Therapists' Feelings in Psychodynamic Therapy

A Study of self-reported Countertransference and long-term Outcome

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"*The problem of counter-transference, which you touch upon, is - technically - among the most intricate in psychoanalysis. Theoretically I believe it is much easier to solve. What we give to the patient should, however, be a spontaneous affect, but measured out consciously at all times, to a greater or lesser extent according to need. In certain circumstances a great deal, but never from one's own unconscious. I would look upon that as the formula. One must, therefore, always recognize one's counter-transference and be able to cope with it, for not till then is one free oneself. To give someone too little because one loves him too much is unfair to the patient and a technical error. This is all far from easy, and perhaps one has to be older for it, too.*" (Letter from Freud to Binswanger, Feb. 20, 1913).

Contents

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Hanne-Sofie Johnsen Dahl

Summary

The therapeutic relationship is one factor that makes consistent contribution to outcome independent of type of therapy (Norcross, 2011). The emotional exchange between persons is a vital part of any relationship, and the psychotherapist's emotional reaction is an inescapable aspect of every psychotherapy session. The totality of what the therapist experiences together with the patient, both conscious and unconscious, may be defined as countertransference (Safran, 2012). 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. The overall aim in this dissertation was to investigate a significant domain within the total countertransference, that is, the feelings the therapists became aware of, acknowledged, remembered, and were willing to report on a feeling word checklist after each session.

The three studies in this dissertation used data from the First Experimental Study of Transference Interpretations (FEST), a randomized clinical trial with dismantling design. FEST aimed at studying the specific effects of a core ingredient in dynamic psychotherapy; the transference work. Transference work was defined as all therapist interventions focusing on the patient-therapist interaction. Hundred patients were included and randomized to dynamic psychotherapy with or without transference work, one session a week for one year. In order to study the therapist s' countertransference, the seven therapists in the FEST study filled in a feeling word checklist (FWC-58; Røssberg & Friis, 2003) after each session. The FWC-58 is a self-report questionnaire, comprising 58 feeling words, and is developed to capture countertransference.

Paper I examined the factor structure and the psychometric properties of the FWC-58. A principal component analysis with promax rotation was conducted, which revealed four subscales with adequate psychometric properties, termed: Confident, Inadequate, Parental and Disengaged. The four subscales overlapped somewhat with earlier research and were deemed theoretically sound. Secondly, the associations between these countertransference factors and variables concerning the therapeutic relationship and patient characteristics were explored. Therapeutic alliance as reported by both patient and therapist showed differential correlations with the factors; the patients' suitability for psychodynamic therapy and relational functioning (personality pathology and interpersonal problems) showed significant correlations with one or more of the countertransference factors. However, there were no significant relations between the patients' level of symptoms and general functioning and the countertransference factors.

Paper II investigated long-term effects of transference work in the context of parental countertransference feelings, and patients' level of personality pathology. Parental countertransference is one of the subscales revealed in Paper I, and is composed of the feeling words: Motherly, Affectionate, Dominating and Important. It was hypothesized that parental countertransference may be of hinder to some patients and facilitating for others, depending on level of personality pathology. Personality pathology was evaluated before treatment as the sum of fulfilled personality disorder criteria items on SCID II. The outcome variables were the Psychodynamic Functioning Scales (Høglend et al., 2000) and Inventory of Interpersonal Problems (Alden, Wiggins & Pincus, 1990), measured at pretreatment, mid-treatment, post-treatment, one year, and three years after treatment termination. Linear mixed models were used to analyze longitudinal data from 74 patients. The results showed that parental countertransference, and the patients' personality pathology strongly influenced the long-term effect of transference work: In the context of low parental countertransference, transference work had a positive effect for all patients. When parental countertransference increased, the positive effect of transference work became even more favorable for patients with high levels of personality pathology. However, for patients with low levels of personality pathology the effect of transference work became negative. These patients did not deteriorate; however, the data suggests they would have been relatively better off without transference work.

Paper III investigated the results presented in Paper II by using both qualitative and quantitative methods. Two cases with divergent results, and different level of personality pathology treated by the same therapist, were strategically chosen. The aim was to explore how high levels of parental countertransference may contribute to either success or failure in one year psychodynamic therapy. The success case, Victor, presented rather severe personality pathology while the other patient, Tim, showed low levels of personality pathology. In both cases the therapist used transference work and reported high levels of parental countertransference. The two dissimilar courses of treatment are presented based on interviews with patients and self-report questionnaires from before, during, and after therapy, as well as quantitative and qualitative process analyses of session transcripts. The results give reason to believe that for Victor, the parental countertransference colored the therapists' interventions in ways that gave rise to a new relational experience. This may have facilitated positive change over time. For Tim, the parental countertransference might be understood as a repetition of earlier relationship patterns which did not promote lasting change.

List of Papers

Paper I

Dahl, H.S., Røssberg, J.I, Bøgwald, K.P., Gabbard, G.O., & Høglend, P.A. (2012). Countertransference feelings in one year of individual therapy: An evaluation of the factor structure in the Feeling Word Checklist-58. *Psychotherapy Research, 22 (1), 12*-25.

Paper II

Dahl, H.S.J., Røssberg, J.I., Crits-Christoph, P., Hersoug A.G., Gabbard, G.O., Perry, J.C., Ulberg R., & Høglend, P.A. Long-term effects of transference work in the context of therapists' parental countertransference and patients' personality pathology. Manuscript resubmitted to *Journal of Consulting and Clinical Psychology,* Aug. 2012.

Paper III

Dahl, H.S.J, Ulberg, R., Marble, A., Gabbard, G.O. & Høglend, P.A. Transference Work, Parental Countertransference Feelings, and Personality Pathology: A Case Comparison Study of Victor and Tim.

Manuscript submitted for publication to *Psychotherapy Research,* Sept. 2012.

Introduction

The idea behind every psychotherapeutic intervention is that it is possible for a person to change both emotionally, cognitively, and behaviorally, and that this change can be stimulated through a "talking cure" or psychotherapy. When Freud and Breuer (1895) presented the first case studies and the "talking cure" as a way to treat hysteria, they were like explorers charting new territory (Kächele, 2012). Freud introduced the term psychoanalysis which was the first modern Western system of psychotherapy and a theory of human development, psychological functioning, psychopathology, as well as a treatment of psychological problems and symptoms. Psychoanalysis was first developed during the early decades of the 20th century by many creative thinkers in addition to Freud (e.g. Karl Abraham, Melanie Klein, Alfred Adler, Sandor Ferenczi, Ernest Jones, Carl Jung). By Freud's death in 1939, psychoanalysis had become an international movement, with many different schools interpreting Freud's work in various ways (Safran, 2012). For example, Ferenczi, had founded the Budapest school which put more emphasis on the analyst's active involvement in the analysis and hence, the relational aspects (Haynal, 1988). In Vienna Freud argued in favor of the analyst's "objective" analysis of the patient and the technical aspects of analysis (Holmqvist, 1994). Hence, the question of whether it is the relationship or techniques that are most relevant for psychotherapeutic change, has been at the centre of clinical discussion from the very beginning. This issue is central also in present psychotherapy research.

The advancement of a scientific field of psychotherapy research started in Europe in the 1930's including large numbers of patients who had been in analysis (Kächele, 2012). However, World War II wiped out the early steps of research, and numerous of psychoanalysts fled to America. In both Europe and America, clinical and theoretical work was prioritized over formal empirical research within psychoanalytic circles. In consequence, when Eysenck (1952), after examining 24 studies including over 7000 patients, claimed that research did not support the notion that psychotherapy was an effective way of stimulating positive change, there was little research available to contradict his claim. Eysenck's data was later reanalyzed and the results came out different; therapy led to positive change far beyond the mere passage of time (Bergin, 1971). The positive side of Eysenck's, provocative conclusion was that it stimulated a vast amount of psychotherapy research (Lambert, 2004). As of today there are many clinical theories and models of therapy available (e.g. interpersonal, humanistic, behavioral, dialectic behavioral, cognitive and short- and long-term dynamic therapies); most are probably either inspired by, or in opposition to psychoanalytic or psychodynamic frames of thought. A large number of these models have been exposed to

psychotherapy research using a variety of different methods in trying to answer questions concerning whether, for whom, how, and why psychotherapy leads to therapeutic change (Lambert, 2004; Roth & Fonagy, 2005). As most psychotherapy research, this dissertation is primarily build on the philosophical platforms of natural science and objectivism. It is essential to keep in mind that objectivism is an assumption rather than a truism of science and psychotherapy (Slife, 2004). Research building on other philosophical platforms, e.g. the hermeneutic perspective emphasizing description, the need for qualitative research and contextualized information, are also of substantial value for understanding therapeutic change.

For clinicians, the multifaceted work of psychotherapy is felt in every session when trying to encourage the development and maintenance of a trusting relationship, while pondering on what to say or do in order to assist patients in their struggle towards change. However, as a researcher there is a pull towards simplicity due to methodological limitations. The studies that were undertaken in this dissertation sought to sustain some of the complexity from the therapy sessions within the limits of empirical research. The main aim was to examine a therapist variable, namely countertransference, defined as the therapists' internal conscious experiences during sessions, using quantitative methods. By necessity, this operationalization reduced the complexity of the countertransference phenomenon (Najavits, 2000).

This introduction will portray how the First Experimental Study of Transference work (FEST), the mother study of this dissertation, as well as the three papers included, fit into the larger field of psychotherapy research. The main focus in FEST is to study the causal relationship between transference work (interventions that focus on patient-therapist interaction in the here and now), a core technique in psychodynamic treatment, and treatment outcome. Techniques that distinguish psychodynamic therapy from other therapies will be outlined, as well as resent research on whether psychodynamic therapy leads to desired outcomes. Theory of transference, as well as some empirical findings is then discussed. Last, the concept at the heart of this dissertation, the therapists' countertransference, will be outlined, including the concepts' historical and theoretical premises, as well as empirical research findings.

Questions and Methods in Psychotherapy Research

Does psychotherapy lead to therapeutic change?

Efficacy studies which focus on clinical trials of specific therapies, aiming at studying causal relationships between treatment and outcome, and *effectiveness* studies emphasizing

external validity shows that therapy leads to change above and beyond what is to be expected with no treatment (Lambert & Ogles, 2004).

Within efficacy research, randomized controlled trials (RCT) are seen as the gold standard due to its particular focus on causality. RCTs goal is to identify potential differences in treatment outcomes that are due to the specific treatment. In RCT patients are randomized to different groups (e.g. interpersonal therapy, medication, medication and psychotherapy, and waiting lists). Manuals and treatment integrity measures make sure that the patients get the treatment they are randomized to. In addition, the patients and evaluators should be blind to treatment group. Hence in these studies, only the therapeutic intervention should vary between groups; all other factors are attempted to be controlled for, and kept equal, in order to enhance the internal validity. In the FEST study, all mentioned criteria for a successful RCT were fulfilled. In most RCTs common factors (e.g. therapist variables, context variables, and relationship variables) are seen as "noise" (Wampold, 2001). However, in FEST, these variables were examined in order to investigate how they affect outcome. RCT's have been criticized for having low external validity. However, it is claimed that this has changed in recent studies (Barber, 2009). Another problem is the implicit assumption in RCT's that everything is the same except the treatment. This criterion is seldom fulfilled in psychotherapy research; usually there are different therapists in the different treatment groups and therapists have an effect on outcome (Nissen-Lie, 2011; Wampold, 2001). Also, the supposition that patients with the same diagnoses will respond in the same way to the same kind of treatment are not fulfilled; moderator analysis within RCTs shows differential prognostic impact of co-morbidity (Barber & Muenz, 1996). In FEST, these problems were circumvented; the same therapist worked in both treatment modalities and the patients were by design, heterogeneous. Unfortunately, there is a lack of RCT studies including long-term follow-ups, both because it is expensive and needs a high level of commitment in the research team. In addition, patients often drop-out. The FEST was an exception in regard to these issues, as it included three years follow-up and there were no drop-outs at the last follow-up.

Effectiveness studies focus on generalization and are conducted in ordinary clinical practice. The therapy under study is sometimes compared with another treatment by randomization, but frequently there is no comparison group. The patients are often rather heterogeneous, and the therapists tend to be those working in ordinary settings and may not have had particular training like in efficacy studies. When there is no comparison group, within group change, rather than between group change is examined; that is the patients' levels of symptoms and problems before therapy are compared to the results after therapy.

There is always a possibility that changes in outcome measures are due to other factors than the treatment (e.g. spontaneous remission, factors independent of therapy, regression to the mean; which in this context signifies that severe symptoms tend to move towards average symptoms). There are criteria that may be used to strengthen the link between treatment and outcome; e.g. the patients should be thoroughly assessed, the correlations should be theoretically plausible, patients with severe or chronic problems are less likely to show spontaneous remission and should be included, consistency of the findings over many studies, etc. (Barber, 2009; Schjelderup, 1955).

Thousands of studies, meta-analyses and reviews of meta-analyses have shown that psychotherapy is generally effective beyond the effects of spontaneous remission, passing of time, regression towards mean, and placebo (Lambert & Ogles, 2004; Smith, Glass, & Miller, 1980). In 1995, the American Psychological Association (APA) Task Force produced a list of efficacious treatments or empirically supported therapies (EST) with the goal of listing EST for each and every diagnosis. Some still argue for this list of EST (e.g. Baker, Fall, & Shoham, 2009), which at first may seem appealing due to its simplicity and predictability. However, remarkably few differences between therapy modalities are found (Wampold, 2001). Recently, APA voted on a Resolution on the Recognition of Psychotherapy Effectiveness, and they concluded: "*That is, variations in outcome are more heavily influenced by patient characteristics and by the clinician and context factors than by particular diagnoses or specific treatment "brands*"" (APA, 2012). Hence, the significance of a list of EST's does not seem to be supported by research.

Does psychotherapy work for the individual patient?

The above question is traditionally answered by case studies, which investigates the *efficiency* of psychotherapy. Case studies and qualitative methods look at phenomena in ways that reveal many facets of human experience that the quantitative studies of efficacy and effectiveness have been partially designed to circumvent; in depth evaluation, subjective views, and how individuals perceive, feel and react to their situations and contexts (Kazdin, 2008). However, traditional case studies have been criticized of being written informally and uncritically, often fragmentary and highly selective, giving too few details for others to make independent evaluations, and leading to one ending and no loose ends (Dattilo, et al., 2010; Messer, 2007; Spence, 2001). Suspicion has been raised that phenomena such as alteration of case material in order to present a more compelling set of assertions and selective memory due to the expected distortion of memory or countertransference is prevalent (Eagle &

Wolitzky, 2011). In order to enhance the case studies' scientific rigor, rather than leaving it as historical litter, a number of strategies and guidelines for systematic and extensive case reports have been developed (e.g. Edwards 2007; Eels, 2007; Fishman, 2005; McLeod, 2010). These developments reflect a rising interest among clinicians and researchers in building clinically useful and empirically sound knowledge from case-studies (Iwakabe & Gazzola, 2009). The FEST study comprises a vast amount of observations, including both quantitative and qualitative data; providing an exceptional base for in-depth investigations of how therapy works for the individual patient. In Paper III, a case comparison study is presented that includes observations from many different sources. The study aimed at providing enough information for others to be able to make their own individual judgments concerning the two cases.

Recently, statistical analysis has made it possible to study efficiency within other designs than case studies: Patient-focused research seeks to identify methods for increasing the individual patient's outcome during the treatment by feedback to therapists (Lambert, 2001). Individual growth curves and hierarchical linear modeling are used to assess the individual patient's change over time (Tasca & Gallop, 2009).

A statistically significant difference between an average patient who received treatment, and an average patient who did not receive treatment, may not be essential. Of greater importance are proportions of *clinically* significant change (Jacobson & Truax, 1991) and how many individuals recover, improve, are unchanged, or deteriorate from the treatment. The investigation of efficiency and clinical relevance has helped to verify that psychotherapy is not only statistically superior to no treatment, but meaningful to patients, therapists, and society (Lambert & Ogles, 2004).

What is most important for outcome; specific techniques or common factors?

Most efficacy research study *specific techniques*. If it is the techniques employed in different treatment models that are the most curative factors in psychotherapy, adherence to designated techniques and competence in delivering the techniques will be of importance (Barber, 2009). However, research has shown that training in delivering treatment does not necessarily lead to improved treatment outcomes (Henry et al., 1993), adherence and competency does not show linear associations to outcome (Barber, 2009), and sometimes competent delivery are related to poorer outcome (Svartberg & Stiles, 1994). The most rigorous way to study the importance of specific techniques is by "dismantling" or "constructive" designs, as was used in FEST. In these studies a putatively active technique or

intervention in a treatment is systematically varied, while keeping the other factors constant across treatments (Johansson, 2008). In the FEST study all patients received psychodynamic therapy, with or without the putatively active technique (transference work), while other factors like, number of sessions, the therapists, amount of support, etc. are the same in both treatment arms.

The idea that *common factors* are at work in all kinds of treatments, was hypothesized by Rosenzweig as early as in 1936, with the "Dodo bird verdict" from L. Caroll's book *Alice in Wonderland*: "All have won and all must have prices". This implies that common factors, rather than specific techniques, are most important for outcome. Weinberger (1995) has summarized five common factors: the therapeutic relationship, expectations, confronting problems, mastery and attributions of outcome. In a review of bodies of literature Wampold (2001) finds little evidence for the specific techniques and strong evidence for a contextual model which relies on the common factors as the most essential agents of change. However, it is a growing consensus that it is a combination of specific and common factors that causes change (Castonquay & Beutler, 2006; Goldfried & Davila, 2005). Based on data from FEST, Høglend et al. (2011) reported that transference work (technique) was especially important for patients with low quality of object relations within the context of low alliance (common factor). Barber et al (2006) reported that high adherence to the techniques of drug counseling worked best when the alliance was weak. Some active and specifically targeted interventions have added something unique over and above the effect of common factors (Høglend, 1999).

Both techniques and common factors, e.g. alliance, are probably influenced by subtle patient-therapist interactions and the manner and context within which the technique is delivered (Henry, Schact, & Strupp 1986; von der Lippe, Monsen, Rønnestad & Eilertsen, 2007). These patient-therapist processes are probably influenced by the therapists' subjectivity, interpersonal style, and countertransference (Muran, 2002; Nissen-Lie, Monsen & Rønnestad, 2010; Tishby & Vered, 2011). In Paper II and III these interactions were investigated further by analyzing transference work (specific technique) and therapists' countertransference (a relational construct) in connection to outcome.

What moderates and mediates change?

The interest for whether a treatment is more or less effective for certain patients have led to research on *moderators* (Johansson, 2008; Kendall, Holmbeck, & Verduin, 2004). Predictors of outcome are baseline variables that influence outcome across different treatments (e.g. problem type, problem severity, gender, therapist training). The study of

moderators aims at moving beyond the study of main effects between treatment modalities. For example, in the FEST study there were no main effects of transference work; both treatments worked equally well. However, transference work leads to a better outcome for patients with personality disorders (Høglend et al., 2010). In another study, comparing three treatments of 16 weeks for major depression (medication, supportive-expressive therapy, and placebo in addition to clinical management) there were no main effects between groups. However, moderator analyses showed that African-American men tended to improve more quickly with talk therapy than with medication or placebo. In contrast, white men fared best on placebo, while black women showed no differences in their responses to the three treatments. Only white women, showed the expected pattern: a quicker response to both medication and talk therapy than to the placebo (Barber, Barrett, Gallop, Rynn, & Rickels, 2012). So far the research on moderators does not tell *why* the moderator makes a difference (Kazdin, 2009).

Moderators have received far more attention than *mediators* of effectiveness; that is, the mechanisms or processes through which a therapy produces change (Kazdin, 2009). Mediators are not baseline variables, but are variables that change during the course of treatment. A mediator is a potentially causal link that explains the "mechanism" through which a given treatment promotes change (Johansson, 2008). That is, a process that takes place during treatment within the patient which accounts for the association between treatment and outcome. Statistically a mediator accounts for some (or all) of the associations between treatment and outcome (Johansson & Høglend, 2007). Increased level of insight mediated the moderated long-term improvement for the transference group in FEST (Johansson et al., 2010). Hence, the mediator, insight, seems to be a key mechanism of change in psychodynamic therapy, which supports fundamental theoretical claims within psychoanalytic theory.

