aspect of WAI. After the first, seventh, 16th and last session the patients and therapists were presented with a 100 mm visual analogue scale with the poles "totally wrong" and "totally right." On the scale the patients had to judge whether: "I am sure that my therapist understands me and helps me." The therapists had to judge whether: "I really like to treat this patient." The marks were given points as if the line was a 100-point scale; for example, a score right in the middle would give 50 points. When examining the associations in this study we use the average HUS score. The test-retest reliability over 7 weeks during treatment for patient-rated HUS was satisfactory, $r\ (81) = .60$, $p < .001$. The correlation with WAI in session 7 was $r\ (81) = .65$, $p < .001$. The average HUS rated by patient and average HUS rated by therapist were correlated, $r\ (81) = .45$, $p < .01$, a moderate overlap.

**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, Williams, Gibbon, & First, 1990). All therapists had prior training in using SCID-II, but no inter-rater reliability was documented in 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 other available material were discussed by the patient's therapist and at least one independent clinician, until consensus was reached (Spitzer, 1983). Data from the clinical history and an in depth psychodynamic interview as well as data on education, social functioning and working career were used as additional material in the consensus evaluation. The personality disorder criteria are the sum of positive criteria on the SCID-II. Only two patients did not fulfil any PD criteria at the beginning of therapy.

**Patient suitability for psychodynamic psychotherapy.** Each patient had a 2-h psychodynamic interview, with an independent evaluator at intake. The interview was audio recorded. Suitability for dynamic psychotherapy was assessed by several selection criteria modified after Sifneos (1992). Comparable reliability and aspects of predictive validity of the criteria have been established in several studies (e.g., Barth, Nielsen, Haver, & Havik, 1988; Høglend, 1993; Husby, 1985). The criteria used in this study following Valbak's (2004) review are: (1) Motivation for insight and change, which comprise an evaluation on whether the problems are recognized as psychologically determined, if there is a clear desire for self-understanding, whether the patient wishes to actively change, and to what extent the patient has realistic expectations. (2) Psychological mindedness, which includes an assessment of the patient's ability to comprehend motivational factors and defensive manoeuvres underlying attitudes or problematic interpersonal patterns in other people or hypothetical situations. (3) Quality of interpersonal relationships; including an evaluation of whether there is evidence for at least one stable and mutual interpersonal relationship in the patient's history, quality of intimate sexual relationships, and whether the patient has good friends. These dimensions were rated independently by the clinicians on

8-point Osgood scales, where 8 denotes the most suitable. Intraclass correlation (ICC), averaged over three raters, ranged from 0.74 to 0.84. The unit of analysis was the mean score of the three clinicians.

**Inventory of Interpersonal Problems-circumplex version (IIP-C).** The IIP-C (Alden, Wiggins, & Pincus, 1990) is a self-report instrument designed to assess interpersonal problems in eight domains (domineering, vindictive, cold, avoidant, non-assertive, exploitable, overly nurturing and intrusive) situated around the circumplex, with two main dimensions representing affiliation and control. The IIP-C comprises 64 items that asks 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.

**Symptom Check List-90-R (SCL-90-R).** The SCL-90-R (Derogatis, 1992), administered to the patients before treatment, is a 90-item self-report measure of general psychiatric symptoms and distress; the mean score of all items is the General Symptom Index (GSI).

**Global Assessment Scale (GAF).** The GAF (Endicott, Spitzer, Fleiss, & Cohen, 1976) is a 1–100 scale that contains 10 descriptive levels to anchor ratings on symptoms and dysfunctions. The GAF was included as the fifth axis in the DSM-III (American Psychiatric Association, 1980). Assessment was made at pre-treatment based on the initial interview. Intraclass correlations (ICC) averaged over three raters was 0.93.

### Statistical Analyses

For exploring the factor structure, as well as to simplify and reduce the amount of data, a principal component analysis (PCA) was conducted on the 58 items, with promax (oblique) rotation. In opposition to a varimax rotation, promax rotation allows for the subscales to correlate if this is the best simple structure. When studying psychological constructs such as feelings correlations seems plausible (Fabrigar, Wegener, MacCallum, & Strahan, 1999). However, the same factor structure was obtained using both kinds of rotations.

