Factor Structure, Reliability, and Validity of the Therapist Response Questionnaire

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Abstract

The aim of this study was to examine the stability of the factor structure and psychometric properties of the Therapist Response Questionnaire (Betan, Heim, Zittel Conklin, & Westen, 2005; Zittel Conklin & Westen, 2003), a clinician report instrument able to measure the clinician's emotional reactions to the patient in psychotherapy. A national sample of psychiatrists and clinical psychologists (*N* 332) of psychodynamic and cognitive–behavioral orientation completed the Therapist Response Questionnaire, as well as the Shedler-Westen Assessment Procedure-200 (Westen & Shedler, 1999a, 1999b), to assess personality disorders and level of psychological functioning, regarding a patient currently in their care. They also administered the Symptom Checklist–90– Revised (Derogatis, 1994) to the patients. Exploratory and confirmatory factor analyses revealed 9 distinct countertransference factors that were similar to 8 dimensions identified in the original version of the measure: (a) helpless/inadequate, (b) overwhelmed/disorganized, (c) positive/ satisfying, (d) hostile/angry, (e) criticized/devalued, (f) parental/protective, (g) special/ overinvolved, (h) sexualized, and (i) disengaged. These scales showed excellent internal consistencies and good validity. They were especially able to capture the quality and intensity of emotional states that therapists experience while treating personality-disordered patients, as well as to better differentiate them; additionally, they tapped into the complexity of clinicians' reactions toward patients experiencing severe psychiatric symptomatology. Results seem to confirm that Therapist Response Questionnaire is a valid and reliable instrument that allows to evaluate patterns of countertransference responses in clinically sensitive and psychometrically robust ways, regardless of therapists' orientations. The clinical and research implications of these findings are addressed.

Keywords: personality disorders, SWAP–200, symptom severity, therapist emotional response, TRQ

A therapist's emotional responses to a patient, or countertransference, represent a crucial dimension of the therapeutic relationship across different theoretical approaches to treatment (Fauth, 2006; Gelso, 2014; Gelso & Hayes, 2007). Moreover, they are very useful in the diagnostic understanding of the patient's psychological functioning and personality, as well as in clinical practice to improve the psychotherapy outcome (Hayes, Gelso, & Hummel, 2011). Historically, the concept of countertransference was introduced by Freud (1910), who defined it as a result of the patient's influence on the analyst's unconscious feelings or, in other words, the analyst's transference to the patient. Deriving from unresolved psychological conflicts of the analyst, countertransference was considered a hindrance to the patient's treatment because it created blind spots or distortions in the clinician's perception of the patient; therefore, it had to be eliminated through rigorous psychoanalysis (Freud, 1912). This classical and overly restrictive perspective of countertransference as a disturbing factor predominated for many decades in psychoanalysis. Gradually, however, several theorists promoted a radical revision of this concept, broadening its boundaries and recognizing that all the feelings, thoughts, attitudes, and behaviors experienced by the clinicians in treating patients could be used in clinical practice as a source of valuable information about patient's intrapsychic and interpersonal dynamics (Heimann, 1950). According to this expanded view, labeled totalistic (Kernberg, 1965), if properly used and managed, countertransference can benefit all the treatments (of different approaches) rather than hinder them. The amount of empirical investigations on countertransference is disproportionate to the broad body of clinical and theoretical literature. The two main problems in the development of systematic research in this area are the lack of a clear and shared conceptual definition, and the difficulties in capturing and evaluating this complex and multifaceted construct (that includes both conscious and unconscious aspects).

Beyond the different theoretical conceptualizations of countertransference (for a review, see Hayes, 2004; Hayes et al., 2011), researchers have mostly studied therapists' reactions to the patient from the clinician's, external observer's, and supervisor's perspectives (Colli & Ferri, 2015). The clinician's perspective was typically employed to measure the quality and intensity of the internal emotional experience of the therapist. For this purpose, empirical investigators have commonly used self-report instruments—such as the State Anxiety Inventory (e.g., Hayes & Gelso, 1991), the Therapist Appraisal Questionnaire (e.g., Fauth & Hayes, 2006), the Feeling World Checklists (e.g., Dahl, Røssberg, Bøgwald, Gabbard, & Høglend, 2012; Røssberg, Hoffart, & Friis, 2003), and the

Therapist Response Questionnaire (e.g., Zittel Conklin & Westen, 2003)—more than qualitative methods (Hayes et al., 1998) and interviews (e.g., Bourke & Grenyer, 2010; Tishby & Wiseman, 2014). The main limitation of these self-report measures is the possible influence of social desirability bias or implicit defensive processes. These mechanisms do not affect the research based on observer perspective, in which trained raters use transcripts or audio/video recording of psychotherapy sessions (e.g., Bandura, Lipsher, & Miller, 1960; Hayes & Gelso, 1993; Rosenberger & Hayes, 2002), or other studies in which supervisors rate how countertransference feelings influence therapists' emotional state in session (e.g., Friedman & Gelso, 2000). However, using therapists as the main informants of their emotional reactions also has several advantages: Especially, self-report instruments allow us to obtain data regarding the relational experience of the clinician with the patient from the widest and most direct observational basis (for more details, see Kächele, Erhardt, Seybert, & Buchholz, 2015; Westen & Weinberger, 2004).

In the present study, we used the Therapist Response Questionnaire (TRQ), originally called the Countertransference Questionnaire (Betan, Heim, Zittel Conklin, & Westen, 2005; Zittel Conklin & Westen, 2003). It is a 79-item clinician-report questionnaire that, based on a practice network approach (Shedler & Westen, 2004; Westen & Shedler, 1999a, 1999b), allowed pooling of the experience of dozens of clinicians and thereby identified common patterns of countertransference reactions in clinical practice. Betan et al. (2005) asked 181 clinicians of various theoretical orientations to measure with this instrument their affective, cognitive, and behavioral responses to a nonpsychotic patient in their care. To examine the factor structure of the TRQ, the authors conducted a principal component analysis (PCA) and identified the number of factors to be subjected to promax rotation. Factor analyses with seven, eight, and nine factors were run to maximize interpretability, and the most parsimonious solution (accounting for 69% of the variance) included eight countertransference dimensions that were clinically and conceptually coherent: (a) overwhelmed/disorganized (.90), (b) helpless/inadequate (.88), (c) positive (.86), (d) special/overinvolved (.75), (e) sexualized (.77), (f) disengaged (.83), (g) parental/protective (.80), and (h) criticized/mistreated (.83). The authors also asked therapists to assess the personality pathology of their patients with a *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM–IV*) Axis II criteria checklist. They rated the presence or absence of each criterion of the checklist to obtain both a categorical diagnosis of each disorder (by applying *DSM–IV* cutoffs) and a dimensional measure of *DSM* personality disorders (by adding the number of criteria that patient met for each disorder). To assess the validity and clinical applicability of the TRQ, Betan et

al. (2005) examined the relationship between the TRQ's eight factors and dimensional measures of the personality disorders aggregated at the *DSM–IV* clusters level using partial correlations. The findings showed that cluster A (paranoid, schizoid, and schizotypal personality disorders) was associated with the criticized/mistreated pattern; cluster B (antisocial, borderline, histrionic, and narcissistic personality disorders) correlated to overwhelmed/disorganized feelings, helplessness, hostility, disengagement, and sexual attraction; and cluster C (avoidant, dependent, and obsessive–compulsive personality disorders) was associated with therapists' nurturant and warm feelings. Moreover, these results were not affected by clinicians' theoretical preconceptions.