The Therapeutic Relationship

In the conclusions to APA's Task Force of Evidence-Based Therapy Relationships, Norcross and Wampold (2011) state that the therapeutic relationship makes modest but consistent contributions to psychotherapy outcome independent of the specific type of treatment. They assert that practice and treatment guidelines should explicitly address therapist behaviors, as well as therapist qualities that promote a facilitative therapeutic relationship; in addition, the relationship should be adapted to the patient characteristics. Bordin (1979) proposed that it is the tear and repair of the relationship that makes it stronger

and leads to patients change. As of today no school of therapy would probably view the relationship as totally irrelevant. However, the significance of the therapeutic relationship varies between treatment modalities (Hill & Knox, 2009). Even though techniques are seen within the context of the relationship for behavioral and cognitive-behavioral therapies, as well as in certain schools of early psychoanalysis, it is the *techniques* that are placed at the center of the therapeutic change process (Goldfried & Davila, 2005). Humanistic therapies and later psychodynamic therapies identify the therapeutic relationship as the major wheel to accomplish change (Hill & Knox, 2009). Accordingly, there is no doubt of the importance of attaining and maintaining a therapeutic relationship. However, what *is* the therapeutic relationship? One suggestion is that it consists of three elements: The working alliance, the real relationship and the transference-countertransference configuration (Gelso, 2009; Hill & Knox, 2009). Or as Horvath (2009) suggests, three "layers" of constructs: Feelings, relational inferences, and relational processes wherein alliance and transference-countertransference are included.

The terms *working alliance* and *the real relationship* were first coined by Greenson (1967). In the work of Bordin (1979) the specific components of the pan-theoretical concept of working alliance were outlined as composed of three factors: First, the presence of a personal *bond* between therapist and patient; second, an agreement between patient and therapist regarding the *goals of treatment;* and third, an agreement as to the *means* by which these goals may be achieved. The facilitation of an optimal working alliance is found to be important to the change process in large meta-analyses (e.g. Flückinger et al., 2012; Horvath et al., 2011). The most used alliance measure to date across all types of therapy, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), is based on Bordin's model. The papers in this dissertation include WAI, as well as a one item scale concerning the bond aspect of the alliance (The Help and Understanding Scale; Bøgwald 2002).

In an effort to amplify the personal relationship between therapist and patient the term *real relationship* has been suggested to separate the personal relationship from alliance and transference-countertransference configurations (Gelso, 2009). The real relationship is theorized to consist of two elements: realism and genuineness. Compared to the working alliance, the real relationship is based on an accurate sense of the persons involved; whether the person is liked or not, based on the unfolding relationship (Gelso, 2009). The research on the real relationship is at an early stage. One study suggests an association between the real relationship and outcome, which was stronger in predicting outcome than the robust measurement of alliance (Fuertes et al., 2007). In discussing these findings, McCullough

(2009) suggests that the real relationship may represent the core of the therapeutic alliance and that the alliance may be composed of vital real relationship qualities that need to be carefully defined. Gelso (2009) sees the transference-countertransference configurations as a distortion of the real relationship and the alliance. For others the alliance, the real relationship and the transference-countertransference configurations are seen as inextricably linked (Gabbard, 2010, Joseph, 1985; Safran, 2012). The suggestion of feelings as the first level in the relationship (Horvath, 2009), seems intuitively plausible. Through becoming aware of one's own feelings the therapist may identify transference-countertransference processes. The level of overlap between the alliance, the real relationship and transference-countertransference is a complex phenomenon that probably changes over time in therapy.

To conclude on general psychotherapy research; countless studies have shown that psychotherapeutic treatment works. Therapy seems to be cost-efficient, and patients who have received therapy tend to reduce their health care utilization, to be healthier and use less medical care of all types (Lambert & Ogles, 2004). Hence, efficacy, effectiveness, and efficiency studies all conclude that therapy promotes change in patients' emotions, cognitions, and behaviors. Techniques and common factors probably work together to enhance outcome. Results from studies of moderators and mechanisms of change, indicate systematic variation as to what works for whom and why; however, this field of research is still in its very beginning. Even if therapy works, a relatively consistent number of patients (5 to 10%) deteriorate while in treatment (Lambert & Ogles, 2004). If one of ten gets worse from therapy, it is a considerable problem. As much as 40% of client improvement in psychotherapy may be attributed to client variables and extra therapeutic factors (Lambert, 1992). Those are the factors therapists cannot control. However, the patient variables are in a dynamic and ever changing context of therapist variables and therapist behavior (Clarkin & Levy, 2004) and variability in outcome can be explained by the individual therapists. Wampold and Brown (2005) found that 5-8% of outcome could be attributed to therapist. Therapists who get better outcomes generally are the therapists who are better able to form an alliance with a variety of patients (Wampold, 2010). Hence, we need more knowledge concerning the therapeutic relationship and how the therapists' subjectivity and personality interact with patient characteristics in predicting treatment outcome.

Within psychodynamic therapy transference and countertransference is one way to understand important aspects of the therapeutic relationship. Even if various scholars differ on how they understand the phenomena, the concepts are considered a unifying focus of

psychoanalysis and psychodynamic therapy (Arundel & Bellman, 2011), and are central in this dissertation.

Psychodynamic therapy

The building of psychoanalytic theory did not rest after Freud, as of today mainstream psychoanalysis see relational factors as crucial and as a major tool for achieving change. In addition to psychoanalysis, which is an in-depth, time consuming treatment, there are numerous short term and less intensive psychoanalytically oriented or psychodynamic therapies, which seeks to be founded on both theory and research. Theory and recommendations for technique are in constant development as well as in dialogue with other areas of theory and research, from developmental psychology to neurobiology. This is thoroughly presented in Levy, Ablon, and Kächele's (2012) book on psychodynamic research: "Evidence-based practice and practice-based evidence". Seven features reliably distinguished psychodynamic therapies from other therapies, as determined by empirical examination of actual session recordings and transcripts (Shedler, 2010). These are basic techniques and may be summarized as:

- Focus on affect and expression of the full range of emotion, including contradictory feelings.
- Exploration of warded off and avoided material and aspects of experience which often involve distressing thoughts and feelings.
- Identification of recurring themes and patterns in patients' thoughts, feelings, self-concepts, relationships, and life experiences.
- A developmental focus and discussion of past experience in order to shed light on current psychological difficulties
- Focus on interpersonal relations and experiences.
- Focus on the therapeutic relationship (the technique which is experimentally manipulated in this research project). The recurrence of interpersonal themes in the therapy relationship is thought to provide a unique opportunity to explore and rework them in vivo.
- Exploration of wishes, dreams and fantasies through the encouragement to speak freely about whatever is on the patients mind.

The above mentioned techniques are applicable independent of treatment length. In time-limited therapy three additional principles are recommended:

- The patient should be instructed about the principles of dynamic therapy
- Negotiation of a focus is essential
- The therapist has to be active in keeping the pre-determined focus in the center of attention
- Attention to time-limit and termination phase

In FEST a time-limited psychodynamic treatment based on a manual which draw from the above mentioned techniques, and more specifically from Malan's (1976) brief dynamic psychotherapy are investigated. However, manuals in psychodynamic therapy are manuals of principles, not step-by-step procedures.

Experimental research on psychoanalytic and psychodynamic constructs and treatments was hampered by the assumption that methods within natural science did not apply to psychoanalysis. Studies resting on hermeneutic epistemology or psychoanalytic methods were the ones accepted, and still are, in certain circles (Green, 1997; Hoffman, 2009; Warren, 2012). Hence, there are far more quantitative outcome studies on other treatments; specifically cognitive behavioral therapies which held a positive view on experimental research. Lately, however, there is an increasing amount of studies on psychodynamic therapies (see Levy et al., 2012). Different meta-analysis investigating therapeutic change after psychodynamic therapy support the efficacy of psychodynamic therapy for a range of specific disorders; depression, anxiety, panic, somatoform disorders, eating disorders, substance-related disorders, and personality disorders (Abbass, Kisely, & Kroenke, 2009; Clarkin, Levy, Lenzedweger, & Kernberg, 2007; Leichsenring & Leibing, 2003; Leichsenring, Rabung, & Leibing, 2004; Milrod et al., 2007). Studies that include patients suffering from a range of mental disorders have shown large effect sizes (Abbass, Hancock, Henderson, & Kisely, 2006; de Maat, de Jonghe, Schoevers, & Dekker, 2009; Leichsenring & Rabung, 2008; Shedler, 2010). In sum, the available evidence indicates that psychodynamic therapies are efficacious, efficient, and effective in promoting change and evidence indicate that the benefits are lasting (Shedler, 2010).

Unconscious mental life

The emphasis on unconscious mental life might be the one factor that distinguishes psychodynamic theory most from other therapeutic theories, and is often referred to when discussing transference and countertransference. Freud's claim "we are not masters of our own house", is at the core of psychodynamic therapy. That is, we are all motivated by forces

outside conscious awareness (Safran, 2012). The idea of the unconscious is at odds with the basic assumption in cognitive therapy which holds that thoughts can easily be retrieved and recognized. Research in cognitive science has shown that much thinking and feeling goes on without conscious awareness (e.g. Berridge and Winkielman, 2003; Galdi, Arcuri, Gawronski, 2008; Kihlstrom, 2004 p92). There is growing support also within cognitive therapy for the existence of a "cognitive unconscious" that influences the behavior of both therapist and patient (Kihlstrom, 2004). Neuroimaging studies of the human brain have suggested that certain structures, such as the striatum and the amygdala, can process incoming stimuli before they reach conscious awareness, and, as a result, may mediate nonconscious effects on human cognition and behavior (Jensen, et al., 2012; Carlsson, 2004). Rather than "unconscious mental life", terms like "implicit mental processes" or "procedural memory" are often used in studies from these fields of knowledge (Gabbard, 2011). New findings demonstrate that the unconscious mind plays a key role in pain and placebo experiences (Jensen et al., 2012). In this latter study, the researchers reported that placebo and nocebo (negative placebo) effects rely on brain mechanisms that are independent of cognitive awareness (Jensen et al., 2012). The experimental study employed pictures; one may suppose that the same placebo and nocebo effects will be evident in real world situations (e.g. Independent of cognitive awareness, a crowded desktop will for some patients indicate a busy and lenient therapist, for others; a chaotic and unreliable therapist).

It is noteworthy that empirical research from different domains shows that crucial aspects of memory, perceptual, judgmental, affective, and motivational processes are not always consciously accessible (e.g. Roffman, Gerber, & Glick, 2012). Since we cannot deliberately reflect upon and judge these mental activities which are outside our awareness, they are expected to be more automatic, fast, and powerful, and probably fundamental to human behavior. In psychodynamic theory the unconscious mental life is believed to incorporate forces in the form of memories and affects that are too threatening to the individual, impulses and wishes that are in conflict and/or not allowed into awareness because we have learned that they are unacceptable through cultural conditioning. Psychodynamic theory does not only consider what is not fully known but maintains that there are things we seem not to *want* to know (Shedler, 2006). In a study by Greenwald and colleagues (1998), unconscious racist tendencies were investigated. The white research participants claimed they were non-racist. However, the results showed that they acted radically different than they anticipated; they acted racist. In Freud's words: "*In the former case the dissension is between two powers, one of which has made its way to the stage of what is preconscious or conscious*

while the other has been held back at the stage of the unconscious" (p 433, 1917). Empirical studies have found that the therapists' unconscious countertransference behavior affects the therapeutic relationship (e.g. Hayes, 2004). Hence, when therapists are asked to report their feelings we assume there is much the therapists do not know, cannot know, and may not wish to know about their countertransference.

Transference and Transference Work

Freud (1905) conceptualized the patients' fantasies, thoughts, and feelings concerning the therapist, as the "transference"; a living reconstruction of the patient's repressed historical past "transferred" onto the relationship with the analyst. At first he claimed that the transference implied that the patients had a somewhat distorted experience of him which hindered the patients' free association. Free association was thought to be the central technique to understand the neurotic symptoms; insight into the cause of the symptoms would make them disappear (Breuer & Freud, 1885). Consequently, the transference reaction had to be removed for further therapeutic work. Later, Freud came to the opposite conclusion: the transference is not a hindrance, but the most essential tool for understanding how the patient conceives and construes reality. This will consequently enable the therapist and the patient to make meaning of the patients' symptoms. Hence, Freud's aspiration changed to working with and through the transference in order to help the patients be aware of their own contribution to how they perceive the outer world; their own "looking glasses".

Today, transference is thought to be shaped through the interaction between innate characteristics, past object representations, fantasy, emotional experiences, real life experiences, and the here and now experience of the therapist, and may take many forms. In psychodynamic theory, the transference or fixed assumptions are considered to have been rather adaptive solutions to earlier life circumstances. However, when life changes, the assumptions remain, but they are no longer adaptive. This is thought to give rise to different kinds of psychological difficulties (Shedler, 2010). For example, it may have been a reasonable strategy for a child in the hands of a fragile mother to keep calm and not express anger. However, as an adult in work relations, as a partner or a mother, it may no longer be an adequate response to conceal signs of disagreement, protest or self-assertion. In therapy, this may give rise to transference themes like: "I have to accept everything you say, or else you will not help me"; or "I idealize you, and you must save me from my misery"; or "You are not trustworthy and I better not let you into my life". Focusing on the feelings, themes and conflicts that arise in the therapeutic relationship may bring these unconscious, assumptions

into direct communication and enable the patient (and the therapist) to distinguish what is real in the therapeutic relationship from what are enactments influenced by transference.

One goal of psychodynamic therapy is to expand freedom and choice by helping people to become more aware of their experiences in the here and now, and allowing for new, alternative interpretations and behaviors. When the therapist focuses on the relationship in the here and now, it may be defined as *transference work* (Høglend, 1990; 1994; Piper et al., 1991). Transference work is thought to be central for enhancing flexibility in how to construe outer reality, which in turn may give ground for better adaptive and interpersonal functioning and less proneness to experience symptoms. Different psychotherapy modalities emphasize working with the therapeutic relationship, e.g.: Cognitive behavioral therapists (e.g. CBASP; McCullough, 2003) may work with "interpersonal discrimination exercises", humanistic and client-centered therapies might be "processing the relationship" (Hill & Knox, 2009), existential therapy with "the here and know process comments" (Yalom, 1995), and again others with the transtheoretical "metacommunication" (Kiesler, 1996). In psychodynamic therapy, however, transference work is not simply addressing the transactions between therapist and patient, it also includes transference interpretations, that is; the interpretative linking of dynamic elements (conflicts), direct manifestations of transference, and allusions to transference, as well as repetitive interpersonal patterns to transactions between patient and therapist (Høglend, 1990). An example of a transference interpretation could be: "So, you avoid talking about the fact that this is our last session (defense); you felt anxious and uncomfortable (affect) when discussing the sadness and anger you felt (impulse) when your father died (parents). You did the same after your divorce (others) and now again when you and I are ending this therapy (therapist)".

Despite the widespread view of the importance of transference work in psychodynamic therapy, among clinical theorists there are divergent views about which type of patients under what circumstances may benefit from transference work (Gabbard & Westen, 2003; Kernberg, et al., 2008). Moreover, the research in the field has been ambiguous. Earlier naturalistic studies reported no treatment effects or even negative effects of increasing frequency of transference work (Connolly et al., 1999; Høglend, 1993; Ogrodniczuk, Piper, Joyce, & McCallum, 1999; Piper et al., 1991). Transference work has also been found to have a greater impact on in- session outcome than other interventions in psychodynamic therapy, but in both positive and negative directions, leading Gabbard to coin transference interpretations "a high risk - high gain" phenomenon (Gabbard et al., 1994). However, correlational findings are subject to several possible explanations (Stiles & Shapiro,

1994). To address these problems, Høglend et al. (2006) designed the first dismantling, randomized clinical trial to test the long-term effects of transference work in psychodynamic therapy (First Experimental Study of Transference; FEST). One hundred patients were randomized to one year of dynamic psychotherapy with a moderate level of transference work or to the same type of therapy without the use of transference work. The main finding from FEST showed no overall main effect of transference work. This fits in with most research comparing two different treatments; there is no overall difference. However, when including patient characteristics as moderators, there were clear and significant differences as to what works for whom. It was demonstrated that patients with low quality of object relationships (Høglend et al., 2006), especially women (Ulberg et al., 2009), and patients with personality disorders (Høglend et al., 2010) benefited significantly more from therapy with transference work than without transference work. This effect was sustained during the three years follow-up period (Høglend et al., 2008). Furthermore, Høglend et al. (2011) reported that transference work was especially beneficial for patients within the context of low alliance. On the other hand, transference work was negative for patients with mature relationships in the context of high alliance. Freud claimed "…*we need not bother about it [the transference] as long as it operates in favor of the joint work of analysis. If it then changes into a resistance, we must turn our attention to it"* (p 443; 1917). In their review of the empirical research on transference work, Høglend and Gabbard (2012) argue that the effects of transference interventions probably depend not only on patient characteristics, but on several features of the interpretations themselves, and the context in which they are delivered. Furthermore, the attitude and subjectivity of the therapist, as well as his or her countertransference reactions, may have an impact on the quality of interpretations and how they are delivered (Muran, 2002).

Countertransference

There is surging interest in therapist's countertransference, and a vast amount of literature has been written on the subject (e.g. 9453 hits on "countertransference" in the PsycINFO database, Oct. 2012). Laplanche & Pontalis (1973) suggested that Freud was not particularly interested in the countertransference, since he only mentioned it a couple of times in his technical writings. However, Freud also found "*the problem of counter-transference […] - technically- among the most intricate in psychoanalysis"* (1913). Hundred years later, this postulation may still be relevant.

Historical and Theoretical premises

The concept of countertransference was first mentioned in passing by Freud (1909) in a letter to Jung. Again, in another letter (1911) he tactfully warned Jung about becoming involved with a young female patient. In addition, he stated: "*I believe an article on "counter-transference" is sorely needed; of course we could not publish it, we should have to circulate copies among ourselves*" (p. 476). Countertransference was introduced in his technical writings in "The Future Prospects of Psycho-Analyses" (Freud, 1910):"*We have become aware of the 'countertransference' which arises in the physician as a result of the patient's influence on his unconscious feeling, and we are almost inclined to insist that he shall recognize this countertransference in himself and overcome it*" (p 144). He continues "*…no psycho-analyst goes further than his own complexes and internal resistances permit…..anyone who fails to produce results in a self-analysis of this kind may at once give up any idea of being able to treat patients by analysis*" (p 145). Two years later Freud writes in "Recommendations on analytic technique (2012): "*…he [the analyst] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient...*" (p115). This last postulation, if followed, would surely generate strong feelings and may be seen as a contradiction to his earlier technical writings on countertransference.

Freud's therapeutic ambition, supported by the scientific ideal in those days, was to be neutral and objective. The surgeon's instruments; a knife and a mirror were employed as metaphors for the analyst's tools (Freud, 1912). In line with the goal of objectivity, countertransference was seen as a deviation and disruption to this ideal (Zachrisson, 2008). Freud's definition of countertransference is later named the classical or narrow definition (Kernberg, 1965). In the beginning of the 20th century, there were no standardized ethical guidelines for medical personnel. Realizing that the patient's aggression and sexuality possibly will exert considerable pressures on the therapist, Freud suggested understanding the countertransference as a disturbing factor. If needed, the analyst should seek further psychoanalysis to overcome the countertransference. This could have been understood by the psychoanalytic society as a wise and useful reminder: "do not act on strong feelings that may arise during analysis", an idea which could have led to fruitful discussions. Instead, a long silence concerning countertransference followed. The scarce literature on the subject in this first period of psychoanalyses may indicate that analysts tried to keep all evidence of countertransference out of the clinical sessions (Wolstein, 1988). The potency in Freud's technical metaphors (clean knife and a mirror) was probably shame inducing for the therapists when their inner world was not neutral; at times possibly struggling to contain strong feelings

or in turmoil. Also Freud's lack of writing on countertransference, probably contributed to the silence that lasted for almost 40 years were nothing substantial was added to the study of countertransference (Etchegoyen, 1999). Hence, Freud's narrow countertransference definition was for a long time widely accepted in mainstream psychoanalytic discourse.