Due to the multiple questionnaires used after each session with the same patient (and therapist), we conducted a PCA both on data from each session (*all data)*, and on aggregated data to verify whether the same factor structure was obtained. In this context the *aggregated data* are the average of the individual feeling words over the course of a single patient's entire psychotherapy conducted by one therapist. To select the number of factors to rotate we used the Kaiser eigenvalue $> 1$ criteria, a scree plot, parallel analysis, variance accounted for by the factor solution and interpretability. For discriminating purposes we wanted to keep the items that correlate highly with only one subscale. Similarly to Friedman and Gelso (2000), a specific procedure was pursued to eliminate items that did not follow suit. Items from the initial factor matrix were excluded if they loaded less than 0.40 on all factors and above 0.30 on more than one factor. We reran the factor analysis, and repeated the procedure to yield a final factor solution that contained items that loaded at least 0.40 on one, and only one factor and not above 0.30 on any other factor. The internal consistencies of the subscales were measured by Cronbach's alpha.

Correlations between the subscales were calculated as Pearson product moment coefficients ($r$), as were the correlations between the mean subscale scores and the other variables. Only the words that loaded high enough ($>0.4$) on only one factor were included in the subscales. Cohen and Cohen (1983) suggest that $r = .10$, .30 and .50 are small, medium and large ES, respectively.

## Results

### Factor Analyses

The following calculations are from the analyses on all data, which includes 2279 questionnaires. The Kaiser-Meyer-Olkin measure verifies the sampling adequacy for the analysis, KMO $>.87$ (Tabachnick & Fidell, 2007). Bartlett's test of sphericity $x^2$ (1653) = 32549.064, $p < .001$, indicates that correlations between items were sufficiently large for principal component analyses (PCA). The PCA reveals four subscales that provide the best fit for the data and give clinical and theoretical meaning. The four subscales explain 41% of the variance and are displayed in Table I. The subscales were named Confident, Inadequate, Parental and Disengaged. The item loadings are presented in the pattern matrix, which shows the unique relationship (uncontaminated by overlap among factors) between each subscale and each observed item (Tabachnick & Fidell, 2007). The first subscale, Confident, explains 15% of the variance and includes feeling words that are likely when the therapist experienced being in a safe and helpful position. The Inadequate subscale explains 12% of the variance and includes words that are expected when feeling as in an underdog position and not being of much help. The Disengaged subscale explains 8% of the variance and incorporates words illustrating the feeling of not being in touch with the patient, but rather being bored, sleepy

Table I. Feeling Word Checklist-58: pattern matrix obtained via promax rotation showing the unique relationships between each factor and each observed item

| | Confident | Inadequate | Disengaged | Parental |
|---|---|---|---|---|
| Total control | **.74** | −.05 | .22 | −.01 |
| Clever | **.72** | .06 | .14 | .06 |
| Overview | **.71** | −.03 | .07 | .00 |
| Attentive | **.70** | .05 | −.11 | −.03 |
| Receptive | **.69** | .02 | −.14 | .07 |
| Confident | **.60** | −.02 | −.04 | .045 |
| Helpful | **.59** | .12 | −.07 | −.06 |
| Happy | **.58** | −.03 | −.11 | .09 |
| Enthusiastic | **.56** | .00 | −.17 | .09 |
| Calm | **.56** | −.15 | .06 | −.17 |
| Objective | **.51** | −.02 | .15 | −.06 |
| Inadequate | −.06 | **.65** | .19 | −.01 |
| Anxious | .02 | **.65** | −.13 | .02 |
| Threatened | −.02 | **.64** | −.10 | .01 |
| Stupid | −.06 | **.62** | .09 | −.07 |
| Distressed | .06 | **.58** | −.02 | .03 |
| Insecure | −.05 | **.58** | .01 | .15 |
| Helpless | .04 | **.56** | .03 | −.03 |
| Overwhelmed | −.01 | **.53** | −.16 | −.04 |
| Cautious | .23 | **.47** | .09 | −.08 |
| Rejected | −.02 | **.45** | .13 | .00 |
| Disliked | −.13 | **.44** | −.07 | .06 |
| Embarrassed | .04 | **.44** | .04 | −.09 |
| Bored | .02 | −.07 | **.77** | .06 |
| Tired of | .00 | .11 | **.64** | .04 |
| Sleepy | −.13 | −.05 | **.61** | .06 |
| Indifferent | −.01 | .01 | **.57** | .09 |
| Aloof | .12 | .04 | **.55** | −.12 |
| Motherly | −.09 | .00 | .08 | **.89** |
| Affectionate | .01 | .03 | −.01 | **.86** |
| Dominate | −.04 | −.04 | .14 | **.59** |
| Important | .29 | −.03 | −.11 | **.55** |

