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Title Page

Countertransference Responses Mediate the Relationship Between Patients' Overall Defense Functioning and Therapists' Interventions

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Abstract

Objective: The aim of this work was to investigate the relationship between therapists' techniques (supportive/expressive intervention level – ESIL), therapists' countertransference (CT) and patients' defense level of functioning (ODF). We hypothesized that CT could play a mediating role in the relationship between patients' ODF and therapists' ESIL. **Method:** 65 psychotherapy sessions were rated by two different raters each with the Psychodynamic Interventions Rating Scale and the Defense Mechanisms Rating Scale. Clinicians used the Therapist Response Questionnaire to provide information on their CT. The 65 sessions referred to 65 clinicians (25= females, 40= males; 38 = psychodynamic, 27 = cognitive). More than half of the patients (n = 40; 61.5%) had a diagnosis of personality disorder. Among clinical disorders the most frequent were mood (n = 12) and anxiety disorders (n = 11). Five patients had no diagnosis.

Results: Four CT responses (parental; positive; criticized; overinvolved) completely mediated the relationship between patients' ODF and therapists' ESIL, while no effect resulted in relation to overwhelmed, helpless, sexualized and disengaged CTs. No effect of theoretical orientations on mediation pathways was found. **Conclusion:** Both positive and negative CT feelings seemed to play a crucial role in the relationship between therapists' interventions and patients' ODF.

Keywords: countertransference, therapist interventions, patient defenses, interpretations, hostility, mediation analysis

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Countertransference Responses Mediate the Relationship Between Patients' Overall Defense Functioning and Therapists' Interventions

Over the years several authors have focused on the study of common and relational factors from one side and technical and specific factors related to the process and outcome of psychotherapies (Cuijpers, Rejinders, & Huibers, 2019; Lambert, 2013; Norcross & Wampold, 2019). In the investigation of the role of relational factors in psychotherapy, many efforts have been made to study the countertransference responses of the therapists and their effect on the process and outcome of treatment (Hayes, Gelso, Goldberg, & Kivlighan, 2018).

Countertransference (CT) has been defined at least in five different ways: classical, totalistic, complementary, integrated and relational. The classical point of view defined countertransference as the unconscious reaction of the clinicians, based on their unresolved conflicts, to the patient's transference and conceptualized it as an obstacle to the psychotherapy process. From a totalistic perspective CT was described as the set of therapist's reactions to the patient (conscious and unconscious, emotional and cognitive, intrapsychic and behavioural), which were considered as inevitable and related in part also to the patient's inner world. This approach recognized the importance of focusing on countertransference reactions to understand patients' ways of functioning and helped in considering CT as potentially beneficial rather than an obstacle such as in the classical approach. The complementary approach, that in part overlaps with the totalistic one, saw CT a as a complement or counterpart to the patient's relational style: the patient exhibits certain "pulls" on the therapist that reflecting on them could understand patient's interpersonal world. An integrated definition of CT instead included learnings from all three conceptualizations (Gelso & Hayes, 1998, 2007) and has defined CT as the internal and external reactions in which unresolved

conflicts of the therapist, usually but not always unconscious, are implicated and all of the therapists' reactions are important and worthy of investigation. The relational perspective described CT as mutually constructed by the patient and the therapist (Mitchell, 1988); Moreover the needs, unresolved conflicts, and behaviors of both are believed to contribute to the manifestation of CT during the session.

With the advent of intersubjective and relational theories we saw a change in the conceptualization of the therapeutic relationship and of the mechanisms that underlie the link between technique and relationship (Aron, 2001; Mitchell, 1988; Ogden, 1995). Relational theorists have enlarged the seminal meaning of the term enactment, that originally was used to describe only episodic, discrete events that can occur during therapy (Jacobs, 1986) and used it to describe the whole psychotherapy process that is therefore the product of repeated enactments, an unconscious affectively charged repetition of past events and/or emotional experiences from the patient and therapist (Maroda, 1999).

An important consequence of this conceptualization of the psychotherapy process was that therapeutic interventions were not considered uniquely as the product of a technical decision, since they are also affected by the dynamics of the relationship in the here and now, and therefore were considered as indirect ways by which therapists co-regulated the relationship with the patient and communicated their feelings during the sessions. Following this approach therapists' interventions were seen as *complex relational events* because they communicated something very important about what sort of relatedness is possible between the patient and the therapist (Mitchell, 1988) and were considered as an emerging product of the patient-therapist interaction structures (Jones, 2000): The content and/or the form of therapists' interventions were partially influenced by their experience of the relationship with the patient.

This theoretical conceptualization, which is now widely accepted in the psychodynamic literature, has also been confirmed by different disciplines such as linguistic and communication sciences, which have pointed out that each communication has both referential and persuasive facets:

the referential aspect is the explicit content of the communication, while the persuasive aspect is the implicit interpersonal statement conveyed by the communication (Safran & Muran, 2000). In other terms, while we are talking and using words, we are doing things and actions with these words (Austin, 1975; Searle, 1969). This means that we also have to re-define therapists' interventions as actions that are the product of the relational context in which they are expressed.

Countertransference and Patients' Level of Functioning

As we anticipated in the previous paragraph, different theoretical approaches defined in different ways CT and, as a consequence, the operationalization of CT depended on the theoretical definition adopted by the researchers. Most empirical studies on CT used an operational definition that involves the therapists' unresolved conflicts as the origin and some characteristics of the patient as the trigger for CT reactions. These CT reactions were operationalized as clinicians' withdrawal or avoidant behaviors (Bandura, Lipsher, & Miller, 1960; Robbins & Jolkovski, 1986), therapists' perceptual distortions of clients, inaccurate recalls of what clients discussed in session (Fauth & Hayes, 2006; Fiedler, 1951) and in-session anxiety management (Hayes & Gelso, 1991, 1993, 2001; Yulis & Kiesler, 1968).