Other voices concerning countertransference were also to be heard, however, less well known. Ferenczi (1919), founder of the Budapest school, was concerned that analysts following Freud would be too reserved and technical, and not sufficiently emotionally responsive to promote emotional development in patients. Ferenczi endeavored to elaborate and advance a theory of countertransference as a useful therapeutic tool in itself rather than as an obstacle for the cure, well ahead of other psychoanalysts (Cabré, 1998). Freud and Ferenczi came to disagree over many topics, especially over incest; fantasy vs. trauma and the concept of countertransference. Ferenczi's views were for a long time seen by many psychoanalysts as erroneous, his ideas were "forgotten" and condemned to silence (Cabré, 1998). A fear of being seen as one of his followers may well have made it even more controversial to discuss countertransference in the following years. In addition, to divergent views in theoretical and technical matters, they worked with decidedly different patients: many of Freud's patients were from the upper class; while Ferenczi worked primarily with the less privileged; prostitutes and alcoholics (Haynal, 2005). Ferenczi was concerned with the two-person situation in therapy and used his countertransference to guide interventions and self-disclosures. He was eager to try mutual analysis; where the analyst and the patient analyzed each other. He considered *not* admitting feelings to patients as hypocrisy, in the same way as parents that abused their children had been hypocritical. Ferenczi was concerned about the potential power inherent in being a parent or an analyst, making it possible to abuse ones positions. He thought he could avoid this by self disclosure (Haynal, 2005). In fact, both Freud and Ferenczi were worried that the therapeutic process could be damaged by the countertransference; either by enactments (Freud), or suppression (Ferenczi). Henceforth, they suggested entirely opposite solutions to the threat.

Throughout the 1940's, there were many changes in the psychoanalytic community. New groups of analysts were gathering across the world due to World War II, and vast amounts of new patients (e.g. war veterans) challenged both theory and technique. Increasingly, people who Freud had thought was not fit for analysis went into analysis (e.g. Freud, 1917): patients with more severe diagnoses like borderline pathology, narcissism and psychotic disorders, but also children and adolescents. Analysts met many patients with early injuries and the emotional bond between therapist and patient were increasingly thought of as

a curative factor. This change took place both in the U.S. through the development of interpersonal theory by Sullivan, Fromm, Horney, Fromm-Reichmann, and so on, and in Europe, especially in Great Britain through the object-relations theory of Winnicott, Fairbairn, Klein, and others. In Winnicott's article; "Hate in the countertransference" (1949), he argued for the importance of recognizing hatred in the countertransference, as all relationships will arouse conflicting emotions. Winnicott claimed that if hateful feelings are unacknowledged they will be expressed more or less covertly in relation to the patient. In one case, he informed his young patient about his anger, and argued that this self-disclosure was essential for the boy to understand himself and for the relation to survive. Winnicott may have tried to incorporate the perspectives of both Freud and Ferenczi when he separated countertransference into "objective countertransference" (what almost everyone would feel together with the patient) and "subjective countertransference" (the therapist's neurotic way of responding).

This new perspective was elaborated upon in 1950, when Heimann's article "On Countertransference" was published. She claimed that countertransference is the totality of the therapist's feelings, attitudes and behavior, both conscious and unconscious. What was truly innovative in her perspective was that these experiences may be used as a source of insight into the patient's unconscious mental life. The therapist's internal reaction was something which could recount how other people reacted to the patient, and the countertransference was "a royal road" to understanding the patient's transference. As opposed to being only shameful, countertransference was from now on often presented with a positive zeal, as something that enriches the work and may be of help in guiding interventions. Paula Heimann' definition (1950) is later labeled the totalistic definition of countertransference (Kernberg, 1965) and is today widely acknowledged (Echtegoyen, 1991; Gabbard, 2001; Safran, 2012; Segal, 1977). The change in attitude from the classic to the totalistic definition implied a long, interesting, and at times rather fierce discussion between different opponents and schools within the psychoanalytic tradition (e.g. Wolstein, 1988). In addition, other definitions have been suggested: The *complementary* (Racker, 1957) or *objective* (Kiesler, 2001; Winnicott, 1949) countertransference definition views the therapist's reactions as a complement to the patient's interpersonal style and behavior. For example the patient's maladaptive interpersonal style will exert a certain "pull" on the therapist to feel and respond in specific ways similar to most therapists' reaction, rather than being byproducts of the therapists' unconscious conflicts. The *relational definition* view countertransference as mutually constructed by the therapist and the patient in the here and know of the session, and less colored by both patients' and the

therapists' stable interpersonal patterns (Hoffman, 2004; Mitchell, 1993). Some argue more in line with the narrow definition, that countertransference loses its relevance if it is the totality of the therapist experiences, and maintain that the concept should include only the therapist's unresolved, largely unconscious, conflicts (e.g. Gelso and Hayes, 2009).

Zacrisson (2009) has developed a multileveled model, incorporating both helpful and hindering aspects of counter-transference. 1. Classical countertransference: the therapist unresolved conflicts hinder the understanding of the patient. 2. Empathy: the therapist's empathy is used as an instrument to understand the patient, 3. Extended countertransference: The therapist is nudged to understand by the patient (e.g. role responsiveness) 4. Projective identification: The therapist is being forced to understand; the patient affects the therapist in a more fierce way than in role responsiveness (see for example Ogden, 1979). All levels may be informative as to the patient, and the ongoing relationship. In this model "*countertransference becomes a multileveled, ubiquitous phenomenon, referring to the analyst's feelings and fantasies, to the working out of them in relation to the patient, and to the process taking place. This working out unfolds in a continuous oscillation between reflection and empathic atonement and is nowadays often referred to as "countertransference analysis""* (pp 187; Zachrisson, 2009).

Within both traditional behavior therapy and cognitive-behavioral therapy, little focus was originally placed on the relationship, and even less on the therapist's inner world. As therapists within cognitive-behavioral therapy work increasingly with poorer functioning patients the relationship factors are put forward. Some give other names to the phenomenon that may be approximates of countertransference, such as Rudd and Joiner (1997) who prefer "therapeutic belief system", which is the schemas that are developed through one's personal history or as scripts, prototypes, irrational assumptions and automatic thoughts. Singer, Sincoff, & Kolligian (1989) states *"schema represents the mechanisms underlying our hidden agendas that we all - patients and therapists bring to each life experience and situation"*. Also, Marsha Linehan, founder of dialectical behavior therapy (DBT), is concerned with what she has named "relationship acceptance" and experiences which may be seen as countertransferential: *"many therapists are not prepared for the pain they will have to recognize in themselves while working with borderline patients, or the professional chance one must take, the personal doubts one must endure, and the traumatic moments that will come"* (pp. 516, Linehan, 1993). She continues with the old saying "*If you cannot stand the heat, do not go into the kitchen"*, which also gives associations to Freud's well known quote:

"…no psycho-analyst goes further than his own complexes and internal resistances permit…".

Today's clinicians of all persuasions generally accept the idea that countertransference or the therapists' feelings can be a useful source of information about the patient and the therapeutic relationship. It is seen as a joint creation involving contributions from both the therapist and the patient, and is both conscious and unconscious (Gabbard, 2001). The theoretical complexity embedded in the construct (e.g. the unconscious) does not lend itself easily to be studied by standardized methods. Generally, in the field of psychotherapy, there is a gap between clinicians and researchers (Goldfried, 2000). In order for psychotherapy research to bridge this gap, Kazdin (2008) argues for giving greater priority to research that more easily can be translated to clinical practice. Countertransference is most of all a clinical phenomenon. Therapists experience an amalgam of feelings and experiences each day in relationship to their patients. The intensity of emotion in psychotherapy is assumed to draw many therapists to the field (Najavits, 2000). Countertransference has produced vast amounts of theory; indicating clinicians' curiosity and fascination concerning the phenomenon. Research on countertransference might lend itself as useful to clinicians and clinical practice. As of today the empirical research is meager, yet developing within different conceptualizations. By aggregating across cases, empirical countertransference research aims to test hypotheses derived from theory and clinical cases, and discover systematic knowledge concerning the therapeutic relationship, as well as other factors that shape the therapeutic outcome.

Empirical Research on Countertransference

Empirical studies supports the theoretical assertion that countertransference is a result of complex relationships between the therapist, the patient and their unique relationship (Hafkenscheid & Kiesler, 2007; Holmqvist & Armelius, 1996; Holmqvist & Armelius, 2004; Røssberg & Friis, 2003; Whyte, Constantopoulos & Bevans, 1982). Clinicians' experience seems to make an impact on the countertransference; as years of experience increased, intensity in countertransference decreased (McIntyre & Schwartz, 1998). In addition, countertransference is a universal phenomenon across diverse theoretical orientations (McIntyre & Schwartz, 1998; Pope & Tabachnick, 1993). A study was designed to assess countertransference as therapists' conscious cognitive, affective and behavioral responses, as well as the intensity of these reactions, in a random sample of clinicians from a variety of theoretical orientations (Betan, Heim, Conklin & Westen, 2005). Across therapists'

theoretical position they did not report systematically different countertransference reactions. In other words, it seems like theoretical background does not influence the therapists' reactions to the patients. In addition, it has been found that same diagnostic patterns concerning patients' personality disorders emerge across therapists of different theoretical modes (Betan, et al., 2005; McIntyre & Schwartz, 1998). Researchers from other schools of therapy, outside the psychodynamic domain, have also shown an interest in the therapist feelings and emotional reactions (Hoffart & Friis, 2000; Hoffart, Hedley, Thornes, Larsen, & Friis, 2006, Najavits et al., 1995). In a study from cognitive behavioral therapy, it was found that therapists' self-reported positive and negative feelings showed differential correlations with the patients' resistance as observed by raters; in the predicted direction (Westra, Aviram, Connors, Kertes, & Ahmed, 2012).

Most research on countertransference is from the psychodynamic field. However, different research groups do not agree on definitions and too often do not refer each other's studies. The above mentioned research has all studied therapists' self-reported countertransference. A central group of researchers maintain that countertransference is only the therapists reactions to patients based on the therapists' unresolved conflicts, with largely unconscious origins (e.g. Friedman & Gelso, 2000; Gelso & Hayes, 2009). Hence, the source of countertransference is clearly located as residing within the therapist, which is thought to encourage the therapist to take responsibility for their reactions (Hayes, 2004).The general feelings, thoughts and fantasies that the therapists become aware of and may report in a questionnaire, is not countertransference (Fauth, 2006; Gelso & Hayes, 2009). This group of researchers presume that therapists have numerous appropriate responses to patients; these feelings and experiences that is evoked from the patient is best viewed as simply the therapist' affect or cognition (ibid). One may raise questions concerning how the objectiveness of "appropriate responses" in a relationship might be established. The empirical researchers within this countertransference paradigm have investigated the *therapists' observed behaviors* during sessions, conceptualized as withdrawal, under-involvement, over-involvement, or avoidance defined as stemming from the therapists' irrationality (e.g. Hayes, 2004). These behaviors are thought to be unconscious and investigated both in real therapy, by supervisors rating supervisees, and in analogue research (Rosenberger & Hayes, 2002). These countertransference behaviors are found to give an immediate negative therapeutic effect in the session (Williams & Fauth, 2005; Rosenberger & Hayes, 2002, Ligiéro & Gelso, 2002) and adversely affect outcome in the long run (Hayes et al., 1997; Hill, Nutt-Williams, Heaton,

Thompson, & Rhodes, 1996). Managing countertransference successfully is related to better therapy outcomes (Gelso, Latts, Gomez, & Fassinger, 2002; Hayes et al., 2011).

In this dissertation it is argued that as we do not know the unconscious, the unconscious countertransference is not available for inspection, outside supervision or without enactments; forgetting, falling asleep, not being able to collect payments, or end the session, which may be indications of unconscious countertransference (Zachrisson, 2009). A supervisor may help the therapist to become aware of unconscious aspects of the countertransference through how the therapist talks about the case, and audio or video tapes from sessions. The above mentioned research on countertransference shows how irrational behavior affects therapy. Hence, to enhance the therapist's awareness of "blind spots" might be crucial. Supervision and therapy is seen as important factors in becoming a dynamic psychotherapist.

In regular sessions, increased awareness concerning the conscious counter-transference is thought to bring hindering aspects due to unconscious phenomena closer to awareness. Additionally, aspects of the countertransference that are out of awareness may become gradually more conscious as the same interpersonal patterns are repeated in the therapeutic dyad. The belief, maintained in the present studies, that countertransference is a relational phenomenon, makes the disentanglement of the therapist's own material from that of the patient, an important albeit impossible task that never will tell "the true story" as to what belongs to whom. All therapists' reactions are by its nature the therapists' responsibility, as every reaction is colored by the therapists' subjectivity. Every therapist would probably respond in the face of intense despise or anger; however, the response is idiosyncratic to each therapist. An objective, appropriate reaction seems difficult to decipher. Hence, the therapist's subjective, conscious experience is claimed to be an essential part of the total countertransference reaction and is studied through the investigation of the *therapists' inner experiences* during sessions. That is; what the therapists become aware of, acknowledge, remember, and are willing to report after sessions.

In this line of countertransference research, a variety of questionnaires are designed to assess differential responses, as well as their intensity (Betan, et al., 2005; Holmqvist & Armelius, 1994; McIntyre & Schwartz, 1998; Røssberg & Friis, 2006, Schmidt, Wagner, & Kiesler, 1999). Some investigate the *objective countertransference* which refers to "all covert psychological reactions and action tendencies of therapists that are evoked by patients' maladaptive interpersonal styles" (p 393, Hafkenscheid & Kiesler, 2007). The clinical importance of objective countertransference is widely acknowledged, the empirical

knowledge is still in its infancy (ibid). Objective countertransference has been investigated with the Impact Message Inventory (IMI-C); therapists rated their cognitions, emotions and action tendencies (the impact message) towards patients. The hypothesis that interpersonal impact generalize across therapists was explored across group therapy, inpatient settings, and individual therapy plus group therapy, hence all patients had more than one therapist. They found that some maladaptive interpersonal styles are more generalizable across therapists than others; especially countertransference reactions to the IMI-C dominant scale appeared to be generalizable while the reactions to the affiliation scale were found to be less so (Hafkenscheid, 2003; Hafkensheid & Kiesler, 2007).

Therapist feelings is at times viewed as synonymous with countertransference or at least, as one of the main road to understand countertransference (Holmqvist & Armelius, 1996a, Røssberg et al., 2003). This dissertation continues the work on therapists' countertransference with the use of a Feeling Word Checklist (FWC), a self-report questionnaire designed to assess therapists' feelings, which use started in 1982 (Whyte et al., 1982). Different authors have since used diverse FWC; the feeling words varies from 16 words (Colson, Allen, Coyne, & Dexter, 1986), 18 words (Mitchell & Hastings, 1998) 30 words (Holmqvist & Armelius, 1994; Whyte et al., 1982), 36 words (Hoffart & Friis, 2000), 48 words (Holmqvist, 2001) and 58 words (Rossberg et al., 2003; Thylstrup & Hesse, 2008). The main reason given for the expansions of words in the development of the questionnaire, are clinical; the therapists using the instrument found that the checklist lacked important feelings. The reason for expansion is also research oriented; that is, the search for more stable scale-structure. For higher precision the instrument has also changed from a simple yes/no format to Likert scales. Paper I provides further information on the history, as well as data concerning the reliability and factor structure of the FWC-58 as used to capture an aspect of the total countertransference.

The concept of countertransference stems from individual therapy; still the many versions of FWC are mainly used by staff working with inpatients. Only Holmqvist and colleges have used FWC on both staff (Holmqvist & Armelius, 1994; Holmqvist & Armelius, 1996b; Holmqvist & Armelius, 2004; Holmqvist & Armelius, 2006) and individual therapist (Holmqvist, 2001; Holmqvist, Hansjons-Gustafsson, & Gustafsson, 2002). In the first data set, the observations were based on the FWC-30 by staff working with inpatients. Holmqvist and colleges found subscales that were arranged around two dimensions: "Negative – Positive" and "Intense – Less intense" feelings (Holmqvist, 1996). In the one study of FWCs used in individual therapy, 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, Hansjons-Gustafsson, & Gustafsson, 2002). The four factors were examined in relation to the patients' relationship patterns, which showed scattered correlations across therapists. However, when examined qualitatively, patterns of ties between relationship episode content (CCRT patterns) and therapist feelings could be detected (ibid). In this study, therapists general pattern of feelings were consistent over different patients and over time, yet feelings varied toward the individual patient (Holmqvist, 2001). This corresponds with earlier research; the therapist contribution is larger than the patients' contribution to the countertransference. Based on analyses of large amounts of FWC observations, Holmqvist & Armelius (1996) have suggested that approximately 15% of variance in therapist's feelings may be accounted for by reactions to patients individually.

When Røssberg and colleagues (2003) examined the underlying structure in the FWC-58 as used by staff working with inpatients, again seven factors were found. However, they did not replicate Holmqvist's bipolar factors (1996) but found them to be unipolar and named them; Important, Confident, Rejected, On Guard, Bored, Overwhelmed, Inadequate (Røssberg et al., 2003).

The FWC-58 as used in individual therapy is examined for the first time in Paper I. Results from this study is brought further in Paper II and III. The research on FWC pattern and outcome is sparse and there seems to be no previous research on FWC and outcome in individual therapy. However, from a day treatment program different countertransference feelings were found to be associated with positive outcome ("important" and "confident") vs. negative outcome ("disengaged" and "overwhelmed") (Røssberg, Karterud, Pedersen & Friis, 2007; Røssberg, Karterud, Pedersen & Friis, 2010). The optimal affective climate for inpatients with borderline pathology seemed to be an emotionally engaged staff experiencing both aggressive and warm feelings, and *not* a relaxed stance (Holmqvist, 2000a; 2000b). Furthermore, it has been reported that therapists' insecurity mediates the relationship between personality disorder severity and persistence in interpersonal problems (Hoffart, Hedley, Thornes, Larsen, & Friis, 2006).

Segal (1977) writes: *"Countertransference is the best of servants and the worst of masters"* (p. 31). The dual edged nature of emotion as both harmful (when too intense) and helpful (when used as a guide) is clinically familiar (Epstein & Feiner, 1979). Theory and clinical anecdotes, as well as single-case studies are predominating in the literature concerning countertransference. Empirical research is scarce. The therapist's countertransference and feelings are at the core of psychodynamic thought and there is an

interest in the phenomena also outside the psychodynamic domain. The therapeutic relationship is seen as essential for change, and relationships without feelings do not exist. Thus, there is a need for further studies on countertransference, using different methods, in order to understand more of the phenomenon, the relational impact, and associations to outcome. To the author's knowledge, the dual edged nature of countertransference has not yet been investigated over time in individual therapy using a quantitative measure, in addition to outcome measures, combined with qualitative analyses. As such, investigating countertransference, by aggregating data over many cases and using statistical methods is an explorative venture where hypotheses must be taken from theory and clinical knowledge, and therefore, could not be very precise.

Aims of the present studies

The overall aim in this dissertation was to study more rigorously a significant domain within the total countertransference construct using quantitative methods. The following questions were addressed in the dissertation:

I. Research on countertransference indicate systematic patterns in underlying factors, however, the patterns depends on the numbers and words included in the questionnaires, and probably on the context.
   a) How many clinically meaningful factors did the items in FWC-58 constitute when used in individual therapy, and what were their psychometric properties?

   Clinicians assert that different patients evoke different feelings in therapists. Since countertransference is defined as a relational construct, one would expect it to vary most in relation to the patients' relational problems, and less with symptoms and level of functioning.

   b) Hence, were there relationships to be found between the factors in FWC-58 and patients' suitability for psychodynamic therapy, relational characteristics, level of symptom and functioning, as well as with the therapeutic alliance?

II. The results of the first study revealed four subscales in the FWC-58. The one with highest mean value was a parental subscale including the words: Motherly, Affectionate, Dominating, and Important. Theory claims that patients with different levels of personality pathology need the therapists to adopt dissimilar roles in order to achieve positive outcome. Parental countertransference is hypothesized to make a difference in regard to what patients with disparate levels of personality pathology may have a need for.

a) Are level of parental countertransference associated with specific long-term effects of transference work, and do these associations change as a function of different levels of patients' personality pathology?