*Note*. Items with loadings $>.40$ on one factor and $<.30$ on the other factors are listed. A number of items ($n = 26$) did not load strongly on any single factor or loaded nearly as strongly on two factors, as is standard in factor-analytic studies. These items are excluded and not listed here.

and aloof. The last subscale explains 7% of the variance and includes words such as motherly, affectionate and dominating; hence a protective or Parental subscale. The same factors emerged when we ran the PCA on the aggregated data. These factors contain 31 of the 58 items.

## Validation and Evaluation

The correlations between factor scores in the reduced set of items and the subscale scores were as high as $> 0.96$ on all factors. This implies that the subscale scores may substitute the factor scores without loss of information.

The internal consistencies of the subscales as measured with Chronbach's alpha were acceptable. The alpha was 0.85 for the Confident subscale, 0.78 for the Inadequate subscale, 0.64 for the Disengaged subscale and 0.73 for the Parental subscale.

The mean value over all treatments is lowest on the Inadequate subscale, where the mean = 0.14 ($SD = .25$). The Disengaged subscale is slightly higher, with a mean = 0.18 ($SD = .32$). The Confident subscale has a mean = 0.32 ($SD = .42$), while the Parental subscale shows the highest value, having a mean = 0.62 ($SD = .69$). Table II shows the intercorrelations between the four subscales using data from every session ($n = 2279$) and also from aggregated data over each patient's treatment period ($n = 75$). As displayed in the table, there were no strong intercorrelations between the four subscales derived from each session. Over treatments (aggregated data) there is one significant positive correlation; that is between the Confident and the Inadequate subscales.

The alliance was on average rated high by the patients; WAI mean = 5.17 ($SD = .73$) and HUS mean = 82.57 ($SD = 12.12$), and somewhat lower by the therapists; HUS mean = 67.40 ($SD = 12.19$). Table III reveals no significant associations between WAI and CT feelings. The HUS measures show a significant positive relationship between patient-rated HUS and Confident CT, and therapist-rated HUS shows significant positive correlations with both Confident and Parental CT, and a significant negative correlation with Disengaged CT. Inadequate CT shows negative correlations to all measures of alliance, but none is significant.

Table IV shows that the patients had a mean of 10.5 ($SD = 7.0$) PD criteria (range: 0–31 criteria), as measured with SCID II. The evaluations of suitability for psychodynamic therapy show that the patients' mean score on all the three measures is just above five, which indicates moderate suitability. The mean values on patient self-reported interpersonal problems and symptoms illustrate that the patients report mild to moderate problems and symptoms on both measures, as well as mild to moderate levels of

Table II. Pearson correlation coefficients between the four CT feeling subscales in the Feeling Word Checklist-58; both on data from each session and on data aggregated over treatments

| | Confident | Inadequate | Parental | Disengaged |
|---|---|---|---|---|
| All data ($n = 2279$) | | | | |
| Confident | – | | | |
| Inadequate | .05* | – | | |
| Parental | .05* | .01 | – | |
| Disengaged | −.03 | .11** | −.08** | – |
| Aggregated data ($n = 75$) | | | | |
| Confident | – | | | |
| Inadequate | .26* | – | | |
| Parental | −.08 | .13 | – | |
| Disengaged | .14 | .17 | −.04 | – |

*Correlation is significant at the .05 level (two-tailed).
**Correlation is significant at the .01 level (two-tailed).