In two recent studies, the TRQ was used to examine the patterns of therapists' emotional responses systematically related to patients' personality disorders (Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Gazzillo et al., 2015). In another study, the same research group employed it to investigate the relationship between countertransference and patients' symptom severity, exploring the mediated effect of severe symptomatology on the relationship between patients' personality pathology and therapists' responses (Lingiardi, Tanzilli, & Colli, 2015). Additionally, Satir et al. (2009) examined the emotional responses of clinicians treating female patients with eating disorders (EDs) in their care using a TRQ version for adolescents. Overall factor structure of this measure was similar to those of the TRQ's original version and consisted of six dimensions (angry/frustrated, warm/competent, aggressive/sexual, failing/incompetent, bored/angry at parents, and overinvested/worried) that were consistently associated with patients' personality styles. However, no research to date has replicated the TRQ's factor analysis to verify accurately the underlying internal structure identified by Betan et al. and show the generalizability of their findings on other therapist-patient populations; moreover, no research has reexamined the goodness of the psychometric properties of this tool.

The present study aims to (a) test the stability of the TRQ's factor structure and the reliability of its scales on a new and larger clinicians' group and (b) assess the validity and clinical usefulness of this measure in investigating the associations between patterns of therapists' responses and patients' personality pathology, psychological functioning, and symptom severity. We explored the following hypotheses:

Hypothesis 1: The TRQ is characterized by a robust factor structure, and its scales have a high reliability in evaluating broad-band countertransference reactions.

Hypothesis 2: This measure shows good validity and can be used to measure patterns of clinicians' responses in psychotherapy in a clinically sophisticated and psychometrically sound way. The TRQ's

scales are especially able to capture the quality and intensity of distinct emotional responses evoked by personality-disordered patients in therapists of different theoretical orientation.

More in detail, consistent with clinical and empirical literature (mentioned above), we hypothesized positive and systematically predictable associations of moderate magnitude (Cohen, 1988) between (a) the paranoid, schizoid, and schizotypal personality disorders and therapists' disengaged or criticized/mistreated responses; (b) the antisocial, borderline, histrionic, and narcissistic personality disorders and overwhelmed/disorganized, helpless/ inadequate, special/overinvolved, or sexualized patterns of countertransference; and (c) avoidant, dependent, and obsessive–compulsive personality disorders and clinicians' parental reactions. Overall, clinicians' emotional responses toward patients with globally lower personality functioning and more severe psychiatric symptomatology are characterized by stronger negative feelings of being overwhelmed, disorganization, helplessness, and frustration.

Method

Participant Sampling

A sample of psychodynamic and cognitive–behavioral therapists has been recruited by e-mail from the rosters of the largest Italian associations of psychotherapy, several institutions of the National Health System, and centers specialized in the treatment of personality disorders. Therapists had at least 3 years of postpsychotherapy licensure experience and performed at least 10 hours per week of direct patient care. Clinicians were directed to select a patient according to the following criteria: at least 18 years old; nonpsychotic and not treated with drug therapy for psychotic symptoms; in treatment for a minimum of eight sessions and a maximum of 6 months (one session per week); agreed to participate in a research protocol on psychological assessment. We required a minimum of eight sessions and a maximum of 6 months of treatment to maximize the likelihood that therapists provided accurate information about patients and their therapeutic relationship in the initial phases of treatment. To minimize selection biases, we asked clinicians to consult their calendars to identify the last patient they saw during the previous week who met the study criteria. To minimize rater-dependent biases (i.e., therapist effects), each clinician furnished data on only one patient. Of the 1,200 clinicians contacted, 345 indicated their willingness to participate, for an overall response rate of 29%. Comparing the data available between the responders and nonresponders with the *t* test, we did not detect statistically significant differences in gender and therapeutic orientation. We also had a response rate of 28% of their patients (*N* 332). All participants (therapists and patients) provided written informed consent. They received no remuneration. In this study, we considered only the complete data relative to 332 separate therapist–patient dyads.

Therapists

This sample consisted of 332 Caucasian therapists, including 180 (54%) women and 152 (46%) men; 70% were clinical psychologists, and 30% were psychiatrists. Their mean age was 47 years (*SD* 9.8, range 34–62). Two main clinical–theoretical approaches were represented: psychodynamic (*N* 169) and cognitive–behavioral (*N* 163). The average length of clinical experience as a psychotherapist was 10 years (*SD* 4.5, range 3–25), and the average time spent per week practicing psychotherapy was 16 hours (*SD* 3.9, range 13–30). Sixty-five percent of the patients were from independent practice and the remaining 35% from public mental health institutions.

Patients

This sample consisted of 332 Caucasian patients, including 174 (52%) women and 158 (48%) men. Their mean age was 40 years (*SD* 5.2, range 25–66). One hundred fifty patients had only a *DSM–IV–TR* axis I diagnosis, 101 had only an axis II diagnosis, 46 had comorbid axis I and axis II diagnoses, and 35 had two or more axis II diagnoses. Among patients with psychiatric diagnoses (alone and comorbid with personality disorders), 52 had a generalized anxiety disorder, 50 an eating disorder, 45 a panic disorder, 31 a dysthymic disorder, and 18 a substance (cannabis) use disorder. Among patients with personality pathology (alone and comorbid with psychiatric diagnoses), 18 had a cluster A diagnosis, 71 a cluster B diagnosis, and 58 a cluster C diagnosis. Finally, among patients with two or more personality disorders, 6 had a double cluster A diagnosis, 13 a double cluster B diagnosis, 11 a double cluster C diagnosis, and 5 had three diagnoses (3 between clusters B and C; 2 between clusters C and A). The mean Global Assessment of Functioning (GAF) score was 52 (*SD* 12.1). The length of treatment (one session per week) averaged 4 to 5 months (*SD* 0.9; range 2–6).