III. So far, the investigations were based on statistical aggregation and significance testing of differences in mean values. In-depth examining of two therapeutic processes using both quantitative and qualitative data may further our understanding of the predictions revealed in Paper II by exploring how a similar countertransference reaction may contribute to either success or failure in time limited psychodynamic therapy.

a) Does self-reported parental countertransference shine through differentially in the therapeutic process and in the transference work depending on the patients' level of personality pathology?

b) If so, is it plausible that in the two cases, the parental countertransference contributed to the long term success and failure observed?

The Present Study

Design and Method in the First Experimental Study of Transference (FEST)

The present dissertation used data from the First Experimental Study of Transference (FEST). FEST is a randomized controlled trial (RCT) with dismantling design, plus follow-up evaluations 1 year and 3 years after treatment termination. The main objective for the FEST study has been to examine long term effects of a specific technique, a core ingredient in psychodynamic therapy; namely, *transference work*.

Hundred patients were allocated by simple randomization, without stratification, into two treatment groups after completion of the pre-treatment ratings. The patients were not informed as to which technique was used or the study hypotheses. They were simply told that the aim of the study was to explore the long-term efficacy of psychodynamic therapy. Treatment completers' were those patients who terminated treatment in agreement with the therapist. Written informed consent was obtained from each of the 100 participants included in the study. Only the patients' therapist learned the result of the random assignment procedure. The random assignment code was kept on a separate computer, belonging to the research assistant. The other clinicians remained blind to the patient's treatment group. The Regional Ethics Committee, Health-region 1, Norway, approved the study protocol.

Treatment Conditions

The hundred patients included in the study were offered weekly sessions of 45 minutes, for up to one year. The sessions were audio recorded. Fifty-two patients were assigned to dynamic psychotherapy with low to moderate use of transference work (transference group). Forty-eight patients were assigned to dynamic psychotherapy of the same kind but without transference work (comparison group). Treatment manuals of principles, not step-by-step procedures, were used for both treatment conditions (Høglend, 1990; 1994). In the pilot phase of the study, the therapists were trained for up to four years in order to enable them to provide treatment with a low to moderate level of transference work, and treatment without such interventions, with equal ease and mastery. For both treatment groups, psychotherapy was based on general psychodynamic treatment techniques. Since both treatments were exploratory, rather than supportive, the therapists mostly abstained from giving advice, praise, or reassurance.

For the transference group, the following specific techniques were prescribed to the therapists: 1) address transactions in the patient-therapist relationship; 2) encourage the patient to explore thoughts and feelings about the therapy and the therapist; 3) encourage the patient to discuss how s/he believes the therapist might feel or think about him/her; 4) include the therapist in interpretive linking to dynamic elements (conflicts), direct manifestations of transference, and allusions to transference; and 5) interpret and link repetitive interpersonal patterns to transactions between patient and therapist (Høglend, 1994). In the comparison group, these techniques were proscribed. Instead, the therapists consistently focused on interpersonal relationships outside of therapy as the basis for similar interventions, as opposed the here and now relationship between patient and therapist.

Treatment fidelity

Treatment fidelity was assessed by three blind, independent raters, using a manual for process ratings (Høglend, 1994). The raters, two psychiatrists and one psychologist, had 15 to 30 years of clinical experience as dynamic psychotherapists. The training period for the raters included 15 full sessions from each treatment group. A global rating method, rather than rating the exact frequency of the different interventions, was used. The frequency of a certain intervention does not necessarily give a valid measure of how important this type of intervention was in a given session. Both how clearly an intervention is offered and how much it is emphasized should be given weight in the rating process. All items in the manual therefore use a five point Likert scale ranging from “not at all used” (0), “moderately used”

(2), to ”very much used” (4). Four or five full sessions of each therapy (a total of 452 sessions) were rated by two raters, blind to treatment group. Using average scores of the two raters, the reliability estimates (ICC) was above 0.70 for all items. Treatment integrity was excellent (Bøgwald, Høglend, & Sørbye, 1999; Høglend et al., 2006). The only difference between the two treatments was use of the specific transference interventions. The average score across the 5 specific interventions was 1.7 (*SD*=0.7) in the transference group, indicating moderate use of transference work, and 0.1 (*SD*=0.2) in the comparison group, indicating nearly no use at all (t (58.2) =14.8, p<0.005). The average use of supportive interventions was low and equal in the two treatment groups. The therapists' skill in delivering the interventions was high and equal in the two treatment groups.

Therapists

Patients were assigned to one of seven therapists based on availability. The clinical research team consisted of six psychiatrists and one clinical psychologist, all of whom had 10-25 years of experience in practicing psychodynamic psychotherapy. There were two female therapists, five male. Four were fully trained psychoanalysts. Each therapist treated 10-17 patients participating in the study and all therapists treated patients from both groups. This study does not include information of more personal matters concerning the therapists. Earlier results from the FEST study detected no differences in effectiveness between therapists. However, the study did not have sufficient power to detect small to moderate differences between therapists. One of the male therapists used the countertransference questionnaire radically different than the rest of the therapists; all his cases were extreme outliers on this measure. It is thus likely that this therapist used the questionnaire in such a manner that transforming the data would not be appropriate. Hence, the therapist's data were removed from further analysis.

Patients

From 1994-2001, 122 patients were referred to the study therapists by primary care physicians, private specialist practitioners, and public outpatient departments (Figure 1). The study 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. After 13 patients had started therapy, the research group decided to incorporate a questionnaire on CT feelings in the study. Hence, there are CT data from therapists working with 87 patients.

However, 12 of these patients were removed from the data due to the excluded therapist. One patient outlier in the transference group was deleted from analyses of longitudinal data as it became clear during treatment that this patient did not meet study inclusion/exclusion criteria (the patient had been abusing sedatives and painkillers over many years). Finally, seventy-four patients were included in the statistical analyses (Table 1). These patients sought psychotherapy due to depressive disorders, anxiety disorders, personality disorders, and interpersonal problems. After random assignment there were no statistically significant differences between the two treatment groups on the measured variables.

Figure 1. Patient flow in the randomized clinical trial comparing dynamic psychotherapy with or without transference work.

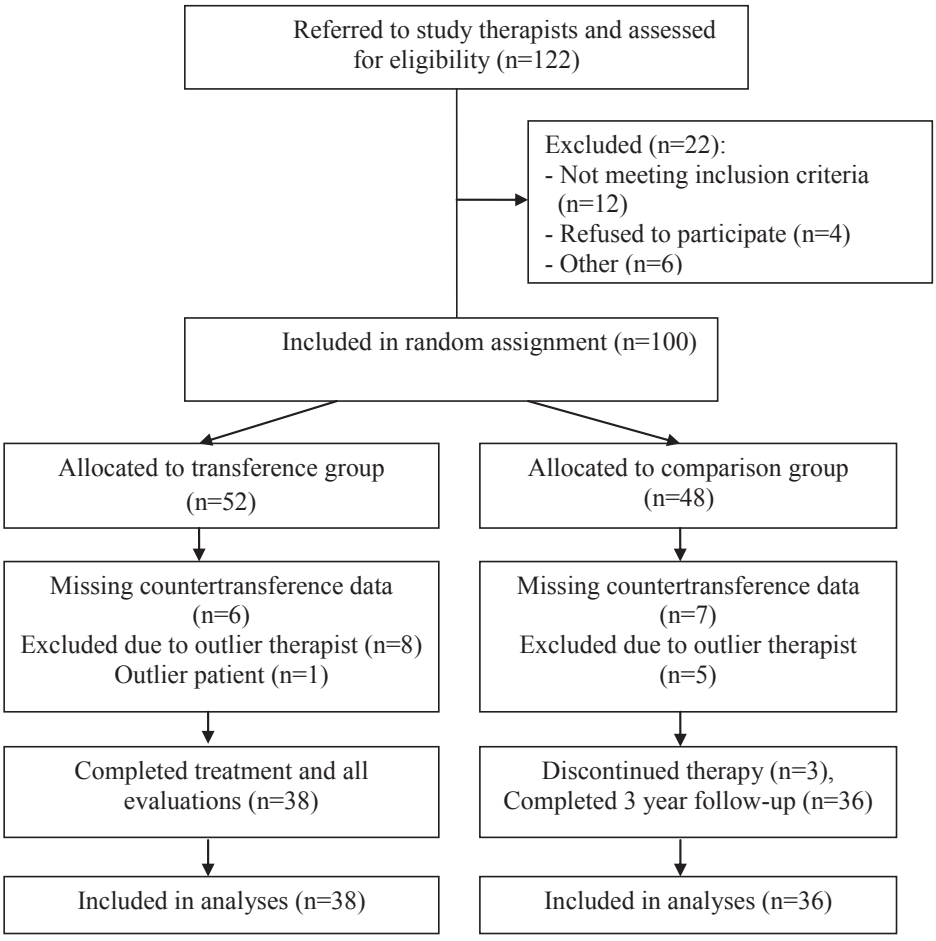

Table 1. Pre-treatment characteristic of 74 patients receiving 1 year of dynamic psychotherapy with transference work or without transference work (Comparison)

		Transference (n = 38)	Comparison (n = 36)	Total (n = 74)
		M (*SD*)	*M* (*SD*)	*M* (*SD*)
	Age	38.0 (8.4)	35.9 (9.4)	37.0 (8.9)
	Expectancy [a]	8.1 (2.2)	8.2 (2.4)	8.1 (2.3)
	Motivation [b]	5.4 (0.6)	5.4 (0.6)	5.4 (0.5)
	PFS [c]	63.3 (4.2)	63.9 (5.0)	63.6 (4.6)
	GAF [d]	61.2 (5.8)	59.6 (6.7)	60.4 (6.3)
	IIP [e]	1.3 (0.6)	1.2 (0.5)	1.2 (0.5)
	GSI [f]	1.1 (0.6)	1.1 (0.5)	1.1 (0.6)
	Sum PD-criteria	11.8 (7.5)	8.9 (6.1)	10.3 (6.9)
		N (%)	*N* (%)	*N* (%)
	Female sex	20 (51)	25 (70)	45 (60)
	Single marital status	12 (31)	19 (53)	31 (41)
	Education > 12 years	10 (26)	12 (33)	22 (30)
	Employed	25 (64)	21 (58)	46 (61)
	Sought help before	28 (74)	23 (64)	51 (69)
Axis I diagnosis:				
	Depressive disorders	14 (36)	19 (53)	33 (44)
	Anxiety disorders	6 (15)	7 (19)	13 (17)
	Adjustment reaction	3 (8)	0 (0)	3 (4)
	Other	6 (15)	2 (6)	8 (11)
	No Axis I diagnosis	5 (13)	6 (17)	11 (11)
Axis II diagnosis:				
	General criteria PD [g]	18 (48)	18 (49)	36 (48)
Cluster C	Avoidant	5 (13)	4 (11)	9 (12)
	Dependent	2 (5)	2 (6)	4 (5)
	Obsessive compulsive	4 (10)	5 (14)	9 (12)
	Passive aggressive	2 (5)	1 (3)	3 (4)
	Depressive	4 (10)	4 (11)	8 (11)
Cluster A/B	Borderline	0 (0)	1 (3)	1 (1)
	Antisocial	1 (2)	0 (0)	1(1)
	Paranoid	3(8)	0 (0)	3 (4)
	Narcissistic	2 (5)	0 (0)	2 (3)
	NOS	4 (10)	7 (19)	11 (15)
	More than one PD	4 (10)	5 (14)	9 (12)

Notes. [a] Target Expectancy (1-12) , [b] Motivation for active change and self-understanding, [c] Psychodynamic Functioning Scales, [d] General Assessment of Functioning, [e] Inventory of Interpersonal Problems- circumplex version, [f] Symptom Check List -90-R, [g] General criteria for any Personality Disorder.

Assessments

FEST includes a vast battery of information and questionnaires concerning the patients and the therapeutic process. All measurements employed in one of the three papers included in this dissertation are presented in the following:

Outcome measures.

In the present study, several outcome measures are employed; clinician rated and self reports. Before treatment, at treatment termination and 1 and 3 years after treatment the patients had a 2-hour semi-structured interview with at least one independent evaluator. The interviews were audio recorded and rated by to other clinicians. The raters were independent (i.e. not the patient's therapist) and blind with regard to treatment group. The self reports were administered at the same time points, as well as in the 16th week of the treatment period. No structured interview was used in this study to determine Axis I diagnoses. These diagnoses were based on the clinical history and assessment of background variables by the patient's therapist.

Clinician rated measures. Change on the *Psychodynamic Functioning Scales* (PFS; (Høglend et al., 2000) over the 4 year study period was the primary outcome measure in this study, chosen a priori. PFS was rated at baseline, at the end of the treatment and 1 and 3 years after treatment termination. PFS uses six scales, with the same format as the Global Assessment of Functioning, to measure psychological functioning over the three previous months. Three of the scales measure interpersonal aspects: Quality of Family Relationships, Quality of Friendships, and Quality of Romantic/Sexual Relationships. The other three measure intrapersonal functioning: Tolerance for Affects, Insight, and Problem Solving Capacity. Inter-rater reliability (ICC) for the average scores of 3 raters on PFS was 0.91. Aspects of content validity, internal domain construct validity, discriminant validity from symptom measures, and sensitivity for change in dynamic therapy have been established in different samples of patients and evaluators (Bøgwald & Dahlbender, 2004; Hagtvet & Høglend, 2008; Hersoug 2004).

The *Global Assessment Scale* (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976) was the third outcome measure and was used to assess the overall psychological, social, and occupational functioning on a hypothetical continuum of mental health on 1-100 scale that contains ten descriptive levels to anchor ratings. The inter-rater reliability (ICC) for average scores of three raters was .92.

The *Structured Clinical Interview for DSM-III-R* (SCID-II; Spitzer, Williams, Gibbon, & First, 1990) was administered by the patient's therapist to assess Axis II diagnoses or personality disorders at baseline and at three years follow up. Following DSM-III-R the personality disorders comprise eleven specific disorders (APA, 1987). A consistent finding is that patients with one specific PD often show a high degree of comorbidity with other PD's (Critchfield & Benjamin, 2006). It has been shown that the number of fulfilled PD criteria independent of specific PD disorders, has an effect on the level of quality of life and interpersonal dysfunction in a linear fashion (Cramer, Torgersen & Kringlen, 2006). 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 decided to focus on overall personality pathology rather than specific personality disorders. The overall personality pathology is the sum of positive criteria on the SCID-II. All therapists had prior training in using SCID-II, but no interrater reliability was documented in this study. The therapist and at least one other independent clinician discussed the PD diagnoses and the SCID II protocols until consensus was reached, and before randomization.

Self rated measures. The second outcome measure chosen a priori was the *Inventory of Interpersonal Problems- circumplex version* (IIP-C, Alden, Wiggins & Pincus, 1990). The IIP-C is a 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". The total mean score IIP-C was used to measure the patients' self-reported problems. The internal consistency, Cronbach's alpha, was 0.85 for the IIP-C total mean score in this study.

The *Symptom Check List-90-R* (SCL-90; Derogatis, 1977) was the fourth outcome measure and 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) which is employed in this study. The SCL-90 is one of the most widely used psychometric instruments in psychotherapy research.

Parental bonding measure

The Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) is a self report questionnaire developed to measure the patients' subjective experience of being

parented to the age of 16. PBI was used to estimate maternal and paternal "care" and "control". Cut-off scores for "high" and "low" categories is: For mothers, a *care* score of 27.0 and a *control* score of 13.5; for fathers, a *care* score of 24.0 and a *control* score of 12.5.

Alliance measures

The patients filled in the *Working Alliance Inventory - short version* (WAI; Horvath & Greenberg, 1989) in session seven. In addition to WAI, the *Help and Understanding Scale* (HUS) (Bøgwald, 2002) was used by patients and therapist after 1st, 7th, 16th and last session. HUS is a 100 mm visual analogue scale with the poles "totally wrong" and "totally right". On the scale the patients judge whether: "I am sure that my therapist understands me and helps me." The therapists judge whether: "I really like to treat this patient". The test-retest reliability over 7 weeks during treatment for patient-rated HUS was satisfactory (r = .60) as well as the correlation with WAI (r = .65).

Countertransference measure

The Feeling Word Checklist- 58 (FWC- 58; Røssberg, Hoffart, & Friis, 2003), comprised of 58 words mainly based on clinicians' subjective experience of countertransference feelings, was used to measure countertransference. The FWC-58 is a 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) (Appendix 1). In the present study the questionnaire was labeled "Countertransference" and the respondent was asked to rate to what degree they had experienced 58 feeling states like helpful, happy, angry, important, empathic, confused, stupid, guilt, bored, enthusiastic, etc, based on their subjective understanding of each word. FWC-58 takes about 5 min to complete and was administered after each session. Paper I in the present dissertation provides further data on the reliability and the factor structure of FWC-58.

Process measures

In order to assess treatment integrity; if, to what extent, and how skilled the therapist interventions were delivered, a global rating method (Høglend, 1995), rather than a rating of the exact frequency of different interventions, was used when listening to the sessions. Both how clearly an intervention is offered and how much it is emphasized should be given weight in the rating process. In addition, amount of supportive interventions were assessed and the general skill of the therapist in delivering interventions. All items in the manual therefore use

a five point Likert scale ranging from "not at all used" (0), "moderately used" (2), to "very much used" (4). With two raters per session, interrater reliability was generally high (ICC range = .70 to .97).

Session transcripts were scored using the *Transference Work Scale* (TWS; Amlo, Ulberg, Høglend, 2011). The TWC has been developed to assess the timing, the content, the valence, and patient's response to the transference work. The interrater reliability of TWS was varied from x - x (Ulberg, Amlo, & Høglend, in press). One of the researchers who developed the scale rated the sessions included in the study.

Session transcripts and audiotapes were employed when the *Structural Analysis of Social Behavior- Work* (SASB; Benjamin, 1996) was used for fine-grained process analyses. It involves measurement of each turn of speech between the therapist (focus on other) and the patient (focus on self), and is aimed at assessing emotional and unconscious aspects of therapeutic interaction. The SASB arranges categories in a circle defined by an underlying horizontal axis of affiliation (hate vs. love) and a vertical axis of autonomy (emancipate vs. control). The inter-rater reliability (weighted kappa) with two coders was on average .72 (Ulberg, Høglend, Marble & Sørbye, 2009).

In addition, the SASB process analysis specifies *the weighted affiliation and autonomy scores*. These scores are calculated separately for the therapist and the patient. The affiliation score is a summary score of the amount of affiliation/ friendliness in the participants' communications and provides a measure of how emotionally close they are. A positive score indicates friendliness, a negative score; hostility. The autonomy score is a summary score of the amount of autonomy; taking or granting (depending on focus), in the participants' communication. A negative autonomy value indicates that the process in the therapist-patient relation is controlling-submitting and a positive value signifies an emancipating-separating process.

Ratings of the therapy and how the therapist is remembered

At the end of therapy and at three years after, the patients rated the *Therapist Interventions and Qualities Inventory* (Bøgwald, 2001) which includes a list of 42 different therapeutic interventions (e.g. focused on the relationship between me and him, gave me homework, really tried to give me what I wanted), and therapist qualities (e.g. paying attention, caring, listening). They were then asked to rate to what degree these interventions and characteristics had been present in the therapy (0 = "no use/feature" to 4 = "conspicuous

use/feature", and how useful they found it (mark on a 10 cm visual analogue scale, from "totally useless" to "very useful").

The patients also rated the *Therapist Representation Inventory* (Orlinsky, Geller, Tarragona, & Farber, 1993), a 16-item instrument covering the patient's introject or representation of his therapist. Each statement is rated on a scale from 1 (not characteristic) to 9 (very characteristic). The questionnaire is believed to capture three aspects of the representation; mourning (e.g. I miss my therapist), failure of internalization (e.g. It feels like I never went in therapy), and therapeutic dialogue (e.g. When I have a problem I think of how my therapist and I would have discussed it).

Negative and positive life events

Before and after therapy, and at the two follow up interviews the patients filled in a questionnaire including twenty-four life events that might have occurred during the prior year and evaluated their negative or positive impact on a scale from -3 to +3.