Table III. Pearson correlation coefficients between alliance measures evaluated by therapist and patient and the four subscales found in FWC-58

| | Confident | Inadequate | Parental | Disengaged |
|---|---|---|---|---|
| WAI session 7 | .17 | −.14 | .05 | −.02 |
| HUS patient | .23* | −.01 | .14 | −.12 |
| HUS therapist | .31* | −.05 | .24* | −.40** |

*Note.* Working Alliance Inventory – short version (WAI): $n = 73$; Help and Understanding Scale (HUS): $n = 75$
*Correlation is significant at the .05 level (two-tailed).
**Correlation is significant at the .01 level (2-tailed).

general impairment according to clinician-rated GAF. Moreover, Table IV shows the correlations between these patient characteristics and CT factors: There are significant negative relationships between number of PD criteria and Confident and Disengaged CT. All three measures of suitability correlate positively with Confident CT. In addition, Motivation correlates negatively with Inadequate CT, and Psychological Mindedness correlates positively with Parental. The subscales Cold and Vindictive from IIP show significant negative associations with Confident CT. In contrast to the relational measures there are no significant correlations between the CT factors and neither GAF nor SCL-90.

## Discussion

In the present study 31 items from FWC-58 constituted four subscales that were conceptually coherent, psychometrically acceptable and clinically recognizable. The four subscales were named Confident, Inadequate, Parental and Disengaged. These are seen as aspects of countertransference phenomena representing different feeling facets.

There are common features between these subscales and subscales obtained in other empirical studies. For example, three of the seven subscales found by Røssberg and Friis (2003) conceptually overlap with ours; Confident, Inadequate and Bored. Most studies from inpatient settings and day hospital units revealed more than four subscales (Hoffart & Friis, 2000; Holmqvist & Armelius, 1994; Katsuki et al., 2006; Røssberg et al., 2003). In the only study from individual therapy, Holmqvist et al. (2002) reported four subscales after factor analysing the FWC-48; one Positive subscale (receptive, objective, motherly, affectionate), and three negative subscales; Negative (manipulated, frustrated, disliked), Dejected (heavy, anxious, overwhelmed), and Distant (bored, tired, absent). The latter subscale corresponds to the Disengaged subscale in our study, another term used for a bored and detached therapeutic stance (Betan et al., 2005). However, the Positive subscale revealed in the study by Holmqvist et al. (2002) includes both the Confident and Parental feelings in the present study. Moreover, the Inadequate subscale in the present study seems to be a mixture of the Negative and Dejected subscales in the study by Holmqvist et al. (2002). The main differences between the two studies could be due to the fact that the present study used a FWC comprising more feeling words and included a higher number of patients (76 vs. 28). In addition, there were different patient samples and therapists in the two studies.

Other studies report subscales incorporating items that describe more aggressive feelings (Holmqvist et al., 2002; Røssberg et al., 2003). In fact, Hoffart and Friis (2000) revealed an Angry subscale, where the aggressive words constituted the third factor, explaining 8.2% of the variance. The same words

Table IV. Mean values and standard deviation of pretreatment characteristics in addition to Pearson correlation coefficients between sum of PD criteria, suitability for dynamic therapy, IIP, SCL-90, GAF and the four subscales found in the FWC-58

| | Mean | *SD* | Confident | Inadequate | Parental | Disengaged |
|---|---|---|---|---|---|---|
| Sum PD criteria – SCID II | 10.5 | 7.0 | −.40** | .13 | .15 | −.37** |
| Suitability for dynamic therapy | | | | | | |
| Motivation for insight and change | 5.4 | .5 | .28* | −.24* | .18 | −.10 |
| Psychological mindedness | 5.5 | .7 | .24* | −.10 | .26* | −.09. |
| Quality of interpersonal relationships | 5.1 | .7 | .26* | −.06 | .00 | −.05 |
| IIP-64 | 1.2 | .5 | −.12 | .04 | .03 | .14 |
| IIP subscales | | | | | | |
| Domineering | .67 | .5 | −.20 | .09 | .20 | .07 |
| Vindictive | .69 | .6 | −.23* | .08 | .07 | .14 |
| Cold | .89 | .7 | −.25* | .05 | .08 | .15 |
| GAF | 60.2 | 6.4 | .04 | .02 | .03 | .06 |
| SCL-90 (GSI) | 1.1 | .6 | −.11 | .18 | .13 | .11 |