Measures

Clinical questionnaire. We constructed a questionnaire for clinicians to obtain general information about themselves, patients, and therapies. Clinicians provided their basic demographic data (age, gender, race), including profession (psychiatrist or psychologist), years of experience, theoretical orientation, employment address, hours of work, and number of patients in treatment, as well as patients' demographic data, education level, socioeconomic status, and *DSM–IV* axis I diagnoses. Clinicians also provided data on the therapies, such as length of treatment and number of sessions.

Therapist Response Questionnaire. The Italian version of the TRQ (Betan et al., 2005; Zittel Conklin & Westen, 2003) was translated by the authors. The adequacy of the translation to its English version was evaluated through a back-translation by a professional translator. The TRQ is a clinician report of 79 items that measure a wide spectrum of thoughts, feelings, and behaviors expressed by therapists toward their patients, ranging 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"). Items are derived by reviewing the clinical, theoretical, and empirical literature on countertransference and related variables, and are written in a straightforward manner, without jargon and near to clinical experience, so that the instrument could be used comparably by therapists of any orientation. The clinicians assess each item on a 5-point Likert scale, ranging from 1 (*not true*) to 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 selfdisclosure, ending sessions on time, and feeling guilty about, responsible for, 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 by 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 (Streiner, 2003). The following values of Cronbach's alpha coefficients were obtained: overwhelmed/disorganized (.79), helpless/inadequate (.87), positive (.84), special/overinvolved (.75), sexualized (.80), disengaged (.78), parental/protective (.80), and criticized/mistreated (.84).

Shedler-Westen Assessment Procedure-200. The SWAP– 200 (Shedler & Westen, 2004, 2007; Westen & Shedler, 1999a, 1999b; for more details on the Italian version and its validity and reliability, see Shedler, Westen, & Lingiardi, 2014) is a wellvalidated and reliable instrument designed to provide a comprehensive assessment of patient personality and psychological functioning. It comprises 200 items or statements written in jargon-free language near to clinical experience to provide a standard vocabulary for case formulation used by therapists of all theoretical orientations. Each item may describe a given person well, somewhat, or not at all. The clinician who has a thorough knowledge of the patient arranges these 200 statements into eight different categories ranging from 0 (*irrelevant or not descriptive of the person*) to 7 (*most descriptive*). Based on the Q-sort method, the SWAP– 200 requires the therapist to assign a specified number of items to each score category (8 items in pile 7; 10 items in pile 6; 12 items in pile 5, etc.) according to the constraints of a fixed distribution (that is asymmetric and resembles the right half of a normal distribution). The Q-sort procedure is designed to maximize reliability and minimize error variance attributable to rater effects by ensuring that different assessors assign scores with the same frequency (Block, 1978). The SWAP–200 assessment provides (a) a personality diagnosis expressed as the matching of the patient

assessment with 10 personality disorder scales, which are clinical prototypes of *DSM–IV* axis II disorders and (b) a personality diagnosis based on the correlation/matching of the patient's SWAP description with 11 Q-factors/styles of personality derived empirically via Q-factor analysis. It also includes a dimensional measure of psychological strengths and adaptive functioning. All SWAP–200 scales and Q-factors make it possible to obtain both categorical and dimensional diagnoses. In this study, we paid attention only to the personality disorder scales (PD scales) and the highfunctioning index, excluding the Q-factors of the alternative empirically derived taxonomy. Reliability and validity of the SWAP– 200 have been tested extensively in several researches and different patient samples, including multiobserver studies comparing diagnosis by treating clinicians with diagnoses by independent assessors based on research interviews (e.g., Blagov, Bi, Shedler, & Westen, 2012; Westen & Muderrisoglu, 2006; Westen & Shedler, 2007; Westen & Weinberger, 2004).

The Symptom Checklist-90-Revised. The Symptom Checklist90-Revised (SCL-90–R; Derogatis, 1994; for more details on the Italian version and its validity and reliability, see Prunas, Sarno, Preti, Madeddu, & Perugini, 2012) is a self-report instrument designed to measure psychopathological disease. It consists of 90 items assessing the personal discomfort of physical status as well as the psychiatric symptoms and mental health status. The respondents evaluate on a 5-point Likert scale, ranging from 0 (*not at all*) to 4 (*extremely*), how much they had been distressed by their psychopathology within the past two weeks. The Global Severity Index (GSI), which is the mean rating across all 90 items, summarizes the level of the patient's general psychiatric symptom severity.

Procedure

After we received the clinicians' and patients' consent to participate, we provided them with the material to conduct the study. Clinicians were asked first to evaluate their emotional responses to the selected patient using the TRQ, and then, between one and three weeks later, to evaluate the same patient's personality using the SWAP–200. We used this interval because the TRQ and SWAP–200 require different time commitments. Whereas the first, a faster and clinician-friendly measure, was completed immediately after a session with the designated patient, the SWAP–200, a more time-consuming assessment method, was completed later. Another aim of this interval was to reduce any possible effect that clinicians' rating of their own emotional responses might have on a concurrent evaluation of patients' personality. We asked therapists to deliver the SCL-90–R to patients at the end of the session wherein they completed the TRQ. Clinicians asked their selected patients to return

the completed test the next week. Thus, we obtained that therapists and patients filled out the measures in the same period of time.

Statistical Analysis

Statistical analyses were performed using SPSS 20 for Windows (IBM, Armonk, NY) and LISREL 8.8 (Jöreskog & Sörbom, 2006). To identify the factor structure of the TRQ, we carried out an exploratory factor analysis (EFA). Consistent with the study of Betan et al. (2005), we conducted a principal components analysis

(PCA) with promax (oblique) rotation[1] on the first half sample and more specifically on the data of 166 clinicians randomly selected from the full therapist sample (N 332). In opposition to a varimax rotation, promax rotation implies the absence of the assumption of orthogonal factors (as well as the tendency to maximize factor loadings within factors) and, when studying psychological constructs such as the emotional responses or feelings, correlations between various subscales seem plausible (Fabrigar, Wegener, MacCallum, & Strahan, 1999; Floyd & Widaman, 1995). However, we used both kinds of rotations to verify whether the factor structure of the TRQ was very stable.

To select the optimal number of factors to be retained and rotated, we took into consideration the Kaiser's criteria eigenvalues 1, the scree plot, the parallel analysis, the percentage of variance accounted for the factor solution, and its interpretability. To maximize the factors' internal consistency (measured by Cronbach's alpha), as suggested by Bühner (2010), we included items that loaded |.45| on one factor and |.30| on all other factors.

To confirm the appropriateness of the factor model of the TRQ, we conducted a confirmatory factor analysis (CFA) on the data of remaining sample of clinicians (N 166) and tested it using several descriptive fit indices (Bentler, 2007). Given that chisquare test statistics have some limitations, including a dependence on sample size (e.g., see Hoyle, 2000), we considered the following fit indices and cutoff thresholds widely recommended by Hu and Bentler (1999): Comparative Fit Index (CFI) .95, Root Mean Square Error of Approximation (RMSEA) .06, Standardized Root Mean Square Residual (SRMR) .08.