Statistical analyses

Principal Component Analysis (PCA)

The Feeling Word Checklist- 58 (FWC- 58; Røssberg et al., 2003) is developed to measure "countertransference"; a latent variable, which cannot be measured directly. Instead there are 58 words trying to grasp different aspects of the countertransference. Factor analysis seeks to reduce the amount of data in order to understand the structure in the latent variables and get a more manageable size of data. The data reduction is achieved by looking for variables that correlate highly with a group of variables but do not correlate with variables outside that group (Field, 2009). A "factor" in factor analysis "explains" the observed correlations among the observed variables and is a hypothetical entity, a construct, or a latent variable that is assumed to underlie tests, scales, and measures of almost any kind (Hagtvedt, 2002). There are different ways of running factor analysis; confirmatory factor analyses are used to test hypotheses, while other variants like principal component analysis (PCA) simply gives an exploratory, empirical summary of the data set. FWC-58 is not a theory driven questionnaire, even so, a confirmatory factor analysis was used in order to test whether the same factors revealed by Røssberg et al., (2003) were to be found in our sample. We did not find the same factors and, hence, PCA was chosen in for the analysis in Paper I.

One has to consider whether sample size and variance are adequate for running PCA. A small sample will give less reliable correlation coefficients and make the results less stable.

There is a discussion whether the sample size needs to be large (> 300) or if is the ratio of subjects to items (e.g. 5:1) that matters (Tabachnick & Fidell, 2007). Also, the variances in the data needs to be large enough to catch the systematic variance in the sample; that is, not too great (few intercorrelations are high >.3), and not too low (many items are perfectly correlated), for PCA to be appropriate. To test the data for factorability Bartlett's test of sphericity needs to be significant to indicate enough correlations between items. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy (range 0-1) indicates whether the pattern of correlations is relatively compact. A value close to 1 is best for factor analysis. The next step in PCA is to determine the smallest number of factors that can be used to best represent the interrelations among the set of variables. There is a conflict between finding the simplest solution and explaining as much of the variance in the original dataset as possible. To assist the decision on how many factors, different statistical procedures may be employed; Kaiser's criterion, Catell's Scree test and Horn's Parallell analysis. However, pragmatic decisions need to be taken as to how many factors; partly guided by theory, by earlier research and by the data at hand.

Before interpreting the determined factors, the factors are rotated to present the patterns of loadings in a manner making it easier to propose possible interpretations. There are two main approaches to rotation: *Orthogonal* rotation, which forces the factors to be uncorrelated, and *oblique* rotation, which allows for underlying constructs to correlate (Field, 2009). They often show the same results, and many researchers use both; reporting the clearest and easiest to interpret. Once the amount of factors has been decided, which rotation to use, and theoretical sound labels are given to the factors, a decision on which items to include in each factor has to be made. Some items load on more than one factor and some items show only low loadings. There is no clear answer to keep or discard each item, since a loading of 0.4 explains only around 16 % of the variance in the item; therefore it seems reasonable not to include lower loadings.

The internal consistencies or the reliability of the subscales were measured by Cronbach's alpha. Cronbach's alpha is not supposed to be the only reliability evidence considered, though it often the case (John & Benet Marinés, 2000). Alpha should be above .8 if the scale is to be reliable. Others claim that when dealing with psychological constructs values below even .7 can realistically be expected because of the diversity of the constructs being measured (Kline, 1999). One of the main problems concerning alpha is that it will be above .7 or .8 if there is enough items in the scale, even if the average correlation between the items is low (John & Benet Marinés, 2000).

Linear Mixed Models (LMM)

In most statistical analyses; t-tests, analyses of variance (ANOVA), analyses of covariance (ANCOVA), and standard regression analyses data is treated as though they are organized at only one level and all observations are independent. Repeated measures ANOVA takes non-independence of repeated measures within patients into account, but cannot analyze non-independence in several levels. ANOVA cannot handle missing data and time points must be equal in space.

In the real world, data are often hierarchical and clustered or *nested* within other variables. To illustrate: when patients are treated by the same therapist (nested within therapist) they are likely to display some degree of relatedness in a statistical sense, which violate the assumptions of independence (Adelson & Owen, 2012). In Paper II the lowest level of data is the repeated measurements over time (level 1) which is nested within patients (level 2), who in turn are nested within therapists (level 3). In this model predictors (e.g. treatment group) is not an additional level. Other authors describe levels as patient (level 1), therapists (level 2), and predictors (level 3). Multilevel linear modeling, and more specifically, linear mixed models (LMM in SPSS version 16; 2008) as used in Paper II, are sophisticated quantitative methods that provide tools to handle non-independency in the data. In addition, it handles missing data, which is a typical problem in research with long term follow-ups, assuming that data are missing at random (Ulberg, 2009). Other advantages are the opportunity to include predictors at every level of analysis, and the possibility to model individual change and variances, as well as modeling nonlinear change in individuals (Tasca & Gallop, 2009).

The need for multilevel analysis depends on the size of the intraclass correlation (ICC). ICC provides an estimate of how similar for example patients treated by the same therapist are (the ratio of random variance for therapists to the total variance). Trivial ICC values indicate that non-independence does not matter, and the data may be analyzed on one level. However, if the ICC values are high (> 0.05) the assumption of independence is violated. When random variances for patients or therapists are very low (>0) the statistical model does not converge, and terms may be unreliable.

In LMM *subject* defines the cluster of observations. Intercepts and slopes can be defined as *fixed effects* and/or *random effects* in LMM. *Random effects* allow variation across units of the sample or individuals; e.g. initial status and rate of growth of dependent variable (Tasca & Gallop, 2009). In Paper II, patient (subject) and therapist (subject) were treated as random effects. That is, randomly distributed intercepts and slopes were fitted for each patient

and random slopes were fitted for each therapist. For example, initial scores on PFS/ IIP (intercept) and PFS/IIP growth rate across the whole treatment period (slope) are assumed to vary randomly between patients (subjects) and therapists. A very low ICC indicated that the intercepts were not non-independent within therapists. *Fixed effects* have a single constant value across all units of the sample or individuals (Tasca & Gallop, 2009). In Paper II treatment group was treated as a fixed effect. Intercept and time were treated as both random and fixed effects.

When random effects are included in the model, a covariance structure is used to estimate the model parameters. If a too simple covariance structure is specified, there is an increased risk of making a Type I error, on the other hand, if it is too complex a Type II error is more likely (Field, 2009). In Paper II, the *variance component* covariance matrix yielded the best goodness-of-fit measures. This is a simple covariance structure which assumes that random effects are independent, that is, no covariance between intercepts and slopes. It is recommended to choose a very small number of relatively uncorrelated predictors, with the help of strong theoretical framework, because correlated predictors are problematic in LMM (Tabachnick & Fidell, 2007) due to the risk of multicollinarity. Centering the variables reduces multicollinarity, and may make predictions more directly interpretable

In LMM, the models are built in a stepwise order. It starts with a simple, unconditional model to a more complicated model. The first step in LMM examines whether there is a significant variance in intercepts. The next step examines the variance in slopes by adding "time" to the model. Then, in the next steps different predictors (treatment, moderators and mediators) may be added to the model.

Effect sizes (converted to Cohen's *d*), derived from the *F*-test for mixed effects model, were calculated as $d = 2\sqrt{\frac{F}{df}}$ where *F* is the *F*-test statistic for the effect of interest in the repeated model as well as other multilevel designs (Verbeke & Molenberg, 2000).

Ethics

The Regional Ethics Committee, Health-region 1, Norway, approved the study protocol. In experimental treatment research there might be a conflict between research and treatment; for example one may be concerned that one group gets the inferior treatment. This could be in the best interest for research purposes, but not for the patient. In FEST, the therapists were highly experienced and thought to be motivated, as they chose to participate in such a time consuming study. Assumingly, both treatment groups got qualified treatment. The treatment limit of one year might not have been suitable for every patient, neither the

obligation to answer all the instruments. It is reasonable to believe that the patients did not exactly understand what it meant to be included in such a thorough study over a period of 4 years including the follow-ups; for better or worse. However, the patients got more therapy than often offered in general public psychiatric care, and there is no reason to believe that it is a disadvantage for the patients' health to be followed up by a group of specialists. When polled, more than 90% of the patients rated the follow-ups positively. And it is a unique feature of this study that 100% of the patients appeared in persona at the 3-year follow-up. An ethical issue that has been of concern is to protect the anonymity of therapists and patients involved; especially in the case comparison study, and efforts have been made in order to achieve sufficient anonymity for the parties involved.

Results

Summary of Paper I

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

To assess the therapists' emotional reactions, which are understood to be part of the countertransference, we used the Feeling Word Checklist (FWC-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, suitability for psychodynamic therapy, severity of personality pathology, interpersonal problems, level of general functioning, and symptoms. To establish the number of subscales in the FWC-58, 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: e.g. confident countertransference showed positive correlations with both patient and therapist evaluation of the HUS scale. Also parental countertransference correlated positive with therapist HUS, while disengaged countertransference showed negative correlations. The patients' suitability and relational functioning (personality pathology and interpersonal problems) showed significant correlations with one or more of the countertransference factors. There were no significant relations between the patients' level of symptoms and functioning and the countertransference factors. To conclude, 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.

Summary of Paper II

Long-term effects of transference work in the context of therapists' parental countertransference and patients' personality pathology.

Transference work is considered a core active ingredient in dynamic psychotherapy. However, there are contradictory findings as for whom and under what circumstances working explicitly with the therapist-patient relationship is beneficial. This study investigates long-term effects of transference work in the context of self-reported parental countertransference feelings, and patients' level of personality pathology. Personality pathology was evaluated before treatment as the sum of fulfilled personality disorder criteria items on SCID II. Parental countertransference was measured with FWC-58 after each session. Parental was the subscale with the highest mean value. In addition, parental countertransference did not immediately appear to be either a facilitating or a hindering facet, which was an intriguing aspect of the subscale. The outcome variables were the Psychodynamic Functioning Scales and Inventory of Interpersonal Problems, measured at pretreatment, midtreatment, post-treatment, one year, and three years after treatment termination. Longitudinal analyses were performed on 74 patients. We used linear mixed models to analyze longitudinal data (SPSS version 16.0, 2008). "Subject" and "Therapist" were treated as random effects. That is, randomly distributed intercepts and slopes were fitted for each patient and random slopes were fitted for each therapist in order to account for nesting (non-independence) in the data. The highest rate of improvement was during therapy, with diminishing returns over time following the end of therapy. Time was coded 1, 2, 3, 5, and 9 with one step for each ½ year, and transformed to a natural logarithm. Time at baseline became thereby 0. The log transformation of time fit the data discernibly better than a linear time slope (change in -2 log likelihood). Intercept and time were treated as both random and fixed effects, while treatment group (coded 1, 0) was treated as a fixed effect. A variance component covariance matrix yielded the best goodness-of-fit measures. The results demonstrated that a significant treatment group (transference vs. no transference) by personality pathology by parental countertransference interaction was present, indicating that parental countertransference had significantly different impact on the effect of transference work, depending on the level of personality pathology. In the context of low parental countertransference, transference work had a positive effect for all patients. When parental

countertransference increased, the positive effect of transference work was enhanced for patients with high levels of personality pathology. However, for patients with low levels of personality pathology the effect of transference work became negative in the context of even slightly elevated parental countertransference. This does not mean that patients with low levels of PD pathology, treated with transference work, by therapists reporting high parental CT, deteriorated. Rather it indicates that they would have been relatively better off without transference work. Hence, parental countertransference impedes the effect of transference work for patients with little or no personality pathology. In conclusion, the feelings of therapists within session and the personality pathology of patients strongly influenced the long-term specific effect of transference work.

Summary of Paper III

Transference work, parental countertransference feelings, and personality pathology: A case comparison study of Victor and Tim.

In this case comparison study the aim is to explore how a therapist's self-reported parental countertransference may contribute to either success or failure in time limited psychodynamic therapy. Two cases with divergent results, treated by the same therapist, were strategically chosen. The success case, Victor, had rather severe personality pathology whilst Tim, showed low levels of personality pathology and did not have a favorable outcome in the long run. In both cases, the therapist used transference work and reported high levels of parental countertransference. The two dissimilar courses of treatment are presented. Pre-treatment interviews and questionnaires from before, during, after therapy, up to three years follow-up, as well as quantitative and qualitative process analyses from session transcripts are used in this in-depth examination. The results give reason to believe that for Victor the parental countertransference colored the therapists' interventions in ways that did not repeat the rejection-frustration relationship patterns that Victor was familiar with. Rather, the interaction with the therapist gave rise to a new relational experience which facilitated positive change over time. In Tim's therapy it seems like the parental countertransference in some way reinforces old dominant-submissive relationship patterns, a pattern that was re-created anew in the relationship with the therapist. Tim did not seem to experience a new relationship pattern, and treatment in the context of the old repetitive pattern did not promote lasting change.

Discussion

Main findings

With the use of a feeling word checklist, the three studies included in this dissertation have investigated therapists' subjective conscious countertransference from different perspectives.

The Feeling Word Checklist-58; subscales and correlations

In the first study, 31 items from FWC-58 constituted four subscales that were conceptually coherent, psychometrically acceptable and clinically recognizable; hence, the therapists' feelings clustered into meaningful categories. The four subscales were named: Confident, Inadequate, Parental, and Disengaged. There are common features between these subscales and subscales obtained in other empirical studies, even if most studies from inpatient settings and day hospital units revealed more than four subscales (Røssberg & Friis, 2003 Hoffart & Friis, 2000; Holmqvist & Armelius, 1994; Katsuki et al., 2006; Røssberg et al., 2003). In the prior study from individual therapy, Holmqvist et al. (2002) also reported four subscales after factor analyzing 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). In this dissertation's first study, several factor solutions were tried out before deciding on the four subscales. For example, a factor solution with seven factors included an Idealized subscale (admired, important, exalted), and a Rejected subscale (disparaged, disliked, rejected), which is theoretically and clinically compelling. The seven subscales explained more of the variance in the data than the four subscales. However, the scales included a number of words that overlapped across subscales, and were not stable across different analyses. All the numerous solutions tried out included slightly different versions of the subscales: Confident, Inadequate, Parental, and Disengaged. Stableness was deemed as more valuable than explained variance; hence, four subscales were decided. The study includes a small number of therapists. If more therapists were included, the variance in data would probably have increased, and additional factors might come forth as stable. The same dilemma might have been present in other studies on factor structure and FWC, since this is a common quandary in principal component analyses.

Of the words encompassed in the FWC-58, 27 words were excluded from further analyses; this does not indicate that they are of no interest. Aggressive words (e.g. angry, frustrated, naughty and suspicious) did not constitute a subscale in paper I. These words

loaded too low on any subscale even when seven subscales were examined. The words had exceptionally low scores (e.g. "angry"; $M = 0.07$); hence, there is not enough variability in the data for a stable pattern to be revealed. However, it would have been of interest to study the sessions were aggressive feelings do occur; low levels of aggressive and hostile feelings are deemed crucial for outcome (Henry & Strupp, 1994; Schut et al., 2005; von der Lippe, et al., 2007). The therapists in this study report overall lower intensity in feelings than in other studies (e.g. Holmqvist, 2001). This may be associated with years of experience which is related to lower intensity (McIntyre & Schwartz, 1998). Also, experienced therapists are shown to be more comfortable with their emotional reactions (Brody & Farber, 1996). Other reasons might be connected to the questionnaire itself, and to contextual factors. The title "Countertransference" on the FWC-58 examined in this dissertation might have affected 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. The data shows that some therapists never reported, for instance, the word "Interested" during whole treatment periods. This seems implausible since the same therapists were interested enough in therapeutic processes to take part in such a thorough research project. However, it is plausible that there were treatments were the therapist did not feel out of the ordinary interested. In addition, it might be that the culture in this therapist group, did not encourage recognizing, accepting, and examining emotions; neither aggressive nor lovable feelings, which could have explained the low intensity. Whether there were clinical and theoretical disagreements concerning the use of countertransference in this group of therapists, is not known. One therapist in the group of seven reported far more feelings than the rest of the group, and the data had to be removed from further analyses. This therapist displayed variance in feelings, had few "0" marks, and reported on all 58 words after each session. It seems as if he examined his inner state thoroughly, and not only the feelings that exceeded the usual therapeutic interest and empathy. These observations may very well be used in future case studies.

When evaluating the subscales, no significant associations between the WAI (alliance) as measured in 7th session and mean value of countertransference over the whole treatment period, across therapists, were found. This is not surprising. The statistics indicate that even if the signifiers are in "expected" direction: positive with confident and parental; negative with inadequate and disengaged, this is by chance. Examining the associations between countertransference in the first sessions and WAI, might shed more light on the pattern of the signifiers and WAI. The positive correlations between patient rated HUS and confident

countertransference in the present study are of particular interest because of the non overlapping perspectives. Also, the therapists HUS correlates with confident countertransference. It would be interesting to study closer the therapeutic process were these patterns are most intense, in both "low HUS-low Confident" and "high HUS-high Confident", relationships. The latter might come close to a recipe for favorable treatment outcome. Whether the strong negative correlation found between the disengaged subscale and therapist rated HUS will have a negative impact on outcome, is unknown so far but will be examined in later studies. As HUS measures to what extent the therapist likes to treat the patient, disengagement might indicate that the therapist does not like to treat the patient very much, and at the same time does not acknowledge hostility and aggression. However in the cases of Victor and Tim, this does not fit. The therapist reported his lowest HUS and low disengagement concerning Victor. As to Tim; the therapist reported one of his highest HUS *as well as* a high level of disengaged countertransference. This is somewhat contradictory and does not fit with the statistical analyses on group means. However, the high level of disengagement with Tim might have had an impact on the relationship and therefore on Tim's deterioration in the long run.

In relation to patient characteristics, a strong negative relationship between level of personality pathology and confident countertransference was found. In addition, there was a strong negative relationship between disengaged countertransference and personality pathology; i.e. more personality pathology, less confidence and disengagement. Overall, patients with higher level of personality pathology show less mature defenses, affect liability, and interpersonal instability (Perry & Bond, 2005), which may affect the therapists' experience of being less disengaged, but also less confident. In the cases of Tim and Victor, the therapist reported lower levels of disengagement with Victor. However, he also reported the highest level of confidence with Victor. Again the therapist does not follow the predictions; he scored lower than his mean level of confident countertransference with both Tim and Victor. The therapist reported that the therapy seemed fine when giving overarching evaluations (high HUS) during the process with Tim. On the other hand, the countertransference he reported after every session indicated that the process did not run as smoothly (low on confident and high on disengagement).

The three evaluations of suitability for psychodynamic therapy showed differential correlations with the countertransference subscales. Higher level of psychological mindedness seems to amplify the therapists' parental countertransference, for example. Why there is an increase in these feelings when patients have a higher level of psychological mindedness, is

unclear. In Paper I, an idea was brought forth that the therapists experienced a greater identification and hence involved themselves more, in a parental way, with psychologically minded patients. The therapist reported high levels of parental countertransference with both Tim and Victor; it is possible that the therapist unconsciously (or consciously) identified himself with differing aspects of both Tim and Victor. However, this is only speculations.

Self reported interpersonal problems showed low correlations with counter-transference, resembling the studies on objective countertransference (Hafkenscheid & Kiesler, 2007), only Vindictive and Cold showed a significant negative association with the confident subscales. The mean level in interpersonal problems were not so high in this sample and did not seem to influence the interpersonal aspect of the process to the extent of producing significant correlations with the therapists' average countertransference feelings, except for a negative effect on confident countertransference. This may also be understood within the context of highly experienced therapists, which probably have worked with patients with more severe problems than this group.

Finally, there is literally no correlation between general countertransference feelings, functional impairment, and self reported levels of depression and anxiety. Paper I indicated that the patients' relational characteristics are more closely associated with therapist feelings than symptomatic measures. These correlations are in keeping with the contemporary psychodynamic view that countertransference is a relational construct (Gabbard, 2010).

General outcome

The FEST study is concerned with between group differences (differences in slopes between transference group and non-transference group), and not with overall outcome for the whole sample (within group change from pre-treatment to post-treatment). Yet, general outcome in the context of elevated parental countertransference was shortly touched upon for patients with low levels of personality pathology: the within group effect size reported were large (1.1 in the transference group and 1.6 in the non-transference group), indicating a considerable change in PFS from pretreatment to three years follow up. ES for high levels of personality pathology in the context of high parental countertransference was not reported in Paper II. However, in an earlier study from FEST patients with personality disorders showed ES ranging from .8 (non-transference group) to 1.7 (transference group) on interpersonal functioning, independent of countertransference feelings (Høglend et al., 2011). Overall ES are large during treatment continuing with small to moderate ES in the three years follow-up period (Høglend personal communication, 2012). Hence, the treatment effect does not only

last; it continues to increase after therapy has ended. Since there is no untreated control group (e.g. waiting list) in FEST, the change might partly be due to other factors than therapy. But large effect sizes are not to be expected in a no-treatment condition; hence, the treatment FEST offered seems effective. To strengthen the study from the "efficiency" perspective, the proportion of clinical significant change, reliable change, no change and reliable deterioration could have been included (Lambert, Ogles, 2009). However, no patient showed reliable deterioration in FEST.