Other studies, influenced by the totalistic and complementary approach to CT, the same we adopted in the present study, have investigated the relationship between the patient's level of psychological functioning and the therapist's emotional responses. For example, Dahl et al. (2012) found a strong negative relationship between the amount of fulfilled personality disorders criteria and the therapists' experience of being in a safe and helpful position. In two other studies that assessed therapists' CT with the Therapist Response Questionnaire (the same measure that we applied in the present study), therapists' negative feelings, such as feeling criticized/mistreated, helpless/inadequate and overwhelmed/ disorganized resulted associated with more severe personality disorders

(Betan, Heim, Zittel Conklin & Westen, 2005) and with a low level of patient psychological functioning (Colli et al., 2014). These results have been confirmed by another study (Gazzillo et al., 2015) that investigated the relationship between therapists' emotional responses and the overall level of personality organization, as described by Kernberg (Kernberg & Caligor, 2005), which showed that the more compromised the patient's overall level of personality functioning was, the more the therapists tended to feel helpless and overwhelmed. It is important to observe that, although the concept of CT is rooted into the psychodynamic approach, the above cited studies on the relationship between patients' level of functioning and therapists' CT found that CT patterns are systematically related to patients' personality pathology across therapeutic approaches (Betan et al., 2005; Colli et al., 2014; Colli & Ferri, 2015).

Redefining the Supportive-Expressive Intervention Level in Relation to Therapists' Countertransference

One way of describing clinicians' interventions refers to the supportive/expressive continuum (Gabbard, 2004; Luborsky, 1984): supportive interventions (e.g. empathic validation, psychoeducational interventions) are aimed at helping the patient cope with symptoms, conscious conflicts or transient problems, improving patient self-esteem, and restoring ego functions, maintaining or reestablishing a consistent level of functioning, given the patient's personality and life circumstances (Dewald, 1971; Ursano & Silberman, 1996); expressive interventions (such as interpretation of defences or transference, confrontations) have the purpose to enhance the patients' cognitive and emotional understanding of their present symptoms and dysfunctional patterns and generally to foster psychological exploration and understanding.

The appropriate proportions of these two types of interventions depend mainly on the patients' characteristics, including symptoms, functional level, and personality features such as underlying personality structure, defensive level, and ego strength (Gabbard, 2014; Luborsky, 1984).

Clinical literature, with few exceptions (Clarkin, Yeomans & Kernberg, 2006), suggested to use preferentially supportive interventions with patients characterized by low levels of personality functioning (e.g. borderline) and on the contrary to use expressive interventions with high functioning patients (Gabbard, 2014). With low functioning patients expressive interventions such as interpretations are considered as "high risk high gain" interventions (Gabbard et al., 1994) and should be provided in advanced phases of the therapy or during sessions where a good therapeutic alliance has been established (Safran & Muran, 2000) or mentalization has been restored (Bateman & Fonagy, 2006). From an empirical point of view several researches have tried to address the relationship between therapists' supportive expressive interventions and patients' functioning, but results are quite heterogenous: some researchers suggested that interpretations can lead to a number of benefits for healthier patients (Horowitz, Marmar, Weiss, Dewitt, & Rosenbaum, 1984; Jones, Cumming, & Horowitz, 1988; Piper, Azim, Joyce & McCallum, 1991). However, contrary to the theoretical expectations, different studies have shown that the use of interpretations with lower functioning patients also produced positive results (Hersoug, Bøwald, & Høglend, 2003; Høglend, 1993; Piper et al., 1991). Another research confirmed the connection between therapists' technique and patients' overall defensive functioning (Siefert et al., 2006): this research suggested that the patients' Overall Defensive Functioning (ODF) was found to predict therapists' overall use of psychodynamic interventions, as well as specific Psychodynamic and Cognitive Behavioral interventions. Despite these differences it is commonly assumed that, when addressing patients' defenses, therapists should consider the patients' level of functioning and ego strength, e.g., interpretations should be adjusted to the patient's functioning to obtain a desirable effect (Hersoug, Bøwald, & Høglend, 2003).

Another way of looking at the supportive/expressive therapists' interventions continuum is in relation to therapist feelings during the interaction. Some authors have tried to study this relationship by investigating the effects of therapist interventions aimed at analyzing the patient-therapist relationship (the higher level of expressive intervention of the supportive/expressive continuum)

studied within the context of patients' personality level of functioning and therapists' in-session self-reported feelings (Dahl et al., 2014, 2017). These studies have suggested that therapists' disengaged feelings may have a negative influence on the effects of the transference work, especially with low functioning patients (Dahl et al., 2017) while in the context of low parental feelings, relationship work was positive for all patients. However, when parental feelings were stronger, the specific effects of transference interventions were even more positive for patients with high levels of personality pathology, but negative for patients with low levels of personality pathology (Dahl et al., 2014). In another study, researchers evaluated the relationship between the interpersonal context and therapists' intervention during low and moderate hostile episodes in psychotherapy. Results indicated that during episodes characterized by higher hostility clinicians tended to use more interpretations and expressive interventions, compared to moments characterized by lower hostility (Anderson et al., 2012): a possible but not unique explanation is that during interactions characterized by greater hostility the therapist used interpretations and expressive interventions in a defensive way, communicating hostility in a covert manner.