*Note.* $n = 75$.
*Correlation is significant at the .05 level (two-tailed).
**Correlation is significant at the .01 level (two-tailed).

were included in the FWC-58; however, diverse aggressive words (e.g., angry, frustrated, naughty and suspicious) did not constitute a subscale in our data; they were excluded from the final solution because the words loaded too low on any subscale, except "frustrated," which loaded high on both the Inadequate and Disengaged subscales. In addition the words had very low scores (e.g., "angry"; $M = .07$). This study includes merely experienced therapists, who are shown to be more comfortable with their emotional reactions, less likely to second-guess themselves in regard to what they say or don't say, and less likely to feel that their emotional reactions are inappropriate or disruptive to treatment (Brody & Farber, 1996). As a consequence, one could assume that there is less frustration and negative feeling overall among experienced therapists, which might also partly explain the low mean values in the Inadequate subscale. Another possibility might be that experienced therapists are somewhat defended against their negative and aggressive feelings towards patients as they may at some level feel that they should be able to master such feelings without them interfering with the treatment. They may consequently be particularly reluctant to acknowledge these facets of CT on a questionnaire. Hence, a "disengaged" stance could be a defensive posture against, for example, aggression and hostility. Therapists may tend to withdraw rather than acknowledge anger, which was surprisingly seldom reported in this study.

Actually, the mean values on all subscale are low, ranging from .14 (Inadequate) to .62 (Confident). Compared to the study from individual therapy by Holmqvist (2001), which used a slightly different version of FWC, these authors found an average score of 1.7 on a Likert scale from 0 to 3 on items resembling those that constitute the Confident subscale. The comparatively low mean values in this study, in particular on the Confident subscale, imply that there are many sessions from which the therapists did not report being "attentive," "calm" or "interested" at all, which is surprising. A plausible explanation for the low mean value in our study might be the different versions of the checklist: In both the Røssberg et al. (2003) and Holmqvist (2001) versions of FWC, the questionnaires begin with: "Together with patient X I felt:," whilst in our questionnaire the only heading is: "Countertransference." This might affect the therapists' response style in such a way that they have not reported all their feelings, only feelings which are more intense than the usual therapeutic interest and attention.

When examining the mean value for one therapist over the course of a single patient's psychotherapy (aggregated score) the correlations between the subscales were expected to be stronger, due to the fact that over time the therapists' feelings were likely to vary more and hence use words from all subscales. Surprisingly, there was only one significant correlation; between Confident and Inadequate feelings. This indicates that the therapists' CT varied more during one patient's psychotherapy concerning confidence and inadequacy and less in respect to involvement and disengagement. If this indicates that Disengaged and Parental CT shows a more stable pattern in each therapeutic relationship, it seems pertinent to understand the reasons behind disengagement. In the present study there is a strong negative correlation between Disengaged CT and therapist rated HUS. As HUS measures to what extent the therapist likes to treat the patient, disengagement could indicate that the therapist does not like to treat the patient very much, but does not acknowledge hostility and aggression.

To our knowledge only one other study has examined therapists' feelings in conjunction with working alliance as rated by both patients and therapists (Najavits et al., 1995). Studying therapists working with cocaine abusers, they observed that therapists' positive emotional reactions showed a positive significant correlation with therapist evaluation of alliance, and negative emotional reactions correlated significantly negative with therapist evaluation of alliance. Najavits et al. (1995) found no significant correlations between therapist emotional reactions and patient evaluation of the alliance. The positive correlations between patient-rated HUS and Confident CT in the present study is of particular interest because of the non-overlapping perspectives. This may indicate that when the therapist feels confident the patient is more likely to appreciate the therapist as helping and understanding; might this come close to a recipe for good treatment outcome? Whether the strong negative correlation found between the Disengaged subscale and whether the therapist likes to treat the patient will have a negative impact on outcome is unknown so far. However, it seems probable to consider this on the basis of elements of the psychotherapy relationships that do work (Norcross & Wampold, 2011).