Therapist feelings and outcome

As mentioned, little research has been done on FWC and outcome, and Paper II is, to the best of my knowledge, the first study from individual therapy showing significant, though complex associations between a countertransference facet and outcome in individual therapy. The outcome was rated by both independent evaluators (PFS) and patients (IIP) over several years after treatment termination. The LMM analyses indicted that for the average patient in FEST, the therapist's parental feelings did not affect the specific effect of transference work significantly. The patient's level of personality pathology was a decisive factor concerning parental countertransference and the specific effect of transference work. The treatment of patients with high levels of personality pathology calls for an active, involved, supporting, and affirmative therapist (Gabbard, 2010; Killingmo, 1989; Mc Williams, 1994; Tähkä, 2006). A neutral and analytic attitude is suggested by the theory of technique with the more "neurotic" patients (Tähkä, 1993; 2006; McWilliams, 1994). High parental countertransference might come close to the stance suggested for patients with high levels of personality pathology and low levels might be closer to the latter.

In Paper II, level of personality was defined as the number of positive criteria on SCID II, the reliability and validity of this measure in this context is of course questionable. There is a significant correlation between positive items on SCID II and quality of life an interpersonal dysfunction (Cramer, Torgersen, & Kringlen, 2006). However, there is possibly quite serious personality pathology that SCID-II does not capture; it is a diagnostic instrument, developed to capture the eleven specific disorders in DSM-III (APA, 1987). One may question whether SCID-II is the best measure of personality pathology when psychodynamic theory is used for building hypotheses and understanding the results. Kernberg's structured interview of personality organization (Stern et al., 2010) might have been still more relevant in this study. Even so, overall personality pathology as measured with SCID-II is assumed to give an indication as to level of personality pathology.

The results in Paper II signify that patients with high levels of personality pathology do best with transference work, and even better if the therapists' countertransference is parental. Also, patients with low levels of personality pathology show a positive effect of transference work. However, in the context of increasing parental countertransference this positive effect declines. What is not indicated in these results are the directions of these associations; whether it is the patients that pull the therapist into a parental position (patient characteristic), whether it is the therapist's ability to sustain a parental attitude in the midst of relational turbulence, or a tendency to feel parental in most situations (therapist characteristic); or if it is a mixture (relational fit) that may account for the results, is not known. Most likely the total parental countertransference is a confluence of the therapist's own unconscious internal object relations and what is induced in the therapist by the patient's unique characteristics (Gabbard, 2001). These different components and their specific effects can only be investigated further by observing what is actually being communicated in the sessions.

In Paper I and II only the therapist's self-reports are examined. Hence we do not know how parental countertransference manifested in the therapeutic process. In the intensive quantitative process analyses in Paper III; the Structural Analysis of Social Behavior (Benjamin & Cushing, 2000) and the Transference Work Scale (Amlo et al., 2012), as well as session transcripts, are utilized to shed light on how therapist interventions are colored by countertransference. The two cases Victor and Tim were strategically chosen in order to shed light on the results from Paper II. Victor's success and Tim's lack of change at the three years follow up after one year of dynamic therapy with transference work, may be related to high levels of parental countertransference as scored by the therapist during the treatment (e.g. Tähkä, 1993; Gabbard, 2010). Victor might have heard the transference work as an invitation to a new kind of relationship with a benevolent parent figure, while Tim perhaps heard the transference work as insisting or as disguised critique of him who did not live up to parental expectations.

The therapist reported more intense countertransference with Victor, except for Disengaged countertransference, which was stronger with Tim. This is in line with the correlations presented in Paper I which indicate a higher level of disengagement with patients with low levels of personality pathology. Tim reported low levels of alliance on WAI and also on HUS. Earlier findings from FEST specify that a low level of transference work was especially beneficial for patients within the context of low alliance (Høglend et al., 2011). The therapist used frequent transference work in the beginning of the therapy with Tim. High

frequency in the beginning has shown a negative association to outcome (Høglend, 1993; Piper et al., 1991). It has been hypothesized that these correlations may be due to the therapists using transference work in order to overcome resistance or try to force insight, which may sound critical rather than help patients when ready (Høglend & Gabbard, 2012). If so, this could partly explain Tim's low alliance scores.

The results in Paper II indicates that it is only when the therapist works with the transference that patients with low levels of personality pathology have a negative effect of increasing parental countertransference. It seems reasonable to assume that therapists' feelings will be more transparent when there is a consistent focus on the therapeutic relationship in the here and now, as is the case in the transference work group. Hence, it might be the focus on a relationship in which the therapist has adopted a parental role that is problematic for the neurotic patients. Transference is generally understood as consisting of both a wish (often unconscious) to repeat old relationship patterns and a wish to find a new object that will respond differently and correctively to the patient's transference (Gabbard, 2010). When transference work is colored by parental countertransference it might be the wish to repeat an old relationship pattern which is fulfilled, like in the case of Tim. Victor's and Tim's therapist had a tendency to feel parental in most situations. Hence, the particular characteristics of the therapist may partially determine which transference wish is fulfilled to a greater extent. The weight of each individual's contribution will probably vary in different patient-therapist dyads; e.g. some therapists feel parental in relation to most patients and some patients will make most therapists feel parental. Yet, every therapist will probably respond to each patient's interpersonal pattern in a personalized nonverbal and verbal manner (Josephs, 1992). This manner reflects both the therapists personal style and character, as well as the therapist's reactive (i.e. induced) experience of the patient's interpersonal pattern, what has been called "role responsiveness" (Sandler, 1976). Victor and Tim's therapist might have a personal style and character that is better suited for patients with high levels of personality pathology when he utilizes transference work. Nevertheless, in therapeutic practice, to assume that one can determine objectively and truthfully which component belongs to whom (therapist or patient), might be to overrate what therapists may know; reality appears much more reflexive and seldom that clear-cut that (Kiesler, 2001).

In order to investigate further how the therapeutic situation is co created, additional aspects of countertransference than the conscious subjective experience, is of interest and other methods than self-reports are required. For example listening to audiotapes which were included in Paper III, gave examples on how parental countertransference may shine through

in the therapeutic work. Video recordings would give additional information on body language. Methods using facial expressions on videotapes (e.g. Merten, 2005), and measures of skin conductance (e.g. Hein, Lamm, Brodbeck, & Singer, 2011) could have added sublime information regarding unconscious aspects of the countertransference and maybe also to those reactions that was not reported due to issues of memory and desirability.

Methodological discussion

Every method employed in the study of process and outcome in psychotherapy has its limitations and sources of error. In order to answer the specific questions raised, the objective is to find "Which model is the least wrong?" (John & Benet-Martinez, 2000). One model, amongst others, in psychotherapy research is the study of causal relationships between phenomena (e.g. is transference work in one-year dynamic psychotherapy essential for outcome?). Different philosophical approaches to causality exist; FEST rests on the perspectives of Cook & Campell (1979). In their view humans have a predisposition to make causal inferences. Knowledge of manipulation of causes in order to discern between casual and non-casual relationships, are of evolutionary significance. Due to this ability humans are able to make changes and control important factors in their environment. Research within this perspective favors the controlled experiment due to the method's ability to eliminate alternative explanations (Lund, 1996).

A casual investigation, like FEST, will include the operationalization of the assumed cause and its effects (independent and dependent variables), and the operationalization of type of person, situation and treatment interval (Lund, 1996). In FEST the dependent variable, transference work, is operationalized as the therapist's focus on the relationship between the therapist and the patient. The dependent variable; treatment outcome, is operationalized with a vast number of questionnaires and interviews. Also other fuzzy variables (e.g. patients, countertransference, relationship, process) investigated in the present studies are operationalized into countable units. The reliability, that is, the consistencies of all these measures are then of particular importance. If the various measures are without reliability, the validity or truthfulness of scientific research will be low. Paper I in this dissertation seeks to investigate the reliability and validity in using a feeling word checklist (FWC) as a measure of countertransference. The FWC-58, which is the foundation of this dissertation, will be discussed in its own right later on.

Most, if not all, measurements in psychotherapy research are subject to some sort of error (John & Benet-Martínez, 2000). Some sources of error may be avoided if considered

before the data collection start (e.g. checking that the person using an instrument has understood what it asks for, and how to score it). The reliability of a measure is enhanced by seeking to reduce the variance due to different errors in many facets of a measurement such as the scales, patients, raters, and occasions, plus interactions of these facets (Hagtvet & Høglend, 2008). Standardized instruments have been checked for reliability, either by test-retest, inter-rater reliability (kappa, intraclass correlation), or internal consistency often referred to as Cronbach's alpha. All outcome measures, in Paper II and III are standardized and checked for formal reliability in different ways, except for SCID II. All therapists had prior training in using SCID-II, and the results were discussed with an independent clinician until consensus was reached, but no interrater reliability was documented. However, no measurement in psychotherapy research will ever be as reliable as, for example, weight scales.

The term validity is at the core of science and refers to the truthfulness of an inference. In experimental science four types of validity are often referred in order to aid empirical designs: statistical conclusion validity, internal validity (causality), construct validity, and external validity. Shadish, Cook and Campell (2002) describe these concepts, which all have their specific sets of threats concerning truthfulness when studying the relation between treatment and outcome.

Statistical conclusion validity concerns the validity of inferences about the association between treatment and outcome or other cause and effect variables. The most widely used way to address if cause and effect covary is to test the significance of the null hypotheses (H_{0}). H_0 states that the difference between the populations' means from which the samples were drawn is zero. The probability that a difference obtained would have occurred by chance is stated with *p*-values. There is a possibility of keeping or rejecting the H_0 on false grounds: Type I error is false positive; the probability of rejecting a true H_0. That is, finding differences that are not true in the population. Type II error is false negative; rejecting a false H_0. That is, rejecting true differences in the population (Cohen and Cohen, 1983). Different threats to the statistical conclusion validity increase the risk of making Type I or Type II errors: sample size, too heterogeneous or too homogenous samples, unreliability of measures, unmeasured covariates, and treatment implementation, and low statistical power. Power is the possibility to reject a false H_0; hence, low power increases the risk of making Type II error. Power depends on effect size (ES) to be detected, alpha level and sample size. The effect size (ES) is a measure of the magnitude of a relationship. In Paper II, Cohen's *d*, which is one way to

account for ES, is reported. Standard ES is set to vary from small (>.2), medium (>.5), to large (>.8) (Cohen, 1988). In FEST, standard power calculation (endpoint analysis) indicated that moderate ES (.55) could be detected for alpha levels of .05 with a power of .80. In Paper II as well as in the FEST-protocol the significant level of 0.10 was decided à priori for the moderator analyses and the sub group analyses in order to balance the risk of Type I and Type II errors. Since the alpha level was liberal in FEST, it may have increased the risk of Type I errors. Moreover, three-way interactions may be unreliable in moderately large patient samples. Large ES indicates a large difference in group means. However, it does not give information regarding within-group variation or the clinical relevance. Hence, some researchers argue for always including estimates of clinically significant change (e.g. Lambert & Ogles, 2009) based on the work of Jacobsen & Truax (1991), which considers change on the individual patient level.

Internal validity refers to whether the inferences concerning the covariation between treatment and outcome reflect a causal relationship. There is always a possibility that changes in outcome measures are due to other factors than therapy (e.g. regression to the mean, spontaneous remission, or outside factors). In a randomized controlled trial (RCT) which emphasize internal validity, a treatment group and a control group (same kind of patients) would be established by randomization. The treatment group receives the treatment under study and the control group does not receive the same therapeutic intervention; rather it is given placebo, waiting list, or another type of treatment. If the control group does not show change, or less change, it supports the assumption that the specific treatment led to a change.

In FEST there is no untreated control group, rather two groups are given similar active treatments; one with and one without transference work. FEST fulfills all criteria for state of the art RCT. Up to date RCT includes a long list of guiding principles: There should be specific inclusion and exclusion criteria; randomization; power to detect moderate effect sizes; longitudinal analyses; primary and secondary hypotheses; preselected moderators and mediators; four or five waves of date over the 4 year study period. Evaluators should be blind to treatment group and patients unaware of treatment hypotheses; use of treatment manuals; experienced and specifically trained therapists; comprehensive treatment fidelity checks from audio recorded sessions; treatments completed and a plan for detailed statistical analyses should be specified before the randomization code was broken. Advanced statistical analyses, like linear mixed models, and independent statisticians should supervise all analyses. If these guidelines are followed, the internal validity is deemed high and the relationship between the

experimentally manipulated variables are seen as causal in nature. However, concepts like alliance, countertransference, and different mediators cannot be experimentally manipulated; hence, these analyses are exploratory and do not indicate causality.

One critical problem of RCTs and all comparative studies is that the researcher's preference for one of the therapies being compared has an impact on the outcome; the so called researcher allegiance effect. Studies have shown that researcher allegiance should be regarded as a causal factor and is a threat to the internal validity (Luborsky et al., 1999; Munder, Gerger, Flückinger, Wampold, &Barth, 2012). In order to correct for this threat it has been suggested that these studies should be conducted by teams with mixed allegiances in order to circumvent this problem (Luborsky et al., 1999). Since transference work is considered an essential element in dynamic therapy, the therapists in FEST may have been biased in favor of transference work (allegiance) and felt that the patients deprived of this technique were getting less than optimal treatment. We cannot rule out this possibility with absolute confidence. On the other hand, when polled at treatment termination, therapists were clearly in favor of using transference work to 65% of the patients with mature object relations, but only to 50% of the patients with more severe personality pathology (Høglend et al., 2011).

Construct validity concerns the validity of inferences between the understanding of the construct and its assessment. It includes convergent validity (similar constructs correspond), discriminate validity (dissimilar constructs are differentiated), and predictive validity. For example the understanding of therapist-patient interaction and the use SASB-work to assess it, concerns construct validity: What is captured, and what is lost by framing the relationship in SASB-terms, needs to be considered. In addition, whether SASB-work is able to discriminate between relationships that predict good or bad outcome is of importance. In outcome research we need to comprehend what kind of change we expect after therapy and how to assess it. Some instruments are developed mainly to measure change in maladaptive thoughts (e.g. Becks Depression Inventory) others interpersonal problems (e.g. Inventory of Interpersonal Problems). One may assume that the validity of IIP as an instrument of change is higher when the focus for therapy is interpersonal problems like in FEST, rather than maladaptive thoughts. Hence, some researchers emphasize the need for mode-specific outcome scales (Høglend, et al., 2000). Multiple sources for assessing change; self-reports, observer-reports and more objective ratings (e.g. went back to work, use of health services), are included in FEST. In Paper II and III different aspects of a person that on theoretical ground is thought to

change during and after psychodynamic therapy is measured. These aspects change in expected direction, something which enhances construct validity.

External validity concerns the degree to which findings can be generalized across different patients and settings. In FEST the inclusion criteria for patients are not particularly narrow. Only patients with psychosis, bipolar illness, organic mental disorder, substance abuse or with mental health problems that caused long-term inability to work (>2 years) were excluded. However, the setting is with highly trained therapists, using manuals, and receiving some supervision. Hence, it is reasonable to believe that the main results from FEST may generalize to other settings with experienced, dynamic therapists. It is less certain that the results will be replicated in a regular clinic, which often includes more inexperienced therapists, receiving little supervision while working with patients who display severe pathology. Experimental control of treatment components does not occur in ordinary clinical practice where therapists strive to tailor their technique to the individual patients.

Methodological discussion concerning the FWC-58

All inferences in these studies build on the assumption that the FWC-58 is a valid and reliable measure for countertransference. This necessitates a discussion concerning reliability and the validity of using a FWC for this purpose.

FWC do not lend itself easily to reliability checks. Countertransference is assumed to be determined also by the patient, making interpretations of test-retest reliability problematic. The subjective nature of feelings is of hindrance to measure inter-rater reliability. IN addition, therapists are probably not highly reliable in scoring FWC after each session: there are times they are more in a rush, more tired of the questionnaire, more in tune with their feelings, remember better and so on. It might be that the single therapist is relatively reliable in the way s/he fills in the form, but that each therapist uses it somewhat differently. Aggregated data increase reliability, but much information is lost.

The Likert scales may also be used more or less in the same way among the therapists. In FEST the therapists did not have a thorough discussion on how to use the scale. Hence, the variation in the observed scores may be somewhat connected to his/ her subjective way of using the scale. However, it seems like six therapists used the FWC-58 in an overlapping manner, and one used it very differently and was excluded from the analyses. This may be a practical issue that could be avoided in the next research trial. Another issue is that the therapists did not comply with the instructions concerning the FWC-58; they did not evaluate

every word after each session. Most of the time, they did not mark "0"; only values that were higher. The reasons why they filled in the questionnaire in this way, is not known. 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 inner experience after each and every session a short version might be more suitable. The long version might be more applicable for infrequent evaluations. Stable, theoretically meaningful factors enhance reliability. The same four factors were found no matter how the principal component analyses were run, and the factors are theoretically sound. A replication of these factors by another research team would definitely enhance its reliability and validity.

Regarding *construct validity*, there are thousands of articles and books on how to understand countertransference, and no definition scholars agree on. In this study countertransference is defined as the totality of all feelings the therapist holds, both conscious and unconscious, in the session towards the patient. Hence, the foci of this study is a construct which enclose what happens within an individual during 45 minutes, and this is to be reported on a questionnaire after the session. The unconscious, we cannot report by definition. Remembrance has a steep curvilinear negative slope, showing primacy and recency effects, we remember best what fits our self-perception or mental schemas, which may or may not be elaborated concerning ones inner life, and we remember things that actually never occurred (Holt et al., 2012). On the other hand, we know that recognizing is better than recall, and that the therapists probably get retrieval cues from 58 words in the FWC, covering many inner experiences. The *feeling* check list includes words comparable to attitudes (e.g. motherly, objective, empathic) and conduct (e.g. tired, helpful, attentive), which may be regarded as confusing (Najavits, 2000). Participants tend to report what they believe to be approved of or desirable in a given context (Podsakoff, MacKenzie, & Podsakoff, 2012). The most troublesome words are missing in the FWC-58; hate, love, jealousy, and erotized or sexualized feelings. The latter has, when acted upon, led to severe violations against patients. From the very beginning of psychotherapy as a treatment for psychological problems, therapists have had sex with their patients, and unfortunately, still this happens (Gabbard, 2010). In one study, 87% have been sexually attracted to their patients and 63% felt guilty, anxious, or confused about the attraction (Pope, Keith-Spiegel, & Tabachnick, 1986), male therapists more than females (Pope & Tabachnick, 1993). Hence, words like "flirtatious" "sexually attracted" and "sexually aroused" ought to have been included in the checklist; it is probably of clinical value when these kinds of feelings arise.

The statistically significant correlations in the data between countertransference subscales and other variables, does not imply causality: Countertransference cannot be experimentally manipulated. Therefore, the associations between parental countertransference and outcome cannot be interpreted as causal in nature. Since treatment group is an experimentally manipulated variable, the relationship between technique and countertransference in the two groups may be seen as causal. In the transference group, there was significantly more parental countertransference in relation to personality disordered patients, than in the non-transference group. It is assumed that the transference work caused an increase in parental countertransference when working with personality disordered patients.

External validity concerns the generalizability of our results to other patient-therapist samples and settings. In this sample only feeling words from six therapists are included in the analyses, and we cannot state to which extent they are a representative sample. The therapists are experts with a great amount of training prior to the study and they had been working together on this project for å long time. One may assume that this is a quite elite group of therapists, and that novice therapist, and therapists without support from colleagues will report differently on FWC-58. The patients were recruited through the ordinary mental health system, and relatively few exclusion criteria were used. However, the study will not generalize to countertransference and therapy with bipolar patients, drug users, people who have been out of work for more than two years, and schizophrenic. More research is needed on other samples of patients and therapists.