Although the above cited studies (Anderson et al., 2012; Dahl et al, 2014, 2017) have investigated the relationship between therapists' technique and CT, the supposed mutual relationship between these two constructs is quite different: in Dahl et al. studies (2014, 2017) CT has been considered a moderator variable and seemed to influence the effect of technique on therapy outcome (in relation to patients' personality functioning), conversely in Anderson et al. (2012), CT seemed to partially affect therapists' techniques. The study of the relationship between countertransference and therapists' interventions that assumed that the former can be partially influenced by the latter was a cornerstone of relational theorists: the content and/or the form of therapists' interventions could be partially influenced by the their experience of the relationship with the patient (Mitchell, 1988). For example, an interpretation or a confrontation (two highly expressive interventions) in

some cases could be considered in part as subtle and covert ways through which the therapists communicate their hostility to the patient (Kohut, 1996) by assuming a "telling rather than listening position" (Anderson et al., 2012 p. 356).

On the contrary, when clinicians are caught by strong feelings of protection and overinvolvement they may tend to avoid expressive interventions such as transference interpretations or confrontations on patient defenses in order to appear as a good therapist (Jones, 2000). This conceptualization of supportive and expressive interventions is possible if we take into account the pragmatic level and the persuasion facets of communication: therapists' expressive interventions are by nature directive (the speaker is guiding the conversation using his or her own frame of reference), and presumptuous (the speaker presumes knowledge of the other, which is associated with higher relative status). Confronting patients' subjective experience and challenging their usual self-narrative tends to pull the patient to the upper limit of their functioning, experience anxiety and a sense of risk. Supportive interventions are the opposite: the therapist is acquiescent (acceding to the other's frame of reference), unassuming (displaying a lower status and deference) and accepting patient experience and their self-narrative, providing a sense of safety (Anderson et al., 2012; Stiles, 1992; Stiles, Gabalda, & Ribiero, 2016). Following this conceptualization, we could wonder if the decision to use expressive rather than supportive interventions represents a process that is related only to the therapists' techniques and to patients' level of functioning or if it may also depend on clinicians' feelings during the interaction with the patient.

Although clinical literature suggested this possible influence of therapists' CT on technique, to our knowledge no study has investigated this hypothesis from an empirical point of view. Some studies investigated this relationship by treating CT reactions (protective or disengaged) as moderating variables in the relation to the effect on therapy outcome of expressive intervention (Dahl et al., 2014, 2017); other studies investigated this relationship at a correlational level and did not directly evaluate the impact of therapists' countertransference on technique (Anderson et al.,

2012); others demonstrated the strict conjunction between therapists' interventions and transference/countertransference patterns but did not directly evaluated the influence of CT on therapists' technique (Jones, 2000).

In light of these consideration the aim of this explorative work was to investigate the relationship between therapists' CT feelings and therapists' supportive expressive intervention level. Starting from the assumption that therapists' interventions stem from patients' (defensive) level of functioning, we hypothesized that CT feelings may interfere leading to different therapists' interventions. Moreover, because the constructs that we investigated are rooted into the psychodynamic literature, especially CT, we wanted to also verify if the relationship among CT feelings, therapists' interventions and patients' level of functioning is influenced by therapeutic orientation.

More specifically the aims of this work were to:

1) Explore the possible mediating role of distinct therapists' CT feelings in relation to patients' overall defense functioning level and therapists' supportive/expressive intervention level. Regarding this aim we hypothesized that different CT responses will mediate the relationship between the patients' defense level of functioning (ODF) and therapists' techniques (therapists' supportive/expressive intervention level – ESIL). Considering the sparse literature on this topic which has never been investigated before we will not provide specific hypotheses about the direction of the mediation for each of the different CT responses.
2) Verify the potential effects of therapeutic orientation on the relationship between patients' defenses, CT feelings and expressive/supportive interventions.

Method

Sampling and Procedure

Sessions. From our initial database of 200 cases with audio recorded sessions we randomly selected 75 cases treated by 75 different clinicians. The initial database was composed by the 55% of patients with PD diagnosis, the other patients had (alone or in comorbidity): mood disorders (17%),

anxiety disorders (10%), eating disorders (14%). A part of the database (4%) was composed by patients with no clinical diagnosis following DSM-5 criteria. The 65% of therapies were psychodynamic (short, long term and psychoanalytic treatments), 30% were cognitive (cognitive behavioral, DBT, cognitive interpersonal) and 5% were of other approaches (eclectic, humanistic etc.) . Then we randomly selected for each patient-therapist dyad a session belonging to the middle phase of treatment (six to nine months from the beginning of the therapy). We decided to select only sessions belonging to the middle phase of treatment because we expected to have a wider range of therapists' techniques than in the initial or termination phases, where we expected to have a lower use of specific therapists' interventions such as interpretations or confrontations.

Patients. The final sample of sessions selected for the study referred to 65 Caucasian participants (i.e., 45 females and 20 males), with an average age of 34 years (min. = 23; max. = 40; *SD* = 4.5). In particular, four patients were of low educational level, 18 of middle educational level, and 43 of high educational level. The majority were middle class (n = 53), while 12 were working class. Only eight participants were married, 57 were single, and one was divorced. The patients, as well as the sessions, were chosen randomly from our database. Patients were recruited from independent practice, from public health services and from the Psychotherapy Service of the University of Urbino. Each patient has been evaluated by their therapist according to DSM–5 (APA, 2013). More than half of the sample (n = 40; 61.5%) had a diagnosis of personality disorder. The most frequent were borderline (n = 17), narcissistic (n = 15) and schizoid (n = 6). Among clinical disorders the most frequent were mood disorders (n = 12) and anxiety disorders (n = 11). Five patients had no DSM-5 diagnosis. They all gave their consent to the audio-recording of the sessions and authorized the use of the transcripts for research purposes, even if they did not know the rationale of the study.