Turning to patient characteristics, we found a strong negative relationship between amount of fulfilled PD criteria and Confident CT. That is, more personality pathology is associated with fewer confident feelings. Oddly enough, this is not mirrored in a positive relationship between PD criteria and Inadequate CT, which supports the unipolar manner of the factors found in FWC-58. A higher amount of PD criteria suggests a decrease in the experience of being in control, feeling clever, have an overview etc. However, it does not amplify feelings

such as anxiety or feeling threatened or stupid. The patients in our study are located at the mild end of the personality disorder spectrum (Høglend, Dahl, Hersoug, Lorentzen, & Perry, 2010), and it is possible that patients with more serious disorders would have increased therapist's Inadequate CT. In addition, there is a strong negative relationship between Disengaged CT and PD criteria; i.e., more personality pathology, fewer feelings of being tired and bored with the patient. As patients with PD, compared to patients without PD, show less mature defences, affect liability and interpersonal instability (Perry & Bond, 2005), this may affect the therapists' experience of being less Disengaged, but also less Confident.

All three evaluations of suitability for psychodynamic therapy show positive correlations with Confident CT. It is not surprising that the therapists feel more confident when working with patients who are fit for the treatment they have been taught to deliver; however, the data seem to validate the subscale. Motivation for insight and change correlates negatively with Inadequate CT, indicating that lack of motivation for this type of dynamic therapy is associated with more feelings of inadequacy than amount of PD criteria or any other patient characteristic studied. Higher level of psychological mindedness seems to amplify the therapists' Parental CT feelings. Parental CT seems to be a rather supportive and guiding stance composed of the feeling words Motherly, Affectionate, Dominate and Important. Why there is an increase in these feelings when the patients have a higher level of psychological mindedness is unclear. However, an intriguing thought would be that the therapists experience a greater identification and hence involve themselves more, in a parental way.

Self-reported interpersonal problems show lower correlations with CT feelings than expected; the subscales Cold and Vindictive are significantly correlated with less Confident CT, corresponding to Røssberg et al.'s (2008) findings where a lower level of positive feelings was reported. However, the present study does not replicate the elevated levels of negative feelings that Røssberg et al. (2008) found. The Cold and Vindictive subscales have earlier been associated with a dismissing attachment style (Horowitz et al., 1993), which could offer some explanation as to the effect on CT; a dismissing attitude towards intimacy and counter-dependency might lead to a less confident therapist. Domineering shows the same pattern as Cold and Vindictive, but the correlation is not significant. One had expected that these measures should correlate more strongly, especially with Disengaged CT if hostile feelings were masked under this factor. However, the level of Vindictive and Domineering did not differ from a normal reference sample (Bjerke, Hansen, Solbakken & Monsen, 2011) in this material; only Cold showed a higher mean value in our sample ($M = .89$ vs. $M = .73$). Hence, minor self-reported interpersonal problems do not seem to influence the interpersonal aspect of the process to the extent of producing significant correlations with the therapists' average CT feelings, except for a negative effect on Confident CT.

Finally, there is literally no correlation between general CT feelings, functional impairment, and self-reported levels of depression and anxiety. In the present study the patients' relational characteristics are by far more closely associated with therapist feelings than symptomatic measures. In this study, measures on patient suitability for dynamic therapy, level of personality pathology and whether the patient has an experience of being cold and vindictive affect the therapists' CT feelings. The patient-therapist relationship is seen as a vehicle for making positive therapeutic change. The therapists' CT feelings are associated with patient relational attributes as well as with evaluations of the alliance. These findings are of importance for further understanding of the therapeutic relationship.

## Limitations and Future Research

The main limitation of the present study is interdependence in the data and/or sample size. The first run of the factor analysis on all FWC-58 questionnaires gave a ratio of cases to items $\approx 40{:}1$, which is a high number for finding a stable factor structure; however, the data are not independent within each case. Using the aggregated scores from the therapist-patient dyads when examining the FWC-58, interdependence is less of a problem; however, it introduces the problem of sample size. The number of therapist-patient dyads is 75 and the FWC contains 58 words, giving a ratio of cases to items $< 2{:}1$, which indicates instability in the factor structure. However, almost identical factors were found with both methods, and our findings fit reasonably well into the existing field of knowledge.