The main limitation in the principal component analyses is interdependence in the data and/ or sample size which concerns the *statistical validity*. The first run of the factor analysis on all FWC-58 questionnaires gave a ratio of cases to items ≈ 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 containing 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.

Regardless of limitations that are put forth concerning the FWC-58, it has a simplicity that may be found intriguing. No session will go by without some of the feelings or inner experiences the 58 words represent have been present. The different FWC versions studied,

have shown interesting associations with other variables, concerning patient, the relationship, and/ or outcome. The observations from FWC-58 in FEST are to my knowledge, the largest available database on therapist feelings in individual therapy. This provides plenty of opportunities to investigate other aspects of countertransference as measured with FWC-58 than those in the present dissertation. In future work, both statistical analyses and in-depth case analyses may be utilized to further our understanding of how countertransference color and interact with the process and outcome of psychotherapy.

Conclusions

This dissertation examines an aspect of the therapists; namely, their self-reported countertransference in relation to patient, process, technique, and outcome variables. By necessity, the use of the FWC-58 to measure countertransference reduces the complexity of the concept. However, the results presented indicate that this simplification does not eliminate the possibility to increase our understanding and to raise new hypotheses concerning the process and outcome in psychotherapy. The studies included add to an evolving body of literature which suggests that patient characteristics, technique variables, and therapist variables are all essential, and interact in complex ways, to determine psychotherapy outcome (Castonguay & Beutler, 2006; Høglend et al., 2011; Luyten, 2012). Examination of any one of these variables in isolation from the others may provide an incomplete understanding of their role in relation to outcome. Quantitative and qualitative methods may be complementary in order to enhance our understanding of how psychotherapy works.

The subscales in the FWC-58 were deemed clinically meaningful with acceptable psychometric properties. The subscales correlated with the patients' relational problems and the alliance in plausible directions. These findings parallel the growing realization of the interpersonal nature of the treatment process (Luyten, 2012). The linkage between the therapist's countertransference feelings and the therapist's and/ or patient's sense of the bond in the dyad takes on particular importance. The positive and negative effects of transference work in the context of elevated parental countertransference indicate that therapists should be particularly alert to their countertransference while working with the here and now of the relationship. Future research may investigate the other FWC-58 subscales (Disengaged, Confident, and Inadequate), as well as single words that were not included in the subscales, in relation to transference work, process and outcome. In-depth qualitative analysis seems to complement the statistical analyses and broaden our understanding of the therapeutic dyad. The studies in this dissertation indicate that self-reported countertransference has a

considerable effect on long term outcome as measured by both patients and observers. This is a reminder of the power of the here and now presence of the therapist, which has been downplayed in many clinical theories (Nissen-Lie, 2011). The results are consistent with clinical theory and empirical research that emphasize the therapist's need to be actively aware of countertransference reactions (e.g. Gabbard, 2010; Hayes, Gelso, & Hummel, 2011; Perry, 2007; Schut et al., 2005). The use of a Feeling Word Checklist may enhance self-awareness and enable therapists to be more attentive countertransference reactions. In addition, a continuous oscillation between reflection and empathic atonement; that is, countertransference analysis (Zachrisson, 2009), may be facilitating when pondering on what to say or do in order to assist patients in their struggle towards emotional, cognitive, and behavioral change with the means of a talking cure. At its best, the countertransference may inform and personalize interventions in ways that turn out to be helpful for the patient.

Studies on "master therapists" indicate that good therapists tend to be flexible in their attitudes and to use a variety of techniques depending on the specific needs of the patients (Goldfried, Raue, & Castonguay, 1988). The individual therapist's ability to deliver specific therapeutic interventions tailored to the needs of the individual patient may be obstructed by countertransference. In order to be well guided by the information in the countertransference, therapists probably need to recognize their own particular vulnerabilities and proclivities toward certain countertransference reactions (Gelso & Hayes, 2009). Countertransference refers to therapists' unconscious and conscious experiences and feelings registered in relation to their patients, as well as to therapists' verbal and nonverbal actions observed with patients during their sessions. As such, countertransference targets therapists during their personal, emotionally charged, and at times vulnerable moments with their patients (Kiesler, 2001). As a clinician and researcher, it is difficult to find a more exciting and challenging empirical arena.

References

Abbass, A., Kisely, S., & Kroenke, K. (2009). Short-term psychodynamic psychotherapy for somatic disorders: Systematic review of meta-analysis of clinical trials. *Psychotherapy and Psychosomatics,* 265-274.

Adelson, J. L. & Owen, J. (2012). Bringing the psychotherapist back: Basic concepts for reading articles examining therapist effects using multilevel modeling. *Psychotherapy,* 152-162.

Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the Inventory of Interpersonal Problems. *Journal of Personality Assessment,* 3-4, 521-536.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

Amlo, S., Ulberg, R., & Høglend, P. (2012). *Manual for coding the content, timing, and valence of transference work interventions and patient responses.* Manual. Oslo, Norway: University of Oslo, Department of Psychiatry.

Arundale, J. & Bellman, D. B. (2011). Transference and countertransference: A unifying focus of psychoanalysis.

Baker, T. B., McFall, R. M., & Shoham, V. (2008). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest,* 67-103.

Barber, J. P., Barrett, M. S., Gallop, R., Rynn, M. A., & Rickels, K. (2012). Short-term dynamic psychotherapy versus pharmacotherapy for major depressive disorder: a randomized, placebo-controlled trial. *J.Clin.Psychiatry, 73,* 66-73.

Barber, J. P. & Muenz, L. R. (1996). The role of avoidance and obsessiveness in matching patients to cognitive and interpersonal psychotherapy: Empirical findings from the Treatment for Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology,* 951-958.

Barber, J. P. (2009). Toward a working through of some core conflicts in psychotherapy research. *Psychotherapy Research,* 1-12.

Benjamin, L. S. (1996). Introduction to the special section on structural analysis of social behavior. *Journal of Consulting and Clinical Psychology, 6,* 1203-1212.

Benjamin, L.S. & Cushing, G. (2000). *Reference manual for coding social interactions in terms of Structural Analysis of Social Behavior.* University of Utah.

Berridge, K. C. & Winkielman, P. (2003). What is an unconscious emotion? (The case for unconscious "liking"). *Cognition and Emotion,* 181-211.

Betan, E., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference Phenomena and Personality Pathology in Clinical Practice: An Empirical Investigation. *The American Journal of Psychiatry,5,* 890-898.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice,* 252-260.

Breuer, J. & Freud, S. (1895). Studies on hysteria. *Standard edition 2.* London: Hogarth Press.

Brody, E. M. & Farber, B. A. (1996). The effects of therapist experience and patient diagnosis on countertransference. *Psychotherapy: Theory, Research, Practice, Training, 3,* 372-380.

Bøgwald, K. P. (2001). Do patients and their therapists agree on the content of treatments? *Journal of Nervous and Mental Disease, 12,* 830-837.

Bøgwald, K. P. (2002). *Contributions to the measurement of process and outcome in psychotherapy*. Unipub, Oslo.

Bøgwald, K.-P., & Dahlbender, R.W. (2004). Procedures for testing some aspects of the content validity of the Psychodynamic Functioning Scale and the Global Assessment of Functioning Scale. *Psychotherapy Research*, *14*, 453–468.

Bøgwald, K.-P., Høglend, P., & Sørbye, Ø. (1999). Measurement of transference interpretations. *Journal of Psychotherapy Practice and Research, 8*, 264–273.

Carlsson, K., Petersson, K. M., Lundqvist, D., Karlsson, A., Ingvar, M., & Ohman, A. (2004). Fear and the Amygdala: Manipulation of Awareness Generates Differential Cerebral Responses to Phobic and Fear-Relevant (but Nonfeared) Stimuli. *Emotion,* 340-353.

Castonguay, L. G. & Beutler, L. E. (2006). Principles of Therapeutic Change: A Task Force on Participants, Relationships, and Techniques Factors. *Journal of Clinical Psychology, 2,* 631-638.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology,* 497-504.

Clarkin, J.F. & Levy, K.N. (2004). The influence of client variables on psychotherapy (p 194-227). In M.J. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change*. (vols. 5th ed.) New York: Wiley.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *The American Journal of Psychiatry,* 922-928.

Colson, D. B., Allen, J. G., Coyne, L., & Dexter, N. (1986). An anatomy of countertransference: Staff reactions to difficult psychiatric hospital patients. *Hospital & Community Psychiatry,* 923-928.

Conolly, M.B., Crits-Christoph, P., Shappel, S., Barber, J.P., Luborsky, L., & Shaffer, C. (1999). Relations of transference interpretations to outcome in the early sessions of brief supportive - expressive psychotherapy. *Psychotherapy Research*, *9*, 485–495.

Cramer, V., Torgersen, S., & Kringlen, E. (2006). Personality disorders and quality of life. A population study. *Comprehensive Psychiatry, 3,* 178-184.

Critchfield, K. L. & Benjamin, L. S. (2006). Principles for psychosocial treatment of personality disorder: summary of the APA Division 12 Task Force/NASPR review. *Journal of Clinical Psychology, 62,* 661-674.

Critchfield, K. L. & Benjamin, L. S. (2006). Principles for Psychosocial Treatment of Personality Disorder: Summary of the APA Division 12 Task Force/NASPR Review. *Journal of Clinical Psychology, 62,* 661-674.

Dahl, H.S.J., Høglend, P.A., Crits-Christoph, P., Gabbard, G.O., Hersoug, A.G., Perry, J.C. et al. (2012). Long-term Effects of Transference Work in the Context of Therapists' Parental Countertransference and Patients' Personality Pathology. *Submitted.*

Dahl, H.S.J, Røssberg, J. I., Bøgwald, K. P., Gabbard, G. O., & Høglend, P. A. (2012). Countertransference feelings in one year of individual therapy: An evaluation of the factor structure in the Feeling Word Checklist-58. *Psychotherapy Research, 22,* 12-25.

Dattilio, F. M., Edwards, D. J. A., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy: Theory, Research, Practice, Training, 4,* 427-441.

de Maat, S., de Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: A systematic review of empirical studies. *Harvard Review of Psychiatry,* 1-23.

Derogatis, L. R. (1992). *SCL-90-R: administration, scoring & procedures manual-II for the revised version and other instruments of the psychopathology rating scale series*. Towson, MD: Cinical Psychometric Research, Inc.

Eagle, M. N. & Wolitzky, D. L. (2011). Systematic empirical research versus clinical case studies: A valid antagonism? *Journal of the American Psychoanalytic Association, 4,* 791-818.

Edwards, D. J. A. (2007). Collaborative versus adversarial stances in scientific discourse: Implications for the role of systematic case studies in the development of evidence-based practice in psychotherapy. *Pragmatic Case Studies in Psychotherapy, 1,* 6-34.

Eells, T. D. (2007). Generating and generalizing knowledge about psychotherapy from Pragmatic Case Studies. *Pragmatic Case Studies in Psychotherapy, 1,* 35-54.

Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry, 6,* 766-771.

Epstein, L. & Feiner, A. H. (1979). Countertransference: The therapist's contribution to treatment. *Contemporary Psychoanalysis,* 489-513.

Etchegoyen, R. H. & Pitchon, P. (1991). *The fundamentals of psychoanalytic technique.* Karnac Books: London.

Eysenck, H.J. (1952). The effects of psychotherapy. *Quarterly Bulletin of the British Psychological Society.*

Ferenczi S. (1919). Technical difficulties in the analysis of a case of hysteria. *Further Contributions to the Theory and Technique of Psycho-Analysis.* London: Karnac Books, 1980.

Field, A. (2009). *Discovering statistics using SPSS* (3nd ed.). London: Sage

Fishman, D. B. (2005). Editor's Introduction to PCSP--From Single Case to Database: A New Method for Enhancing Psychotherapy Practice. *Pragmatic Case Studies in Psychotherapy,* 1-50.

Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology, 1,* 10-17.

Friedman, S. M. & Gelso, C. J. (2000). The development of the Inventory of Countertransference Behavior. *Journal of Clinical Psychology, 9,* 1221-1235.

Freud, S. (1905). Fragment of an analysis of a case of hysteria (1905). *Standard Edition 7,* 7-112. London: Hogarth press.

Freud, S. (1909). Letter from Sigmund Freud to C. G. Jung, June 7, 1909. *The Freud/Jung Letters: The Correspondence between Sigmund Freud and C. G. Jung*, 230-232.

Freud, S. (1910). The future prospect of psychoanalytic therapy. *Standard Edition 11,* 141-151 London: Hogarth Press.

Freud, S. (1912). Recommendations to physicians practicing psychoanalysis. *Standard Edition*, *12,* 111-120 London: Hogarth Press.

Freud, S. (1911). Letter from Sigmund Freud to C. G. Jung, December 31, 1911. *The Freud/Jung Letters: The Correspondence between Sigmund Freud and C. G. Jung*, 475-476

Freud, S. (1913). Letter from Freud to Ludwig Binswanger, February 20, 1913. *The Sigmund Freud-Ludwig Binswanger Correspondence 1908-1938*, 112-113.

Freud, S. (1917). Introductory lectures on psycho-analysis (Part III). *Standard Edition 16,* 431-447. London: Hogarth Press.

Fuertes, J. N., Mislowack, A., Brown, S., Gur-Arie, S., Wilkinson, S., & Gelso, C. J. (2007). Correlates of the real relationship in psychotherapy: A study of dyads. *Psychotherapy Research,* 423-430.

Gabbard, G. O. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology, 8,* 983-991.

Gabbard, G. O. (2006). When is transference work useful in dynamic psychotherapy? *The American Journal of Psychiatry,* 1667-1669.

Gabbard, G.O. (2010). *Long-Term Psychodynamic Psychotherapy: a Basic Text, 2nd Edition.* Arlington, VA: American Psychiatric Publishing.

Gabbard, G.O., Horwitz, L., Allen, J.G., Frieswyk, S., Newsom, G., Colson, D.B., & Coyne, L. (1994). Transference interpretation in the psychotherapy of borderline patients: a high-risk, high-gain phenomenon. *Harvard Review Psychiatry*, *2*, 59-69.

Gabbard, G.O., & Westen, D. (2003). Rethinking therapeutic action. *International Journal of Psychoanalysis*, *84*, 823–841.

Galdi, S., Arcuri, L., & Gawronski, B. (2008). Automatic mental associations predict future choices of undecided decision-makers. *Science,* 1100-1102.

Gallop, R. & Tasca, G. A. (2009). Multilevel modeling of longitudinal data for psychotherapy researchers: II. The complexities. *Psychotherapy Research,* 438-452.

Gelso, C. J. (2009). The real relationship in a postmodern world: Theoretical and empirical explorations. *Psychotherapy Research, 3,* 253-264.

Gelso, C. J. & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities.* Mahwah, NJ, US: Lawrence Earlbaum Associates Publishers.

Gelso, C. J., Latts, M. G., Gomez, M. J., & Fassinger, R. E. (2002). Countertransference management and therapy outcome: An initial evaluation. *Journal of Clinical Psychology,* 861-867.

Goldfried, M. R. (2000). Consensus in psychotherapy research and practice: Where have all the findings gone? *Psychotherapy Research,* 1-16.

Goldfried, M. R. & Davila, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Research, Practice, Training,* 421-430.

Goldfried, M.R., Raue, P.J., & Castonguay, L.G. (1988). The therapeutic focus in significant sessions of master therapists: a comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology, 66*, 803-810.

Green, A. (1997). Science and science fiction in infant research. In J.Sandler et al. (Eds) *Clinical and Observational Psychoanalytic Research.* London: Karnac Books

Greenson, R.R. (1967). *The technique of practice of psychoanalysis.* New York International University Press.

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. K. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology,* 1464-1480.

Hafkenscheid, A. (2003). Objective countertransference: Do patients' interpersonal impacts generalize across therapists? *Clinical Psychology & Psychotherapy,* 31-40.

Hafkenscheid, A. & Kiesler, D. (2007). Assessing objective countertransference: A comparison of two different statistical procedures in three different samples. *Psychotherapy Research, 4,* 393-403.

Hagtvet, K.A. (2002) Psychometrics in Psychiatry. Research seminar, Institute of Psychiatry, UIO.; 2002-12-02 UiO

Hagtvet, K. A. & Hoglend, P. A. (2008). Assessing precision of change scores in psychodynamic psychotherapy: A generalizability theory approach. *Measurement and Evaluation in Counseling and Development,* 162-178.

Hayes, J. A. (2004). The Inner World of the Psychotherapist: A Program of Research on Countertransference. *Psychotherapy Research, 1,* 21-36.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy (Chic.), 48,* 88-97.

Hayes, J. A., Riker, J. R., & Ingram, K. M. (1997). Countertransference behavior and management in brief counseling: A field study. *Psychotherapy Research,* 145-153.

Haynal, A.E. (2005). In the shadow of a controversy. *The International Journal of Psychoanalysis*, 86:457-466

Heimann, P. (1950). On counter-transference. *The International Journal of Psychoanalysis,* 81-84.

Hein, G., Lamm , C., Brodbeck, C., & Singer, T. (2011). Skin Conductance Response to the Pain of Others Predicts Later Costly Helping. *PLoS ONE* 6(8)

Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology,* 434-440.

Henry, W. P. & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process, 51-84. In A. O. Horvath & L. S. Greenberg (Ed). *The working alliance: Theory, research, and practice.* Oxford, England: John Wiley & Sons.

Hersoug, A.G. (2004). Assessment of therapists' and patients' personality: Relationship to therapeutic technique and outcome in brief dynamic psychotherapy. *Journal of Personality Assessment. 83,* 191-200.

Hersoug, A. G., Monsen, J. T., Havik, O. E., & Hoglend, P. (2002). Quality of early working alliance in psychotherapy: Diagnoses, relationship and intrapsychic variables as predictors. *Psychotherapy and Psychosomatics, 1,* 18-27.

Hill, C. E. & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research, 1,* 13-29.

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology,* 207-217.

Hoffart, A. & Friis, S. (2000). Therapists' emotional reactions to anxious inpatients during integrated behavioral-psychodynamic treatment: A psychometric evaluation of a Feeling Word Checklist. *Psychotherapy Research, 4,* 462-473.

Hoffart, A., Hedley, L. M., Thornes, K., Larsen, S. M., & Friis, S. (2006). Therapists' Emotional Reactions to Patients as a Mediator in Cognitive Behavioural Treatment of Panic Disorder with Agoraphobia. *Cognitive Behaviour Therapy,3,* 174-182.

Hoffman, I. Z. (2009). Doublethinking our way to "scientific" legitimacy: The desiccation of human experience. *Journal of the American Psychoanalytic Association,* 1043-1069.

Holmqvist, R. (2000). Associations between staff feelings toward patients and treatment outcome at psychiatric treatment homes. *Journal of Nervous and Mental Disease, 6,* 366-371.

Holmqvist, R. (2001). Patterns of consistency and deviation in therapists' countertransference feelings. *Journal of Psychotherapy Practice & Research. Vol 10(2),* 104-116.

Holmqvist, R. & Armelius, B. A. (1994). Emotional reactions to psychiatric patients. *Acta Psychiatrica Scandinavica, 3,* 204-209.

Holmqvist, R. & Armelius, B. A. (1996a). Sources of therapists' countertransference feelings. *Psychotherapy Research, 1,* 70-78.

Holmqvist, R. & Armelius, B. A. (1996b). The patient's contribution to the therapist's countertransference feelings. *Journal of Nervous and Mental Disease, 11,* 660-666.

Holmqvist, R. & Armelius, K. (2000). Countertransference feelings and the psychiatric staff's self-image. *Journal of Clinical Psychology, 4,* 475-490.

Holmqvist, R. & Armelius, K. (2004). Psychiatric patients' self-image and staff feelings towards them related to gender combinations. *Psychoanalytic Psychotherapy, 2,* 182-201.

Holmqvist, R., Hansjons-Gustafsson, U., & Gustafsson, J. (2002). Patients' relationship episodes and therapists' feelings. *Psychology and Psychotherapy: Theory, Research and Practice, 4,* 393-409.

Horvath, A.O. (2005). The therapeutic relationship: Research and theory: An introduction to the special issue. *Psychotherapy Research. Vol. 15(1-2),*3-7.