Therapists. The 65 sessions selected referred to 65 clinical therapists (i.e., 25 females and 40 males), all Caucasian with an average age of 40 years (min. = 32; max. = 46; *SD* = 4). Two main theoretical approaches were represented: psychodynamic (n = 38) and cognitive (n = 27). Among psychodynamic therapists, five were psychoanalysts practicing long term psychodynamic

psychotherapy once per week, one was a psychodynamic interpersonal psychotherapist, three practiced Transference Focused Therapy and two were Mentalization Based Treatment therapist, while within the group of cognitive behavioral psychotherapists three had a metacognitive interpersonal approach, six a cognitive interpersonal orientation and four were specialized in Dialectical Behavioral Therapy. The average length of their clinical experience was seven years (min. = 4; max. = 13; *SD* = 4). All the clinicians included in this study signed informed-consent forms.

Raters. Two different coding groups were recruited and trained (i.e., one group for each observer-rated instrument). Each team was composed of two raters. The first author of this project was in the DMRS rating group. Raters were blind to TRQ evaluations provided by clinicians. Two raters (one for the DMRS and one for the PIRS) were cognitive therapists and two were psychodynamic therapist. The four raters were psychologists who each had more than 10 years of clinical experience.

Measures

Defense Mechanisms Rating Scale – DMRS (Perry, 1990; 2001). The DMRS was used to evaluate patients' overall defensive functioning. The DMRS is an observer-rated method, similar to the DSM–IV Defensive Functioning Scale (DSM–IV; American Psychiatric Association, 1994; Perry & Ianni, 1998). The DMRS can be used to identify defenses within interviews or psychotherapy sessions. A total of 30 defenses are arranged hierarchically into seven levels based on the general level of adaptiveness. Level 7 (high adaptive) includes: affiliation, altruism, anticipation, humor, self-assertion, self-observation, sublimation and suppression. Level 6 (mental inhibition/neurotic) includes the obsessional defenses of isolation of affect, intellectualization, and undoing. Level 5a (hysterical) includes repression, dissociation, and Level 5b (other neurotic) includes reaction formation, and displacement. Level 4 (minor image distorting) includes idealization, devaluation, and omnipotence. Level 3 (disavowal) includes denial, projection, rationalization, and autistic fantasy. Level 2 (major image distorting) includes splitting of self- and other-images, and projective identification. Level 1 (action) includes acting out, passive-aggression, and help-rejecting complaining.

The overall defensive functioning (ODF) is calculated by dividing the total weighted defense score by the total number of defenses. In the present study the ICC ranged from .61 to .88 with a mean of .72.

Psychodynamic Intervention Rating Scales - PIRS (Cooper & Bond, 1992; Milbrath et al., 1999). The PIRS identifies nine types of interventions based on psychodynamic psychotherapy broadly divided into three categories: interpretive, supportive, and therapy-defining. Each intervention is identified throughout an interview transcript, and the raw count is expressed as a proportion of all interventions. In a study of brief psychotherapy, the inter-rater reliabilities of the categories varied from kappas of 0.83 to 0.99 (Milbrath et al., 1999). Some support for the construct validity of the PIRS was obtained by finding relationships between class of therapists' intervention offered and the patients' initial level of distress, and between subsequent therapists' elaboration and patients' outcome, moreover the PIRS was used in previous works to study therapists' interventions in different psychotherapies, i.e. dynamic therapy, psychoanalysis and cognitive-behavioral therapy (Banon et al., 2013). The present study yielded comparable inter-rater reliability for each category, with all kappas greater than 0.71. In line with previous studies (Despland et al., 2001; Hersoug, Bøwald & Høglend, 2003) we constructed an Expressive-Supportive Intervention Level (ESIL) summary score for the PIRS by rank-ordering the intervention scores from the most supportive (association, level 1) to the most expressive (transference interpretation, level 7) and taking a weighted average.

Therapist Response Questionnaire - TRQ (Betan et al., 2005; Zittel Conklin & Westen, 2003). The TRQ is a clinician-report measure designed to provide a psychometrically valid instrument for assessing countertransference patterns in psychotherapy. TRQ's 79 items measure a wide range of thoughts, feelings, and behaviors expressed by therapists towards their patients that range from relatively specific feelings (e.g., "I feel bored in sessions with him/her") to complex constructs, such as "projective identification" (e.g., "More than with most patients, I feel like I've been

pulled into things that I didn't realize until after the session was over"). Those statements are written in everyday language, without jargon, so that clinicians of all theoretical orientations can use the instrument without bias. The clinicians assess each item on a 5-point Likert scale, ranging from 1 (not true) and 5 (very true). The factor structure of the TRQ comprises eight countertransference dimensions: (a) overwhelmed/disorganized (9 items) indicates a desire to avoid or flee the patient and strong negative feelings, including dread, repulsion, and resentment; (b) helpless/inadequate (9 items) describes feelings of inadequacy, incompetence, hopelessness, and anxiety; (c) positive (8 items) indicates the experience of a positive working alliance and close connection with the patient; (d) special/overinvolved (5 items) describes a sense of the patient as special relative to other patients, and includes "soft signs" of problems in maintaining boundaries, including self-disclosure, ending sessions on time, and feeling guilty, responsible, or overly concerned about the patient; (e) sexualized (5 items) describes sexual feelings toward the patient or experiences of sexual tension; (f) disengaged (4 items) describes feeling distracted, withdrawn, annoyed, or bored in sessions; (g) parental/protective (6 items) is marked by a wish to protect and nurture the patient in a parental way, above and beyond normal positive feelings toward the patient; (h) criticized/mistreated (18 items) describes feelings of being unappreciated, dismissed, or devalued and feelings of hostility toward the patient. The scales' scores are obtained by calculating the average score of the items that make up each countertransference factor. In the present study, the eight factors showed excellent internal consistency. The following Cronbach's alpha values were obtained: overwhelmed/disorganized (alpha = .81), helpless/ inadequate (alpha = .80), positive (alpha = .79), special/overinvolved (alpha = .75), sexualized (alpha = .71), disengaged (alpha = .80), parental/ protective (alpha = .72), and criticized/mistreated (alpha = .81).