To verify the internal consistencies of all the subscales of the TRQ's current version, we calculated Cronbach's alpha reliability coefficients using data of the full sample (N 332), and finally, we ran

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[1] In this study, we replicated for the first time the TRQ's factor structure by performing on a new and larger sample of clinicians the same analyses and estimation procedures (a principal components analysis with promax rotation) followed in the original study of Betan et al. (2005). In future empirical investigations, it would be useful to conduct the principal axis factoring (PAF) or maximum likelihood (ML) as the extraction method, followed by direct oblimin rotation, or alternatively the weighted least squares (WLS) or maximum likelihood with robust standard errors and chi-square (MLR) estimations as the extraction method, followed by oblique rotation.

the bivariate correlations among all the new TRQ factors to obtain the intercorrelations among the subscales.

To examine the convergent validity, we correlated the subscales of the TRQ's current version with the eight of the original version. Then, to assess criterion validity, we conducted the partial correlations (partial *r*, two-tailed) between the new TRQ factors and each personality disorder scale in the SWAP–200 (PD scales), removing the effect of the other nine personality disorders in each analysis. In this way, we obtained results specific and unique to each disorder/countertransference pattern, controlling for the overlap between different personality disorder diagnoses. We used the same procedure adopted by Betan et al. (2005), with the difference that we did not consider the personality pathology at the cluster level, but rather at the level of the individual disorder. In line with their study, to examine whether distinct associations between countertransference and personality disorder were dependent on clinicians' theoretical approaches, we once again ran the partial correlations, eliminating from the sample all the psychodynamic clinicians (remaining *N* 163). Additionally, we performed the bivariate correlations (Pearson's *r*, two-tailed) for four SWAP–200 personality disorders (schizoid, antisocial, borderline, and dependent) to examine their relationships with all the new TRQ factors, without removing the overlap of these personality pathologies and the nine others. Finally, we calculated the bivariate correlations between the subscales of the TRQ's current version and the SWAP– 200 high-functioning scale, as well as the Global Severity Index (GSI) of the SCL-90–R.

Results

Therapist Response Questionnaire (TRQ): Factor Analyses and Reliabilities of the Subscales

The exploratory factor analysis (EFA) was conducted on the data provided by 166 clinicians. The Kaiser–Meyer–Olkin (KMO; Tabachnick & Fidell, 2007) score of .78 confirmed the sampling adequacy to perform the factor analysis. Bartlett's test of sphericity, χ^2(3081) 11634.43, *p* .001, indicated that correlations between items were sufficiently large for principal component analysis (PCA). The PCA revealed a nine-factor solution that provides the best fit and gives clinical and theoretical meaning. This solution is also confirmed by parallel analysis, because the eigenvalue of the nine factor was the last to exceed the threshold of the 95th percentile of the first eigenvalue of the randomly generated data (1.557). It accounted for about 58% of the variance and included nine subscales well marked by at least 4 or 5 items each, suggesting a stable factor structure unlikely to be substantially affected by sample size (Fabrigar et al., 1999). These subscales were obtained using promax rotation; however, they were the same dimensions that also emerged using the varimax

rotation. In Table 1, we presented the factor structure of the TRQ's current version displaying items with factor loadings on all the nine patterns of therapist response labeled (a) helpless/inadequate, (b) overwhelmed/disorganized, (c) positive/satisfying, (d) hostile/ angry, (e) criticized/devalued, (f) parental/protective, (g) special/ overinvolved, (h) sexualized, and (i) disengaged. The nine dimensions of this TRQ's version were very similar to those of the old version (with the exception of the original criticized/mistreated pattern that seems to be split in two new factors: hostile/angry and criticized/devaluated); therefore, the same labels were retained.

The helpless/inadequate factor (9 items) accounted for 8.61% of the variance and included items indicating feelings of inadequacy, incompetence, hopelessness, and a strong sense of inefficacy. The overwhelmed/disorganized factor (11 items) accounted for 7.47% of the

variance and included items describing an intense feeling of being overwhelmed by the patient's emotions and needs, as well as confusion, anxiety, dread or repulsion. The positive/satisfying factor (8 items) accounted for 5.76% of the variance and included items indicating an experience of close connection, trust, and collaboration with the patient resulting from a good therapeutic alliance. The hostile/angry factor (7 items) accounted for 5.64% of the variance and included items indicating feelings of anger, hostility, and irritation toward the patient. The criticized/devalued factor (7 items) accounted for 5.14% of the variance and included

items describing a sense of being criticized, unappreciated, dismissed, or devalued by the patient. The special/overinvolved factor (6 items) accounted for 4.93% of variance and included items indicating that the patient is very special, so much so that the clinician may show some difficulties in maintaining the boundaries of the therapeutic setting (, e.g., s/he self-discloses his or her feelings or more about his or her personal life with the patient than with other patients, or ends sessions late). The parental/protective factor (5 items) accounted for 4.22% of the variance and included items describing a wish to protect and nurture the patient in a parental way, above and beyond normal positive feelings toward him/her.

The sexualized factor (4 items) accounted for 3.72% of variance and included items describing the presence of sexual attraction or feelings toward the patient. The disengaged factor (5 items) accounted for 3.91% of variance and included items describing feelings of annoyance, boredom, withdrawal, or distraction in sessions.

It is important to highlight that the relationships between each subscale and its specific items, which met our previously defined criteria, were unique (or uncontaminated by overlap among other factors)

and robust: In other words, the items of a subscale did not load strongly on any other factor, and their factor loadings on a distinct subscale were optimal (.45 .92).

To determine how well the model emerging from the EFA fit the data, we performed a confirmatory factor analysis (CFA) using data from the remaining therapist sample (N 166), and we verified that all fit indices confirmed the good adequacy of this factor model according to the criteria recommended by Hu and Bentler (1999): χ^2(1793) 2576.25, p .001; CFI .92; RMSEA .051, SRMR .081.

To verify the internal consistencies of all the subscales of the TRQ's current version, we calculated Cronbach's alpha and found that all the reliabilities were excellent, with coefficients almost at or above .80: helpless/inadequate (.90), overwhelmed/disorganized (.85), positive/satisfying (.85), hostile/angry (84), criticized/devalued (.83), parental/protective (.80), special/overinvolved (.79), sexualized (.83), and disengaged (.78). Finally, intercorrelations among the nine TRQ factors ranged from –.23 to .48 with a median of .28.

Table 1

Therapist Response, Patient Personality Pathology, and Symptom Severity: Validity

Convergent validity of the TRQ was examined via correlating the nine subscales of the current version with those of the original version. In Table 2, we depict our results showing very high intercorrelations between all the factors (.78 r .98).