Horvath, A. O. (2009). How real is the "real relationship"? *Psychotherapy Research, 19,* 273-277.

Horvath, A. O. & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 2,* 223-233.

Horvath, A. O., Re, A. C. D., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy (pp. 25-69). In Norcross, Victor C (Ed). *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.).. New York, NY, US: Oxford University Press; US

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist,* 159-164.

Høglend, P. (1990). Dynamisk Korttidsterapi (Brief Dynamic Psychotherapy), 27- 38. In R.Alnaes, P. Ekern, & P. Jarval (Eds.), *Poliklinikken Psykiatrisk Klinikk 25 år*. Norway: Psykiatrisk Klinikk Vinderen.

Høglend, P. (1993). Transference interpretations and long-term change after dynamic psychotherapy of brief to moderate length. *American Journal of Psychotherapy, 4,* 494-507.

Høglend, P. (1994). *Manual for process ratings of general skill, supportive interventions, and specific techniques*. Manual. Oslo, Norway: University of Oslo, Department of Psychiatry.

Høglend, P. (1999). Psychotherapy research: New findings and implications for training and practice. *Journal of Psychotherapy Practice & Research,* 257-263.

Høglend, P., Amlo, S., Marble, A., Bogwald, K. P., Sorbye, O., Sjaastad, M. C. et al. (2006). Analysis of the patient-therapist relationship in dynamic psychotherapy: An experimental study of transference interpretations. *The American Journal of Psychiatry, 10,* 1739-1746.

Høglend, P., Bøgwald, K.-P., Amlo, S., Heyerdahl, O., Sørbye, Ø., Marble, A., ... Bentsen, H. (2000). Assessment of change in dynamic psychotherapy. *Journal of Psychotherapy Practice and Research*, *9*, 190–199.

Høglend, P., Bogwald, K. P., Amlo, S., Marble, A., Ulberg, R., Sjaastad, M. C. et al. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? *The American Journal of Psychiatry, 6,* 763-771.

Høglend, P., Dahl, H. S., Hersoug, A. G., Lorentzen, S., & Perry, J. C. (2010). Long-term effects of transference interpretation in dynamic psychotherapy of personality disorders. *European Psychiatry, 2*, 168-181.

Høglend, P. & Gabbard, G.O. (2012). When is transference work useful in psychodynamic psychotherapy? A review of empirical research. (pp. 449-467). In A. Levy, J.S. Ablon, & H. Kächele (Eds.), *Psychodynamic Psychotherapy Research Evidence-Based Practice and Practice-Based Evidence*. New York: Springer.

Høglend, P., Hersoug, A. G., Bogwald, K. P., Amlo, S., Marble, A., Sorbye, O. et al. (2011). Effects of transference work in the context of therapeutic alliance and quality of object relations. *Journal of Consulting and Clinical Psychology,* 697-706.

Iwakabe, S. & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research,* 601-611.

Jacobson, N. S. & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology,* 12-19.

Jensen, K. B., Kaptchuk, T. J., Kirsch, I., Raicek, J., Lindstrom, K. M., Berna, C. et al. (2012). Nonconscious activation of placebo and nocebo pain responses. *Proc.Natl.Acad.Sci.U.S.A, 109,* 15959-15964.

Johansson, P. (2008). *Moderators and mediators in dynamic psychotherapy*. Faculty of Medicine, University of Oslo: Oslo

Johansson, P. & Høglend, P. (2007). Identifying Mechanisms of Change in Psychotherapy: Mediators of Treatment Outcome. *Clinical Psychology & Psychotherapy,* 1-9.

Johansson, P., Høglend, P., Ulberg, R., Amlo, S., Marble, A., Bogwald, K. P. et al. (2010). The mediating role of insight for long-term improvements in psychodynamic therapy. *Journal of Consulting and Clinical Psychology, 78,* 438-448.

Johansson, P., Høglend, P., & Hersoug, A. G. (2011). Therapeutic alliance mediates the effect of patient expectancy in dynamic psychotherapy. *British Journal of Clinical Psychology,* 283-297.

Joseph, B. (1985). Transference: The total situation. *The International Journal of Psychoanalysis,* 447-454.

John, O. P. & Benet-Martinez, V. (2000). Measurement: Reliability, construct validation, and scale construction (p 339-369). In Reis, Harry T (Ed); Judd, Charles M (Ed).*Handbook of research methods in social and personality psychology*. (pp. 339-369). New York, NY, US: Cambridge University Press

Josephs, L. (1992). The timing of an interpretation: A comparative review of an aspect of the theory of therapeutic technique. *Psychoanalytic Review,* 31-54.

Katsuki, F., Goto, M., Takagi, H., Ozdemir, V., & Someya, T. (2006). Countertransference to psychiatric patients in a clinical setting: Development of the Feeling Checklist-Japanese version. *Psychiatry and Clinical Neurosciences, 6,* 727-735.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research,* 418-428.

Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist,* 146-159.

Kendall, P.C., Holmbeck, G., & Verduin, T. (2004). Methodology, design, and evaluation in psychotherapy research (p 16-44). In M.J. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change*. (vols. 5th ed.) New York: Wiley.

Kernberg, O. (1965). Notes on countertransferences. *Journal of the American Psychoanalytic Association, 1,* 38-56.

Kernberg, O.F., Diamond, D., Yeomans, F.E., Clarkin, J.F., & Levy, K.N. (2008). Mentalization and attachment in borderline patients in transference focused psychotherapy. In E. Jurist, A. Slade, & S. Bergner (Eds.), *Mind to mind: Infant research, neuroscience and psychoanalysis* (pp. 167–201). New York: Other Press.

Kiesler, D. J. (1996). *Contemporary interpersonal theory and research: Personality, psychopathology, and psychotherapy.* Wiley series in clinical psychology and personality.

Kiesler, D. J. (1996). From communications to interpersonal theory: A personal odyssey. *Journal of Personality Assessment,* 267-282.

Kiesler, D. J. (2001). Therapist countertransference: In search of common themes and empirical referents. *Journal of Clinical Psychology, 8,* 1053-1063.

Kihlstrom, J. F. (2004). Availability, accessibility, and subliminal perception. *Consciousness and Cognition: An International Journal,* 92-100.

Killingmo, B. (1989). Conflict and deficit: Implications for technique. *The International Journal of Psychoanalysis, 1,* 65-79.

Kline, P. (1999). *The handbook of psychological testing* (2nd ed.) London: Routledge.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectical therapists. In Norcross, J. C. & Goldfried, M. R. (Eds). *Handbook of psychotherapy integration.,* (pp. 94-129). New York, NY, US: Basic Books.

Lambert, M. J. (2001). Psychotherapy outcome and quality improvement: Introduction to the special section on patient-focused research. *Journal of Consulting and Clinical Psychology,* 147-149.

Lambert, M. J. (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change*. (vols. 5th ed.) New York: Wiley.

Lambert, M. J., Bergin, F. J., & Garfield, S. L. (2004). Introduction and historical overview. In M.J. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change*. (vols. 5th ed.) New York: Wiley.

Lambert, M. J. & Ogles, B.M. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change*. (vols. 5th ed.) New York: Wiley.

Leichsenring, F. & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: a meta-analysis. *American Journal of Psychiatry*, 1223-1232.

Leichsenring, F., Rabung, S., & Leibing, E. (2004). The Efficacy of Short-term Psychodynamic Psychotherapy in Specific Psychiatric Disorders: A Meta-analysis. *Archives of General Psychiatry,* 1208-1216.

Leichsenring, F. & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: a meta-analysis. *JAMA, 300,* 1551-1565.

Levy, R. A., Ablon, J. S., & Kächele, H. (2012). *Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence*. (vols. 1) New York, NY: Springer Science Business Media, LLC.

Ligiero, D. P. & Gelso, C. J. (2002). Countertransference, attachment, and the working alliance: The therapist's contribution. *Psychotherapy: Theory, Research, Practice, Training,1,*3-11.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press

Lund, T. (1996). *Metoder i kasual somfunnsforskning.* Oslo: Universitets forlaget.

Malan, D. H. (1976). *Toward the validation of dynamic psychotherapy: A replication.* Oxford: England

Malan, D. H. (1976). *The frontier of brief psychotherapy: An example of the convergence of research and clinical practice.* Oxford: England

McCullough, L. (2009). The challenge of distinguishing figure from ground: Reaction to Gelso's work on the real relationship. *Psychotherapy Research,* 265-268.

McIntyre, S. M. & Schwartz, R. C. (1998). Therapists' differential countertransference reactions toward clients with major depression or borderline personality disorder. *Journal of Clinical Psychology,* 923-931.

McLeod, J. (2010). *Case Study Research in Counselling and Psychotherapy.* London: Sage Publications Ltd.

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process.* New York, NY, US: Guilford Press.

Merten, J. (2005). Facial microbehavior and the emotional quality of the therapeutic relationship. *Psychotherapy Research,* 325-333.

Messer, S. B. (2007). Psychoanalytic case studies and the Pragmatic Case Study method. *Pragmatic Case Studies in Psychotherapy, 1,* 55-58.

Milrod, B., Leon, A. C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J. et al. (2007). A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *The American Journal of Psychiatry,* 265-272.

Mitchell, G. & Hastings, R. P. (1998). Learning disability care staff's emotional reactions to aggressive challenging behaviours: Development of a measurement tool. *British Journal of Clinical Psychology,* 441-449.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Harvard University Press: USA

Mitchell, S. A. & Aron, L. (1999). *Relational psychoanalysis: The emergence of a tradition.* Relational perspectives book series, Vol. 14. Mahwah, NJ, US: Analytic Press.

Money-Kyrle, R. E. (1956). Normal counter-transference and some of its deviations. *The International Journal of Psychoanalysis,* 360-365.

Munder, T., Fluckiger, C., Gerger, H., Wampold, B. E., & Barth, J. (2012). Is the Allegiance Effect an Epiphenomenon of True Efficacy Differences Between Treatments? A Meta-Analysis. *Journal of Counseling Psychology,*

Muran, J. C. (2002). A relational approach to understanding change: Plurality and contextualism in a psychotherapy research program. *Psychotherapy Research, 2,* 113-138.

Najavits, L. M. (2000). Researching therapist emotions and countertransference.. *Cognitive and Behavioral Practice, 3,* 322-328.

Najavits, L. M., Griffin, M. L., Luborsky, L., Frank, A., Weiss, R. D., Liese, B. S. et al. (1995). Therapists' emotional reactions to substance abusers: A new questionnaire and initial findings. *Psychotherapy: Theory, Research, Practice, Training, 4* 669-677.

Nissen-Lie, H.A. (2011). *Psychotherapists'self-perceptions: Their relationship to the process and outcomes of psychotherapy.* Department of psychology, University of Oslo: Oslo

Nissen-Lie, H. A., Monsen, J. T., & Rønnestad, M. H. (2010). Therapist predictors of early patient-rated working alliance: A multilevel approach. *Psychotherapy Research, 6,* 627-646.

Norcross, J. C. (Ed). (2011). *Psychotherapy relationships that work.* Ney York, NY: Oxford University Press.

Norcross, J. C. & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 1,* 98-102.

Ogden, T. H. (1979). On projective identification. *The International Journal of Psychoanalysis,* 357-373.

Ogrodniczuk, J.S., Piper, W.E., Joyce, A.S., & McCallum, M. (1999). Transference interpretations in short-term dynamic psychotherapy. *Journal of Nervous and Mental Disease*, *187*, 571–578.

Orlinsky, D. E., Geller, J. D., Tarragona, M., & Farber, B. (1993). Patients' representations of psychotherapy: A new focus for psychodynamic research. *Journal of Consulting and Clinical Psychology, 4,* 596-610.

Parker, G., Tupling, H., & Brown, L. B. (1979). A parental bonding instrument. *British Journal of Medical Psychology, 1,* 1-10.

Perry, J.C. (2007). Cluster C Personality Disorders: Avoidant, Obsessive-compulsive, and Dependent (pp 835-854). In Gabbard G.O. (Ed.), *Glen Gabbard's Treatment of Psychiatric Disorders,* (4th ed.). American Psychiatric Press, Inc., Washington, D.C.

Perry, J. C. & Bond, M. (2005). Defensive Functioning, 523-540. In J. M. Oldham, A. E. Skodol, D. S. Bender (Ed): *Textbook of Personality Disorders.* Washington DC: American Psychiatric Publishing, Inc.

Piper, W.E., Azim, H.F., Joyce, A.S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry*, *48*, 946–953.

Pope, K. S. & Tabachnick, B. G. (1993). Therapists' anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice,* 142-152.

Racker, H. (1957). The meanings and uses of countertransference. *The Psychoanalytic Quarterly,* 303-357.

Roffman, J.L., Gerber, A.J. &Click, D.M. (2012). Neural models of psychodynamic concepts and treatments: Implications for psychodynamic psychotherapy (p 193-219). In R.A. Levy, J.S. Ablon, & H. Kächele (Eds). *Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence*. (vols. 1) New York, NY: Springer Science Business Media, LLC.

Rosenberger, E. W. & Hayes, J. A. (2002). Therapist as subject: A review of the empirical countertransference literature. *Journal of Counseling & Development,* 264-270.

Roth, A. & Fonagy, P. (2005). *What works for whom: A critical review of psychotherapy research, 2nd ed.* New York: Guilford Publications.

Rudd, M. D. & Joiner, T. (1997). Countertransference and the therapeutic relationship: A cognitive perspective. *Journal of Cognitive Psychotherapy,* 231-250.

Røssberg, J. I. & Friis, S. (2003). Staff Members' Emotional Reactions to Aggressive and Suicidal Behavior of Inpatients. *Psychiatric Services, 10,* 1388-1394.

Røssberg, J. I., Hoffart, A., & Friis, S. (2003). Psychiatric staff members' emotional reactions toward patients. A psychometric evaluation of an extended version of the Feeling Word Checklist (FWC-58). *Nordic Journal of Psychiatry, 1,* 45-53.

Røssberg, J. I., Karterud, S., Pedersen, G., & Friis, S. (2007). An empirical study of countertransference reactions toward patients with personality disorders. *Comprehensive Psychiatry, 3,* 225-230.

Røssberg, J. I., Karterud, S., Pedersen, G., & Friis, S. (2010). Psychiatric symptoms and countertransference feelings: An empirical investigation. *Psychiatry Research, 1,* 191-195.

Safran, J. D. (2012). *Psychoanalysis and psychoanalytic therapies.* Theories of psychotherapy Series. Washington, DC: American Psychological Association.

Sandler, J. (1976). Countertransference and role-responsiveness. *The International Journal of Psychoanalysis,* 43-47.

Schjelderup, H. (1955). Lasting effects of psychoanalytic treatment. *Psychiatry: Journal for the Study of Interpersonal Processes,* 109-133.

Schut, A. J., Castonguay, L. G., Flanagan, K. M., Yamasaki, A. S., Barber, J. P., Bedics, J. D. et al. (2005). Therapist interpretation, patient-therapist interpersonal process, and outcome in psychodynamic psychotherapy for avoidant personality disorder. *Psychotherapy: Theory, Research, Practice, Training, 4,* 494-511.

Segal, H. (1977). Countertransference. *International Journal of Psychoanalytic Psychotherapy, 6,* 31-37.

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). Experimental and quasi-experimental designs for generalized causal inference. Boston MA: Mifflin and Company, US.

Shedler, J. (2006). *That was then, this in now: An introduction to contemporary psychodynamic thought.* Department of psychiatry, University of Colorado

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist,* 98-109.

Singer, J. L., Sincoff, J. B., & Kolligian, J. J. (1989). Countertransference and cognition: Studying the psychotherapist's distortions as consequences of normal information processing. *Psychotherapy: Theory, Research, Practice, Training,* 344-355.

Slife, B.D. (2004). Theoretical challenges to therapy practice and research: The constraint of naturalism. In M.J. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change*. (vols. 5th ed.) New York: Wiley.

Smith, M.L., Glass, G.V., & Miller, T.I. (1980). *The benefits of psychotherapy.* Baltimore: The John Hopkins University Press.

Spence, D. P. (2001). Dangers of anecdotal reports. *Journal of Clinical Psychology, 1,* 37-41.

Spitzer, R. L., Williams, J. B. W., Gibbon, M., & First, M. B. (1990). *User's guide for the structured clinical interview for DSM-III-R: SCID.* Washington, DC: American Psychiatric Association, Inc.

SPSS Inc: Advanced Models (Version 16.00) [Computer software]. Chicago: SPSS Inc.

Stern, B. L., Caligor, E., Clarkin, J. F., Critchfield, K. L., Horz, S., MacCornack, V. et al. (2010). Structured Interview of Personality Organization (STIPO): Preliminary psychometrics in a clinical sample. *Journal of Personality Assessment,* 35-44.

Stiles, W. B. & Shapiro, D. A. (1994). Disabuse of the drug metaphor: Psychotherapy process-outcome correlations. *Journal of Consulting and Clinical Psychology,* 942-948.

Svartberg, M. & Stiles, T. C. (1994). Therapeutic alliance, therapist competence, and client change in short-term anxiety-provoking psychotherapy. *Psychotherapy Research,* 20-33.

Tabachnick, B. G. & Fidell, L. S. (2007). *Using multivariate statistics*. (vols. 5th ed.) Boston: Pearson/Allyn and Bacon.

Tasca, G. A. & Gallop, R. (2009). Multilevel modeling of longitudinal data for psychotherapy researchers: I. The basics. *Psychotherapy Research,* 429-437.

Thylstrup, B. & Hesse, M. (2008). Substance abusers' personality disorders and staff members' emotional reactions. *BMC Psychiatry,* 8:21.

Tishby, O. & Vered, M. (2011). Countertransference in the treatment of adolescents and its manifestation in the therapist-patient relationship. *Psychotherapy Research, 21,*621-630.

Tähkä, V. (1993). *Mind and its treatment: A psychoanalytic approach.* Madison, CT, US: International Universities Press, Inc.

Tähkä, V. (2006). The nature and mediation of understanding in psychoanalytic interaction. *The Scandinavian Psychoanalytic Review, 2,* 81-92.

Ulberg, R. (2010). *Gender differences in response to transference interpretations in dynamic psychotherapy.* Faculty of Medicine, University of Oslo: Oslo

Ulberg, R., Høglend, P., Marble, A., & Sørbye, O. (2009). From submission to autonomy: Approaching independent decision making. A single-case study in a randomized, controlled study of long-term effects of dynamic psychotherapy. *American Journal of Psychotherapy, 3,* 227-243.

Ulberg, R., Johansson, P., Marble, A., & Høglend, P. (2009). Patient sex as moderator of effects of transference interpretation in a randomized controlled study of dynamic psychotherapy. *The Canadian Journal of Psychiatry / La Revue canadienne de psychiatrie,* 78-86.

Verbeke G, & Molenberg G. (2000). *Linear Mixed Models for Longitudinal Data.* New York: Springer.

Von der Lippe, A. L., Monsen, J. T., Rønnestad, M. H., & Eilertsen, D. E. (2008). Treatment failure in psychotherapy: The pull of hostility. *Psychotherapy Research, 4,* 420-432.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates Publishers

Wampold, B. E. & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology,* 914-923.

Warren, C. S. (2012). Faustian science and the future of psychoanalysis. *Journal of the American Psychoanalytic Association,* 131-144.

Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma. *Clinical Psychology: Science and Practice,* 45-69.

Westra, H. A., Aviram, A., Connors, L., Kertes, A., & Ahmed, M. (2012). Therapist emotional reactions and client resistance in cognitive behavioral therapy. *Psychotherapy,* 163-172.

Whyte, C. R., Constantopoulos, C., & Bevans, H. G. (1982). Types of countertransference identified by Q-analysis. *British Journal of Medical Psychology, 2,* 187-201.

Williams, E. N. & Fauth, J. (2005). A psychotherapy process study of therapist in session self-awareness. *Psychotherapy Research,* 374-381.

Winnicott, D. W. (1949). Hate in the counter-transference. *The International Journal of Psychoanalysis,* 69-74.

Wolstein, B. (1988). *Essential papers on countertransference.* New York, US: New York Unversity Press; US

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York, US; Basic Books.

Zachrisson, A. (2009). Countertransference and changes in the conception of the psychoanalytic relationship. *International Forum of Psychoanalysis, 3,* 177-188.

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