Procedure

Since literature suggests that the Psychodynamic Interventions Rating Scale (PIRS) can categorize a percentage of in-session interventions ranging from 91-93% for cognitive sessions to 98-

100% for psychodynamic and psychoanalytic sessions (Banon et al., 2013) we excluded five sessions (3 cognitive behavioral, 2 psychodynamic) that had > 10% of therapists' interventions that were not categorizable by the Psychodynamic Intervention Rating Scales (PIRS) (the inter rater reliability for all these sessions was higher than .65). Moreover, we excluded also three sessions with a low level (Kappa and Intraclass Correlation Coefficient - ICC < .61) of inter-rater reliability at the Psychodynamic Intervention Rating Scales (1 session; PIRS – See Measures section) or at the Defense Mechanisms Rating Scale (2 sessions; DMRS – See Measures section). Finally, we excluded one session because the TRQ was only partially completed and one session because it was not possible to transcribe the whole session for a low quality of audio recording. At the end of this process we obtained a sample of 65 sessions.

Statistical Analysis

The first explorative aim of the present study, to investigate the relationship between ODF, ESIL and therapists' CT feelings, was pursued by verifying the existence of significant raw bivariate correlations among these variables. The second aim regarding the mediation of the relationship between ODF and ESIL by therapists' CT was tested using the SPSS PROCESS Model 4 (Hayes, 2012; Preacher & Hayes, 2008), which involves a simple mediation analysis with a single M (mediator). The model estimates the total effect (*c*), the direct effect (*c'*) of defense functioning (ODF) on supportive/expressive technique (ESIL) and the indirect effects (*a* x *b*) of ODF on ESIL via therapists' countertransference (seven different patterns of CT) using a 5000 bootstrapped re-samples and a 95% confidence interval to evaluate the indirect effects. These bootstrap estimates serve as a basis for obtaining confidence limits by referring to values at the appropriate percentiles (Preacher & Kelley, 2011).

Finally, regarding the third aim, we examined whether therapists' theoretical orientation impacted the strength of the associations between CT and ESIL through PROCESS Model 1, which is a simple moderation model with a single moderator. In case of significant effect, conditional process analyses trough PROCESS Model 15 would have been carried out to determine whether the

indirect effects were moderated by theoretical orientation. This is a model of moderated mediation that allows to test one or more mediating effect(s) with a single moderator.

Results

Preliminary analysis showed acceptable skewness (comprised between -1/+1) and kurtosis (comprised -3/+3) for all the study variables with the exception of sexualized and disengaged CT (skewness equal to 1.86 and 1.51 respectively) in which there was a high of proportion of zero-scores (48%). After cases with zero-scores on these two scales were eliminated the remainder showed a less skewed distributions (skewness equal to .87 and .45 respectively). The mean ODF (4.22) corresponds to the level of narcissistic defenses with values ranging from borderline defenses (2.72) to obsessional ones (6.00). The mean ESIL corresponds to questions and clarifications level with values ranging from the ones related to supportive strategies (2.50) to ratings related to defense interpretations (6.93) (Table 1). Table 2 reports Pearson's correlations between patients' ODF and therapists' ESIL and CT. Results showed that there were several significant associations between CT and ODF, more specifically positive/satisfying, special/overinvolved and parental/protective CTs were positively associated with patients' ODF, while overwhelmed/disorganized, criticized/mistreated and helpless/inadequate CTs were negatively associated with patients' ODF. Positive/satisfying, special/overinvolved, sexualized and parental/protective CTs were negatively associated with the ESIL, while criticized/mistreated was positively associated with the ESIL.

[Table 1 About Here]

[Table 2 About Here]

Table 3 shows our results in relation to the hypothesis that CT reactions would mediate the relationship between patients' ODF and therapists' ESIL. Four CT responses (parental, positive,

criticized and overinvolved) completely mediated the relationship between ODF and therapists' average ESIL. In these cases, after the introduction of CT mediators the pathway ODF→ESIL became not significant (*c'*), whereas the indirect effects (*a* x *b*) were found to be significant (see also Fig. 1). Figure 1a showed that the therapists who felt more criticized and maltreated, a reaction associated with lower defense functioning patients, intervened with higher level of expressivity. Conversely, clinicians' CT characterized by positive feelings (Fig. 1b), or by reactions of overinvolvement (Fig. 1c) or protection (Fig. 1d) with the patient, was associated with lower level of expressivity of their interventions in favor to a more supportive communication. No effect resulted in relation to overwhelmed, helpless, disengaged and sexualized CTs. In the latter case, although high sexualized CT predicted higher levels of supportive interventions, the hypothesized mediation was not verified because the ODF did not predict sexualized CT. Considering the potential effect of desirability biases, due to the difficulty of the therapists in admitting a certain type of countertransference response, the same analyses were repeated considering only those cases with any amount of sexualized or disengaged CT. However, the results confirmed the lack of mediation effects for both sexualized (Effect=.003, BootLLCI-ULCI=-.081□.264) and disengaged countertransference (Effect=.022, BootLLCI-ULCI=-.225□.270).

It is noteworthy that all our three variables were assessed globally for the session, and this does not permit to identify temporal (causal) relationships. Therefore, the mediational models we tested were based on one of the possible theoretical pathways. To address this point, we analyzed alternative mediational patterns (inverse causal effects) and compared these results with those of our specified mediational pattern above reported. Results from these alternative models (see supplementary materials) showed that there were no mediation effects and that indirect paths did not result significant.