To test the criterion validity, we examined whether specific personality disorders evoked distinct therapists' emotional reactions. The results showed several significant relationships between therapists' responses and patients' personality pathology: The SWAP–200 paranoid, antisocial, and narcissistic personality disorder scales were positively associated with hostile/angry and criticized/devaluated therapist responses; in addition, the paranoid disorder scale was also negatively related to positive countertransference, whereas the narcissistic disorder scale was positively related to disengaged therapist response. The schizoid personality disorder scale was positively associated

with helpless/inadequate and disengaged countertransference; disengaged response was also related to the schizotypal and obsessive personality disorder scales. The borderline personality disorder scale was positively associated with helpless/inadequate, overwhelmed/disorganized, and special/ overinvolved countertransference, whereas sexualized therapist response was positively related to the histrionic personality disorder scale. Finally, parental/protective and special/overinvolved countertransference were positively associated with the avoidant and dependent personality disorder scale, which were also positively related to positive and helpless/inadequate therapist response (see Table 3). To verify whether these specific associations with countertransference/personality disorder were dependent on clinicians' approaches, we performed once again the partial correlations with a sample of cognitive therapists (N 163), excluding from the full sample all the psychodynamic clinicians, and there were no significant differences, suggesting that these results were not affected by therapists' theoretical beliefs.

Table 2 Here

Additionally, we examined the relationships between therapists' emotional responses and four SWAP–200 personality disorders (schizoid, antisocial, borderline, and dependent), without removing the overlap of these specific personality pathologies and the nine others. We found statistically significant associations: The schizoid personality disorder scale was positively associated with helpless/inadequate (r .48, p .001) and disengaged countertransference (r .38, p .001) and negatively related to positive (r –.28, p .001) and parental/protective (r –.15, p .01) therapist responses. The antisocial personality disorder was positively related to hostile/angry (r .58, p .001), criticized/ devaluated (r .53, p .001), and overwhelmed/disorganized (r .21, p .001) therapist responses and negatively associated with positive (r –.39, p .001) and parental/protective (r –.25, p .001) countertransference. The borderline personality disorder was positively associated with overwhelmed/disorganized (r .71, p .001), helpless/inadequate (r .61, p .001), special/overinvolved (r .48, p .001), criticized/devaluated (r .32, p .001), and hostile/angry (r .18, p .001) countertransference and negatively related to positive (r –.37, p .001), parental/protective (r –.26, p .001), and disengaged (r –.21, p .001) therapist responses. Finally, the dependent personality disorder was positively related to parental/ protective (r .49, p .001), special/overinvolved (r .40, p .001), helpless/inadequate (r .38, p .001), and positive (r .11, p

.05) therapist responses and negatively associated with criticized/devaluated (r −.15, p .01) countertransference.

Finally, we investigated the relationship between therapists' emotional responses, patients' psychological functioning, and their severity of symptoms. We found that higher levels of psychological functioning were positively related to positive, r .53, p .001, and parental/protective patterns of therapist response, r .19, p .001, and negatively related to helpless/inadequate, r −.38, p .001, overwhelmed/disorganized, r −.41, p .001, hostile/angry, r −.33, p .001, criticized/mistreated, r −.26, p .001, special/overinvolved, r −.14, p .01, sexualized, r −.14, p .01, and disengaged, r − .19, p .001, countertransference. Results showed that higher degrees of patients' symptom severity were positively associated with helpless/inadequate, r .50, p .001, overwhelmed/disorganized, r .56, p .001, hostile/angry, r .19, p .001, criticized/mistreated, r .17, p .01, and special/overinvolved, r .21, p .001, therapist re sponses and negatively related to positive, r −.47, p .001, parental/protective, r −.22, p .001, sexualized, r −.13, p .05, and disengaged, r −.13, p .05, ones.

Table 3

Discussion

The primary goal of this study was to verify the stability of TRQ's factor structure and the reliabilities of its scales. Exploratory and confirmatory factor analyses identified nine distinct countertransference patterns that were conceptually coherent and clinically sensitive: (a) helpless/inadequate, (b) overwhelmed/disorganized, (c) positive/satisfying, (d) hostile/angry, (e) criticized/ devalued, (f) parental/protective, (g) special/overinvolved, (h) sexualized, and (i) disengaged (see Table 1). These dimensions correspond to a broad spectrum of clinicians' emotional and interpersonal experiences with patients and reflect the complex combination of the therapist's own dynamics, responses evoked by the patient, and the interaction of patient and therapist (Betan et al., 2005).

Comparing these patterns of therapist response with those identified by Betan et al. (2005), there were no significant differences with the exception that the original criticized/mistreated pattern was split into two new different factors: The first, hostile/angry, was characterized by feelings of anger, resentment,

and irritation toward the patient; the second, criticized/devalued, was described by feelings of being criticized, dismissed, or devalued (see Table 2). A possible explanation might be that the criticized/ mistreated countertransference of the TRQ's original version was a heterogeneous pattern of therapist reactions, including distinct emotional states that can be evoked by patients with different modes of interpersonal functioning. For example, a therapist could mostly experience hostility and annoyance with patients who tend to express anger explicitly or implicitly as a possible reflection of their frustration and unacceptable pain; conversely, in treating patients who tend to be defensively overcritical or dismissive, a therapist could feel more unappreciated rather than angry, undergoing the patients' devaluations that could harm his or her selfesteem (Clarkin, Yeomans, & Kernberg, 2006; Gabbard, 2014; Kernberg, 1984; McWilliams, 2011). Nevertheless, the structure factor of the TRQ's current version confirmed the picture that originally emerged in Betan et al.'s (2005) investigation, as shown in Table 2. The portrait of the therapist's emotional responses to the patient was more articulate and complex than global and minimally differentiated distinctions between positive and negative countertransference (Kächele et al., 2015). The dimensions captured by this tool (both old and new versions) allow the identification of distinct experiences of negative countertransference—that is, feeling overwhelmed, helpless, disengaged, mistreated, and hostile, as well as the discrimination of a variety of positive feelings toward the patient, such as feeling overinvolved or protective. These positive experiences share the elements of intimate affiliation and emotional closeness but can also represent potential snares for therapeutic treatment to be recognized and managed.

In general, all of the nine factors of the new TRQ version showed psychometrically robust characteristics: They consisted of at least 4 or 5 items and a maximum of 11 items; their items' factor loadings were very optimal (between .45 .92) and also were comparable to those of the TRQ's old version (between .39 .99); their internal consistencies were excellent with Cronbach's alpha coefficients almost at or above .80, comparing favorably with (if not an improvement over) reliabilities of the original factors.