Only feeling words from six therapists are included in the analyses, and we cannot state to what extent they are a representative sample. More research is needed on other samples of patients and therapists. Another aspect concerning validity may be that the therapists did not evaluate every word of the FWC-58 after each session. We do not know why they filled in the questionnaire in this way; however, it might have been considered too time-consuming to evaluate each of the 58 feeling words after every weekly session. The large number of words might be an

obstacle for optimal reflection on each word. Hence, if the aim is to capture the therapist's inner experience after each and every session a short version might be more suitable. The long version might be more applicable for infrequent evaluations.

In addition, we rely only on the therapists' self-report. Despite the fact that therapists in this study are experienced, there is much they do not know, cannot know, and may not wish to know about their own feelings. One might consider the possibility for the therapists' to have communicated additional feelings they are not aware of or refuse to acknowledge, e.g., the very low level of aggressive feelings reported. In this study, CT is measured as a phenomenological construct which is accessible to the therapist's conscious and may, as noted above, reflect a defensive position that masks unconscious dimensions of CT. Hence, it would be interesting to examine qualitatively therapist-patient relations that did not lead to positive change, in a search for hidden aggression or hostility; that is, to include more objective evaluations in an exploration of discrepancies between the therapists self-reports and what might be recognized as feelings being communicated to the patient, by an external observer. Another exciting venture would be a qualitative study of the sessions from which aggressive words were in fact reported. One could for instance observe whether there seemed to be a rupture in the working alliance in these sessions or whether the patients' outcomes were rated less positive in these relationships. Aggressive and hostile feelings may be more important for the therapeutic relationship than the statistical techniques used in this study are able to portray (Henry & Strupp, 1994; von der Lippe, Monsen, Rønnestad, & Eilertsen, 2008). By operationalizing CT as the therapists' conscious feelings we lose some of the complexity of the CT phenomenon (Najavits, 2000). We have used statistics to examine the central tendency and patterns of consistency in CT feelings. Future research should explore the dispersion and variability of scores.

Future research should also examine the interruption and intrusion of unexpected CT feelings, and in which way they vary in connection to other patient, therapist and relational variables, to therapeutic techniques, and, obviously, to outcome, using both quantitative and qualitative methods.

## Conclusion and Potential Implications for Clinical Work

This study discovered clinically meaningful subscales in the FWC-58 with acceptable psychometric properties. CT has traditionally been regarded as unconscious, at least initially, so that we may only become aware of it through enactments (Gabbard, 2001). However, our findings suggest that once CT feelings makes its way into the conscious awareness of the therapist, there may be significant clinical implications of these feelings for the treatment process. The subscales correlated differentially in a meaningful way with the patients' relational problems and the alliance. These correlations are in line with the contemporary psychodynamic view that psychotherapy involves a two-person psychology, where transference and countertransference are inextricably linked (Gabbard, 2010).

The correlations between non-overlapping perspectives are potentially important for clinical purposes. In particular, in an era where attention to rupture and repair in the alliance is thought to be crucial to the therapeutic action of psychotherapy (Safran & Muran, 2000; Safran, Muran, & Proskurov, 2010), the linkage between the therapist's CT feelings and the therapist's and/or patient's sense of the bond in the dyad takes on special importance. For example, our finding that there is a strong negative correlation between Disengaged CT and therapist-rated HUS suggests that therapists would be wise to reflect on the link between the detachment and more negative feelings towards the patient that may be warded off. Even more important would be to explore with the patient what may have triggered the disengagement.

Our findings lend empirical support to the notion that there are significant associations between CT feelings and other variables concerning the treatment relationship. Those variables involve the internal state of the patient and that of the therapist. Previous research indicates that discussion of what is happening between the therapist and patient may be particularly important for outcome in those patients with personality disorders or low quality of object relations (Høglend et al., 2006, 2008; Johansson et al., 2010). More research is needed to identify specific linkages between outcome and attentions to CT feelings.

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