Regarding the second aim of the study, the potential moderator effect of therapists' theoretical orientation on the associations between CT and ESIL was tested by PROCESS Model 1. The

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results show that both therapists' orientation and interaction CT x T's orientation did not affect ESIL for positive/satisfying (*p* = .55; p = .94, respectively), special/overinvolved, parental/protective (*p*= .53; *p* = .68, respectively) and criticized/mistreated (*p* = .89; *p* = .26, respectively) CTs. Considering these results subsequent models of moderated mediation were not carried out.

[Table 3 About Here]

[Figure 1 About Here]

Discussion

The first aim of this work was to investigate the relationship between three variables: patients' overall defense functioning, therapists' interventions (expressive *versus* supportive) and therapists' CT. Patients' defense level was significantly positively associated with the positive, parental, and overinvolved CTs, and negatively associated with the criticized, disorganized and inadequate CTs. This result is in line with other works which have shown how patients' lower level of functioning tended to be associated with negative CT responses, while a higher level of functioning tended to be associated with a positive CT (Colli et al., 2014; Dahl et al., 2012; Gazzillo et al., 2015; Røssberg et al., 2007).

Contrarily to the theoretical and clinical literature on the relationship between the patients' level of functioning and therapists' sexualized and disengaged CT reactions, in the present study we found no significant association between these variables. A possible explanation may be that these CT reactions are not uniquely associated with patients' level of functioning but also with patients' specific personality style, a variable that we did not assess in the present study. Differently stated, patients with similar levels of functioning could have different personality styles (e.g., narcissistic *versus* histrionic) and this may elicit different responses by clinicians (e.g., detachment versus sexu-

alization). Another possible explanation could be related to the desirability biases that may have influenced therapists' ratings, in particular for erotic CT reactions. In line with this, although the results have been confirmed when therapists who scored "0" in this scale were excluded, it cannot be ruled out that the lack of effect for sexual CT could be due by a restriction in the responses provided by therapists to this CT dimension. In fact, we noted that mean and SD were significantly lower in the sexual than in the others CT dimensions, and this may be due to a difficulty of the therapists in admitting a certain type of countertransference response. This in turn could lead to a lack of associations that we found.

As for the associations between the expressivity of therapists' interventions and CT, the correlational patterns that we found in this study (Table 2) suggested how more expressive interventions were significantly associated with a criticized CT, while supportive interventions are associated with positive, overinvolved and sexualized CTs. However, at this level of analysis, and in light of the positive and negative associations between different CTs and patients' level of defensive functioning, we can't exclude that these associations may also be influenced by the interfering action of the associations between therapists' CT and patients' ODF. For this reason, we analyzed the relationship between patients' ODF and therapists' interventions by using CT responses as mediating factors. In doing so and following Baron and Kenny (1986) indications we analyzed the possible mediating role of CT responses that had a significant relationship with both ODF and therapists' ESIL.

Criticized, positive, parental and overinvolved CT, according to our results, showed a mediating role in the relationship between ODF and therapists' interventions. More specifically, criticized CT seemed to increase the level of expressiveness of therapists' interventions: in other terms, within certain P-T dyads, the use of expressive interventions did not seem to be related to patients' defenses but to the therapists' reactions (e.g. feeling criticized or satisfied). This result seems to suggest that therapists, when they feel criticized and experience hostility in relation to their patients, may react by covering up these feelings and expressing them throughout interventions technically

focused on the insight, but which from a relational standpoint could be considered as less protective and respectful of what is happening in the relationship with the patient.

From a dynamic perspective, it seems that therapists manage their negative feelings with defenses such as intellectualization and /or displacement. In these instances the therapists distance their feelings of being criticized and instead focus on the idea of what the patient is doing and why – in relation to their interaction or to some historical referent (e.g. a parental experience) – while ignoring the bi-directional effect of feelings and actions that, at their worst, constitute a here-and-now enactment.

At its worst, the intellectualization will then be experienced by the patients as a criticism or punishment for their previous behavior toward the therapist. In this case the patients' critical transference begets the therapists' critical CT response, which then stimulates a neurotic defense of intellectualization or displacement, which in turn then reinforces the patients' underlying state of mind that occasioned the critical transference in the first place. In this research we focused only on therapists' CT but in the future, it will be interesting to study both therapists' interventions and CT in relation to patients' transference patterns.

This result is in line with other works which have demonstrated that during hostile interactions therapists tended to use more expressive interventions (i.e. interpretations) when compared to less hostile interactions (Anderson et al., 2012). Our data are coherent with the theoretical contributions of those authors who have stated that sometimes clinicians can cover up their aggressiveness throughout interpretations, i.e. things that the patient should know about him or herself (Kohut, 1996), a sign that they might prefer talking rather than listening. Other authors who have studied the therapeutic alliance rupture and resolution processes (Safran & Muran, 2000) have asserted that during difficult moments in the interaction between the therapist and the patient, such as moments in which the therapist is caught in an hostile interactions with the patient, therapists may tend to adopt more interpretive (and less supportive) interventions. Another possible explanation is that the

increase of the ESIL may represent clinicians' attempt to overcome a negative interpersonal cycle with the patient.

Our results have shown that overinvolved and protective CTs were associated with an increase in the supportive level of therapists' interventions. It is possible that therapists, when experiencing an over-involved relationship with their patients, together with feelings of protectiveness, are less prone to interventions which may be more difficultly accepted by patients (i.e., confrontations and interpretations) and tend to privilege less complex and more protective interventions. An increase in feelings of overinvolvement and protectiveness, together with greater supportiveness, could be interpreted also as the sign of therapist's fear of hurting the patient or of saying something that might provoke a hostile reaction.