The other aim of this study was to verify the validity of the TRQ investigating the relationships between therapists' emotional responses and patients' personality pathology, their psychological functioning, and symptom severity. Consistent with previous studies (Betan et al., 2005; Colli et al., 2014), we found that countertransference patterns were related to specific personality disorders in a clinically coherent and systematically predictable way (see Table 3). Moreover, these associations were not bound to clinicians' theoretical beliefs, showing that patients' interpersonal patterns are quite robust in evoking emotional

responses from therapists regardless of their preconceptions and technical styles. These findings seem to support the notion that therapists' responses may be used as a clinically useful tool in the diagnostic and therapeutic understanding of patients' core dynamics, especially those involving their repetitive and maladaptive interpersonal patterns (Bateman & Fonagy, 2006; Beck, Davis, & Freeman, 2004; Clarkin, Yeomans, & Kernberg, 2006; Gabbard, 2014; Lingiardi & McWilliams, 2015; McWilliams, 2011; PDM Task Force, 2006).

Regarding the specific relationships between therapist responses and personality pathology, our hypotheses seem to be confirmed. Overall, in line with the empirical literature (Betan et al., 2005; Bourke & Grenyer, 2010; Brody & Farber, 1996; Colli et al., 2014; McIntyre & Schwartz, 1998; Røssberg et al., 2007), we found that patients with cluster B personality disorders tend to evoke more heterogeneous, intense, and difficult-to-manage reactions in their therapists than do patients with cluster A and C disorders (see Table 3). It is important to note that the magnitude of partial correlations was quite weak. It is likely that examining the relationships between countertransference patterns and each personality disorder, removing the overlap between that particular disorder and the nine others, has influenced the effect sizes of these associations. Additionally, using these specific analyses could raise some concerns about the interpretation of results: For example, what is avoidant personality disorder after the introversion of the schizoid is removed? What is antisocial personality disorder after the exploitation and lack of empathy of the narcissistic is removed? What is borderline personality disorder after the anxiety, depression, and affective instability of the dependent, avoidant, and histrionic personality disorders are removed? On the other hand, the specificity of these relationships reported in Table 3 are very clinically coherent, which partially mitigates these concerns. In addition, we provided the findings about the bivariate correlations between all of the patterns of therapist's emotional response and four personality disorders (schizoid, borderline, antisocial, and dependent), and, as expected, they showed a more mixed picture but consistent with those of partial correlations. In particular, borderline patients tend to evoke in clinicians negative countertransference reactions and more intense feelings of being overwhelmed, disorganization, helplessness, and apprehension. This heterogeneous pattern could reflect a response to the instability in the emotional regulation and the representations of self and others (all good or all bad) of these patients, characterized by the massive use of primitive defenses, such as spilling and projective identification (e.g., Clarkin, Yeomans, & Kernberg, 2006; Colli et al., 2014). Antisocial patients seem to arouse predominant feelings of annoyance, resentment, and rage, as well as devaluation and disregard, which could be understood as an "enempathic" clinician's response to their severe interpersonal

difficulties (e.g., McWilliams, 2011). Conversely, schizoid patients tend to evoke disengagement and withdrawal but also a sense of helplessness, which could be read as a reaction to the problems in building an intimate and positive connection with them (e.g., PDM Task Force, 2006). Finally, dependent patients seem to elicit intense feelings of protection in therapists—who wish to repair some deficiencies or failures in the patients' relationships with parents or significant others—but also experiences of inadequacy, which could reflect a reaction to a low sense of effectiveness and agency of these patients (e.g., Bornstein, 2012).

In general, our research confirms that patients with lower personality and psychological functioning, as well as higher symptom severity, tend to arouse in clinicians stronger degrees of negative emotional responses and several problems in therapeutic alliance construction (Bender, 2005; Dahl et al., 2012; Dahl et al., 2014; Lingiardi & McWilliams, 2015; Røssberg, Karterud, Pedersen, & Friis, 2010). These findings seem to support the notion that identifying the specific contents and domains of countertransference may aid therapists in increasing the awareness and management of the complexity of their reactions in therapy (Hayes et al., 2011).

This study has some limitations. First, although the design research implied, as illustrated above, that therapists completed the TRQ and SWAP–200 at different times (first the TRQ and then the SWAP–200 between one and three weeks later), the method of data collection (clinician report) of patient personality pathology and countertransference from a single informant might be vulnerable to some biases. In other words, the perceptions of the personality disorders could be influenced by the perception of countertransference (and vice versa): For example, therapists who perceive their clients in a sexual manner perceive them as being histrionic, and those who perceive their clients in a parental manner perceive them as being dependent. Future investigations should examine patients' psychopathology and therapists' responses in therapy via other methods of measurement and perspective (e.g., via an independent observer or supervisor). However, previous research has suggested that clinicians tend to make highly reliable and valid judgments if their observations and inferences are quantified using psychometrically sophisticated instruments such as those used in our study (e.g., Blagov et al., 2012; Westen & Shedler, 1999a, 1999b; Westen & Weinberger, 2004). With respect to the validity of SWAP–200 diagnoses, some research has documented that even laypersons or clinically inexperienced raters who know a person well enough can provide valid and reliable personality assessments (see Mullins-Sweatt & Widiger, 2007). Regarding the TRQ, although this clinician-report represents an useful face-valid method of assessing the therapist's reactions, it shares the inherent limitations of self-report,

especially those based on the patients' abilities to report on their own feelings (e.g., Westen & Weinberger, 2004). In future studies, it would be useful to evaluate the psychotherapy process using external raters to verify which variables could converge and diverge with the patterns of therapists' responses from the TRQ.

Second, the sample size and characteristics might cause some concerns about the stability of the factor structure of the TRQ and the generalizability of findings. However, for the implementation of exploratory and confirmatory factor analyses, several authors recommend that an adequate sample size is of at least 100 participants as long as the factors are well-marked by a sufficient number of items (4 or 5) with loadings above .45 (as in this study) and conventional case-to-item ratios do not take into consideration a range of variables that qualify them in one direction or the other (e.g., Bühner, 2010; Fabrigar et al., 1999). With respect to the characteristics of the sample, it is important to note that whereas clinicians participating in this research were all Italian and Caucasian, in Betan et al.'s (2005) study, they were from North America and were predominantly Caucasian (92.8%).

Lastly, therapists' response rate to the request for participation in this research was 29%, and the sample is not fully representative of the clinician population. The response rate could reflect the significant time commitment expected of participants for no monetary compensation. In fact, this percentage seems to be in line with those of other empirical investigations, in which therapists were asked to complete a quite similar battery of measures on a voluntary basis (33%–35%; Westen & Shedler, 1999a, 1999b; Westen, Shedler, & Bradley, 2006). Moreover, in Betan et al.'s (2005) study, in which clinicians received a consulting fee, the response rate was lower (approximately 10%). However, it is hardly likely that our results were affected by therapists' response rate. Compared with the nonresponders, participating therapists became available to offer some hours of their time to this study, but they were unaware of the purposes of this investigation and had no particular interest in joining the research project.