Following Vygotskij's (1987) theory of the zone of proximal development, supportive interventions may be seen as communications situated on a lower level of the patients' zone of proximal development, while expressive interventions are on a higher level. We may speculate that a clinician who feels protective toward a patient may tend to provide interventions on a lower level than the one that the patient is experiencing. This in turn may prevent or decelerate the process of therapeutic change, since the therapist does not push the patient or explore areas that are not close to patients' level of functioning. At the same time, expressive interventions may push the patients too far from their capacities and, in turn, generate hostile or rejecting reactions from the patient and consequent negative CT reactions (Ribeiro et al., 2014; Stiles, Gabalda, & Ribeiro, 2016; Zonzi et al., 2014).

It is also important to note that in our results complete mediations were found, in other words therapists' emotional response eclipsed the effect of patients' functioning, leading to think that interventions seem to be more influenced by the emotional exchange between the patient and the therapist rather than being technically tailored on the patients' characteristics. Finally, our results do not seem to be influenced by therapists' theoretical orientation, suggesting that even though findings may come from a dynamic model, they may also apply to people and therapy in general,

and not only to dynamic therapy. This suggests that we may be approaching an understanding of a fundamental mechanism of psychotherapy.

This result could be surprising if applied to cognitive behavioral therapy that is supposed to be, at least in its original formulation (Beck, 1967; Ellis, 1971), symptom-focused or protocol-based, and where the therapeutic relationship is described as necessary and yet secondary to technique, and the role of therapist has been intended as the one of an empiricist collaborator, a provider of techniques rather than an emotionally involved partner in the relationship. In this work we found that cognitive behavioral (CBT) therapists in our sample provided expressive interventions such as interpretations and confrontations. We also found that they did not significantly differ from psychodynamic (PDT) therapists in terms of Expressive Intervention level, at least to the level of sensitivity that the PIRS is able to capture.

It is important to further investigate and reflect on this issue from our point of view. Cognitive behavioral therapies have changed throughout the years, and several authors have recognized the importance of the interpersonal dynamics that unfold during treatment (Safran & Segal, 1996; Dimaggio, Montano, Popolo, & Salvatore, 2015). The third wave of cognitive therapy refers to models of psychotherapy which may differ from one another but are all characterized by a greater emphasis on the contextual and experiential change strategies (Carvalho, Martins, Almeida, & Silva, 2017; Hayes & Hofmann, 2017) in which the emphasis is on exploring a person's thoughts and beliefs surrounding the content of their thoughts (i.e., metacognitions) (Dimaggio & Lysaker, 2010).

The afore mentioned theoretical changes may also reflect in everyday clinical practice of CBT therapists. For example, the expressive interventions that were rated in our CBT sessions were interventions aimed at confronting or interpreting patients' relational schemes (e.g. Therapist: "It looks like we are experiencing here something that often happens when you are involved with someone: When you need help you seem to have problems with asking for it, and at the same time you seem to believe that the other person can understand your needs even without asking."). Our

results are in line with other works which have indicated that the amount of interpretations in the various theoretical approaches was not statistically different (Crits-Christoph & Connolly Gibbons, 2002; Gazzola, Iwakabe, & Stalikas, 2003).

Limitations and Future Directions

In the present study we have evaluated the relationship between therapists' CT and interventions, but we did not focus on the impact that therapists' interventions have on the patients, or on the (short and long term) outcome. Future studies should be focused on the interaction between therapists' CT, their interventions and the outcome of the session and of the treatment. In this study we have evaluated variables that are not just session-specific but are most likely patient- and therapist-specific: in other words, certain patients will have a specific defense style, certain therapists will have specific reactions and intervention strategies. General patterns that do not account for patient- and therapist-levels may not accurately describe the relationship that exist among these variables.

As mentioned in the results section, one important limitation of the present study is the impossibility to establish causal relationship because variables were assessed globally for the session and we don't have temporal sequences. For different therapist-patient dyads, the timing of defense, CT, and intervention within the session may be very different. For many, intervention may precede a defensive maneuver, which leads to a specific CT response and so on. Although the results we found when we tested alternative models corroborates our findings, we want to highlight that this does not definitively overcome this limit of the study. Another limit related to data measured at global session level is that we cannot capture the fluctuations of CT feelings inside the session and their role in relation to the interventions: for example we cannot exclude that in a part of the session a clinician may experience negative feelings (e.g., a criticized CT) and later in the session, after working through and reflecting on these feelings and reducing them, propose the expressive intervention to the patient. Nonetheless, the current results do add further evidence the importance of

conducting further moment to moment process studies in which the temporality of defense-CT-ESIL level are addressed (Perry, Petraglia, Olson, Presniak, & Metzger, 2012).

Moreover, we have assessed the level of therapists' expressiveness in relation to patients' level of functioning during the session, but we did not consider patients' global (trait) level of functioning. We can't assume that patients' level of functioning in session totally represents patients' "usual" level of functioning and this may influence our results, since we can't exclude the possibility that therapists' CT in relation to patients who function at their usual level of functioning is different to the CT that a therapist may experience in relation to a patient who has a fluctuation and is working differently from his or her usual level of functioning.

Another important limitation is related to the fact that we didn't consider the possible influence of other variables (e.g. therapeutic alliance) which may have improved our understanding of the interactive processes studied here. In line with this consideration, and following the relational theory, the therapeutic relationship may be considered as a transference and countertransference matrix, in which these processes (transference and countertransference) can't be considered separately but must be analyzed as a whole. In the present study we have considered patients' level of functioning in relation to therapists' CT but not the transference patterns active during the sessions: in future studies it will be important to assess also patients' in-session relational patterns in order to have a deeper understanding of the relationship between the technique and the psychotherapy

Conclusion

The present study illustrates how therapists' CT may influence their technique, and how CT mediates the relationship between patients' defensive level of functioning and therapists' interventions (expressive *versus* supportive). Results show that in the context of hostile reactions, therapists tend to adopt more expressive interventions above and beyond patients' level of functioning. On the contrary, when experiencing positive, parental or overinvolved reactions, therapists tend to adopt more supportive interventions. These data seem to suggest that the CT of the therapists has a crucial

role in predicting their technical approach to the patient, and that therapists' CT mediates the relationship between patients' defensive level of functioning and therapists' technique.

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Figure 1

*Mediating Effects of CT on the Relationship Between ODF and ESIL (N = 65). ODF: Patients overall defensive functioning; ESIL: Therapists expressive supportive intervention level; CT: countertransference; c=Total effect; a, b, c'=Direct effects *p≤0.05. **p≤0.01.*

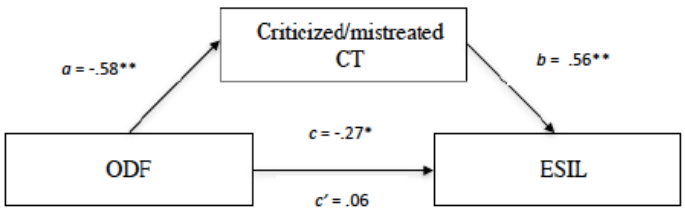


Fig. 1a. *Mediating Effects of criticized/mistreated CT*

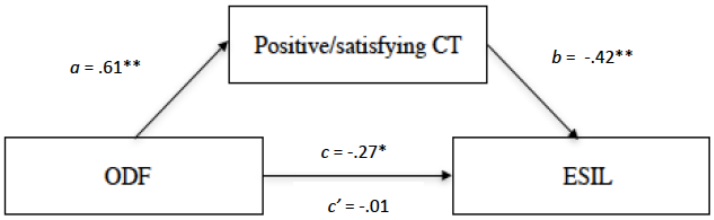
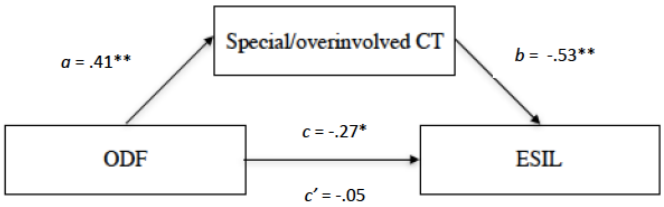


Fig. 1b. *Mediating Effects of positive/satisfying CT*



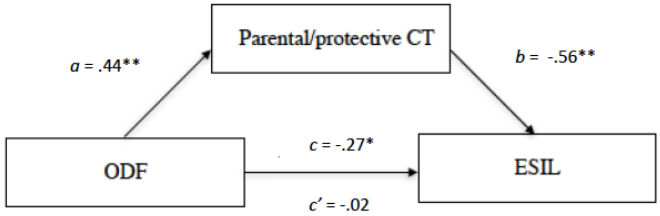


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Fig. 1c. *Mediating Effects of special/overinvolved CT*

Fig. 1d. *Mediating Effects of parental/protective CT*

Table 1
Descriptive Statistics (N =65)

	M	*SD*	% zero-rating
ODF	4.22	.86	/
ESIL	5.18	1.18	/
overwhelmed/disorganized CT	2.11	1.10	26.6
helpless/inadequate CT	2.28	1.16	25.2
positive/satisfying CT	2.23	1.13	23.6
special/overinvolved CT	1.98	1.19	29.7
sexualized CT	1.50	.84	48.1
disengaged CT	1.80	1.26	48.1
parental/protective CT	1.94	1.13	20.3
criticized/mistreated CT	2.51	1.49	29.1

Note. ODF: Patient's overall defensive functioning; ESIL: Therapist's expressive supportive intervention level; CT: Therapist's countertransference

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Table 2
Bivariate Correlations Between CT, ODF and ESIL (N =65)

	ODF	ESIL
overwhelmed/disorganized CT	-.49**	.12
helpless/inadequate CT	-.71**	.19
positive/satisfying CT	.61**	-.43**
special/overinvolved CT	.41**	-.56**
sexualized CT	.13	-.34**
disengaged CT	.03	.17
parental/protective CT	.44**	-.57**
criticized/mistreated CT	-.58**	.53**
ESIL	-.29*	-

Note. ODF: Patient's overall defensive functioning; ESIL: Therapist's expressive supportive intervention level; CT: Therapist's countertransference. *p≤0.05. **p≤0.01.

Table 3.

Mediating Effects of CT on the Relationship Between ODF and ESIL (N = 65)

Mediator (CT)	R^2	Direct effects			Indirect effect *a* x *b*[#] LLCI - ULCI	Indirect effect
		a	*b*	*c'*		
overwhelmed/disorganized	.24	-.48**	-.01	-.27	-.32 .16	.01
helpless/inadequate	.07	-.71**	-.01	-.27	-.42 .38	.03
positive/satisfying	.38	.61**	-.42**	-.01	-.54 -.10	-.30
special/overinvolved	.17	.41**	-.53**	-.05	-.55 -.08	-.25
sexualized	.02	.13	-.30*	-.22	-.37 .13	-.11
disengaged	.00	.03	.18	-.27	-.04 .06	.01
parental/protective	.19	.44**	-.56**	-.02	-.60 -.08	-.29
criticized/mistreated	.34	-.58**	.56**	.06	-.74 -.20	-34

Note. *p≤0.05. **p≤0.01; CT: Therapist's countertransference. *a*: direct effect of ODF on CTs; *b*: direct effect of CTs on ESIL; c': direct effect of ODF on ESIL; total effect (c) = -.27 was significant at p< .05 level; [#] LLCI-ULCI that does not contain zero indicates a significant indirect effect at p<.05 level.