Finally, this is the first study that replicated the validation study of the TRQ in an effort to confirm the goodness of psychometric characteristics of this measure in capturing and assessing therapists' emotional reactions to the patient in therapy, as well as to highlight its potential strengths in the clinical context and empirical research.

References

Bandura, A., Lipsher, D. H., & Miller, P. E. (1960). Psychotherapists approach–avoidance reactions to patients' expressions of hostility. *Journal of Consulting Psychology, 24,* 1–8. http://dx.doi.org/10.1037/ h0043403

Bateman, A. W., & Fonagy, P. (2006). *Mentalization based treatment for borderline personality disorder: A practical guide*. Oxford, UK: Oxford University Press. http://dx.doi.org/10.1093/med/9780198570905.001 .0001

Beck, A. T., Davis, D. D., & Freeman, A. (2004). *Cognitive therapy of personality disorders* (2nd ed.). New York, NY: Guilford Press.

Bender, D. S. (2005). The therapeutic alliance in the treatment of personality disorders. *Journal of Psychiatric Practice, 11,* 73–87. http://dx.doi .org/10.1097/00131746-200503000-00002

Bentler, P. M. (2007). On test and indices for evaluating structural models. *Personality and Individual Differences, 42,* 825–829. http://dx.doi.org/ 10.1016/j.paid.2006.09.024

Betan, E., Heim, A. K., Zittel Conklin, C., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *The American Journal of Psychiatry, 162,* 890–898. http://dx.doi.org/10.1176/appi.ajp.162.5.890

Blagov, P. S., Bi, W., Shedler, J., & Westen, D. (2012). The ShedlerWesten assessment procedure (SWAP): Evaluating psychometric questions about its reliability, validity, and impact of its fixed score distribution. *Assessment, 19,* 370 –382. http://dx.doi.org/10.1177/ 1073191112436667

Block, J. (1978). *The Q–Sort method in personality assessment and psychiatric research*. Palo Alto, CA: Consulting Psychologists Press.

Bornstein, R. F. (2012). Dependent personality disorder. In T. A. Widiger (Ed.), *The Oxford handbook of personality disorders* (pp. 505–526). New York, NY: Oxford University Press.

Bourke, M. E., & Grenyer, B. F. S. (2010). Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. *Psychotherapy Research, 20,* 680–691. http://dx.doi.org/10 .1080/10503307.2010.504242

Brody, E., & Farber, B. (1996). The effects of therapist experience and patient diagnosis on countertransference. *Psychotherapy: Theory, Research, Practice, Training, 33,* 372–380. http://dx.doi.org/10.1037/ 0033-3204.33.3.372

Bühner, M. (2010). *Einführung in die Test- und Fragebogenkonstruktion* [Introduction to test and questionnaire-construction] (3rd ed.). München, Germany: Pearson Studium.

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy for borderline personality: Focusing on object relations*. Washington, DC: American Psychiatric Publishing.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Colli, A., & Ferri, M. (2015). Patient personality and therapist countertransference. *Current Opinion in Psychiatry, 28,* 46–56. http://dx.doi .org/10.1097/YCO.0000000000000119

Colli, A., Tanzilli, A., Dimaggio, G., & Lingiardi, V. (2014). Patient personality and therapist response: An empirical investigation. *The American Journal of Psychiatry, 171,* 102–108. http://dx.doi.org/10 .1176/appi.ajp.2013.13020224

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. http://dx.doi.org/10 .1080/10503307.2011.622312

Dahl, H. S. J., Røssberg, J. I., Crits-Christoph, P., Gabbard, G. O., Hersoug, A. G., Perry, J. C., . . . Høglend, P. A. (2014). Long-term effects of analysis of the patient-therapist relationship in the context of patients' personality pathology and therapists' parental feelings. *Journal of Consulting and Clinical Psychology, 82,* 460–471. http://dx.doi.org/10 .1037/a0036410

Derogatis, L. R. (1994). *Symptom checklist-90-R: Administration, scoring, and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.

Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E. J. (1999). Evaluating the use of exploratory factor analysis in psychological research. *Psychological Methods, 4,* 272–299. http://dx.doi.org/10 .1037/1082-989X.4.3.272

Fauth, J. (2006). Toward more (and better) countertransference research. *Psychotherapy: Theory, Research, Practice, Training, 43,* 16–31. http:// dx.doi.org/10.1037/0033-3204.43.1.16

Fauth, J., & Hayes, J. A. (2006). Counselors' stress appraisals as predictors of countertransference behavior with male clients. *Journal of Counseling & Development, 84,* 430–439. http://dx.doi.org/10.1002/j.1556-6678 .2006.tb00427.x

Floyd, F. J., & Widaman, K. F. (1995). Factor analysis in the development and refinement of clinical assessment instruments. *Psychological Assessment, 7,* 286–299. http://dx.doi.org/10.1037/1040-3590.7.3.286

Freud, S. (1910). The future prospects of psychoanalytic therapy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 11, pp. 139–151). London, UK: Hogarth Press.

Freud, S. (1912). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 111–120). London, UK: Hogarth Press.

Friedman, S. M., & Gelso, C. J. (2000). The development of the inventory of countertransference behavior. *Journal of Clinical Psychology, 56,* 1221–1235. http://dx.doi.org/10.1002/1097-4679(200009)56:91221:: AID-JCLP83.0.CO;2-W

Gabbard, G. O. (2014). *Psychodynamic psychiatry in clinical practice* (5th ed.). Washington, DC: American Psychiatric Publishing.

Gazzillo, F., Lingiardi, V., Del Corno, F., Genova, F., Bornstein, R. F., Gordon, R. M., & McWilliams, N. (2015). Clinicians' emotional responses and *Psychodynamic Diagnostic Manual* adult personality disorders: A clinically relevant empirical investigation. *Psychotherapy, 52,* 238–246. http://dx.doi.org/10.1037/a0038799

Gelso, C. (2014). A tripartite model of the therapeutic relationship: Theory, research, and practice. *Psychotherapy Research, 24,* 117–131. http://dx .doi.org/10.1080/10503307.2013.845920

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

Hayes, J. A. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy Research, 14,* 21–36. http://dx.doi.org/10.1093/ptr/kph002

Hayes, J. A., & Gelso, C. J. (1991). Effects of therapist-trainees' anxiety and empathy on countertransference behavior. *Journal of Clinical Psychology, 47,* 284–290. http://dx.doi.org/10.1002/1097-4679(199103)47: 2284::AID-JCLP22704702163.0.CO;2-N

Hayes, J. A., & Gelso, C. J. (1993). Male counselors' discomfort with gay and HIV–infected clients. *Journal of Counseling Psychology, 40,* 86–93. http://dx.doi.org/10.1037/0022-0167.40.1.86

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy, 48,* 88–97. http://dx.doi.org/10.1037/ a0022182

Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. *Journal of Counseling Psychology, 45,* 468–482. http://dx.doi.org/10.1037/0022-0167.45.4.468

Heimann, P. (1950). On counter-transference. *The International Journal of Psychoanalysis, 31,* 81–84.

Hoyle, R. M. (2000). Confirmatory factor analysis. In H. E. A. Tinsley & S. D. Brown (Eds.), *Handbook of applied multivariate statistics and mathematical modeling* (pp. 465–497). San Diego, CA: Academic Press. http://dx.doi.org/10.1016/B978-012691360-6/50017-3

Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling, 6,* 1–55. http://dx.doi.org/10.1080/ 10705519909540118

Jöreskog, K. G., & Sörbom, D. (2006). LISREL for Windows (Version 8.8) [Computer software]. Skokie, IL: Scientific Software International.

Kächele, H., Erhardt, I., Seybert, C., & Buchholz, M. B. (2015). Countertransference as object of empirical research? *International Forum of Psychoanalysis, 24,* 96–108. http://dx.doi.org/10.1080/0803706X.2012 .737933

Kernberg, O. (1965). Notes on countertransference. *Journal of the American Psychoanalytic Association, 13,* 38–56. http://dx.doi.org/10.1177/ 000306516501300102

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press.

Lingiardi, V., & McWilliams, N. (2015). The psychodynamic diagnostic manual–2nd edition (PDM-2). *World Psychiatry, 14,* 237–239. http://dx .doi.org/10.1002/wps.20233

Lingiardi, V., Tanzilli, A., & Colli, A. (2015). Does the severity of psychopathological symptoms mediate the relationship between patient personality and therapist response? *Psychotherapy, 52,* 228–237. http:// dx.doi.org/10.1037/a0037919

McIntyre, S. M., & Schwartz, R. C. (1998). Therapists' differential countertransference reactions toward clients with major depression or borderline personality disorder. *Journal of Clinical Psychology, 54,* 923– 931. http://dx.doi.org/10.1002/(SICI)1097-4679(199811)54:7923:: AID-JCLP63.0.CO;2-F

McWilliams, N. (2011). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process* (2nd ed.). New York, NY: Guilford Press.

Mullins-Sweatt, S., & Widiger, T. A. (2007). The Shedler and Westen Assessment Procedure from the perspective of general personality structure. *Journal of Abnormal Psychology, 116,* 618–623. http://dx.doi.org/ 10.1037/0021-843X.116.3.618

PDM Task Force. (Ed.). (2006). *Psychodynamic diagnostic manual*. Silver Spring, MD: Alliance of Psychoanalytic Organizations.

Prunas, A., Sarno, I., Preti, E., Madeddu, F., & Perugini, M. (2012). Psychometric properties of the Italian version of the SCL-90-R: A study on a large community sample. *European Psychiatry, 27,* 591–597. http://dx.doi.org/10.1016/j.eurpsy.2010.12.006

Rosenberger, E. W., & Hayes, J. A. (2002). Origins, consequences, and management of countertransference: A case study. *Journal of Counseling Psychology, 49,* 221–232. http://dx.doi.org/10.1037/0022-0167.49.2 .221

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, 57,* 45–53. http://dx.doi.org/10.1080/ 08039480310000257

Røssberg, J. I., Karterud, S., Pedersen, G., & Friis, S. (2007). An empirical study of countertransference reactions toward patients with personality disorders. *Comprehensive Psychiatry, 48,* 225–230. http://dx.doi.org/10 .1016/j.comppsych.2007.02.002

Røssberg, J. I., Karterud, S., Pedersen, G., & Friis, S. (2010). Psychiatric symptoms and countertransference feelings: An empirical investigation. *Psychiatry Research, 178,* 191–195. http://dx.doi.org/10.1016/j.psychres .2009.09.019

Satir, D. A., Thompson-Brenner, H., Boisseau, C. L., & Crisafulli, M. A. (2009). Countertransference reactions to adolescents with eating disorders: Relationships to clinician and patient factors. *International Journal of Eating Disorders, 42,* 511–521. http://dx.doi.org/10.1002/eat.20650

Shedler, J., & Westen, D. (2004). Refining personality disorder diagnosis: Integrating science and practice. *The American Journal of Psychiatry, 161,* 1350–1365. http://dx.doi.org/10.1176/appi.ajp.161.8.1350

Shedler, J., & Westen, D. (2007). The Shedler-Westen Assessment Procedure (SWAP): Making personality diagnosis clinically meaningful. *Journal of Personality Assessment, 89,* 41–55. http://dx.doi.org/10.1080/ 00223890701357092

Shedler, J., Westen, D., & Lingiardi, V. (2014). *The evaluation of personality with the SWAP-200.* Milan, Italy: Raffaello Cortina Publisher.

Streiner, D. L. (2003). Being inconsistent about consistency: When coefficient alpha does and doesn't matter. *Journal of Personality Assessment, 80,* 217–222. http://dx.doi.org/10.1207/S15327752JPA8003_01

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

Tishby, O., & Wiseman, H. (2014). Types of countertransference dynamics: An exploration of their impact on the client-therapist relationship. *Psychotherapy Research, 24,* 360 –375. http://dx.doi.org/10.1080/ 10503307.2014.893068

Westen, D., & Muderrisoglu, S. (2006). Clinical assessment of pathological personality traits. *The American Journal of Psychiatry, 163,* 1285– 1287. http://dx.doi.org/10.1176/appi.ajp.163.7.1285

Westen, D., & Shedler, J. (1999a). Revising and assessing axis II, Part I: Developing a clinically and empirically valid assessment method. *The American Journal of Psychiatry, 156,* 258–272.

Westen, D., & Shedler, J. (1999b). Revising and assessing axis II, Part II: Toward an empirically based and clinically useful classification of personality disorders. *The American Journal of Psychiatry, 156,* 273– 285.

Westen, D., & Shedler, J. (2007). Personality diagnosis with the ShedlerWesten Assessment Procedure (SWAP): Integrating clinical and statistical measurement and prediction. *Journal of Abnormal Psychology, 116,* 810–822. http://dx.doi.org/10.1037/0021-843X.116.4.810

Westen, D., Shedler, J., & Bradley, R. (2006). A prototype approach to personality disorder diagnosis. *The American Journal of Psychiatry, 163,* 846–856. http://dx.doi.org/10.1176/ajp.2006.163.5.846

Westen, D., & Weinberger, J. (2004). When clinical description becomes statistical prediction. *American Psychologist, 59,* 595–613. http://dx.doi .org/10.1037/0003-066X.59.7.595

Zittel Conklin, C., & Westen, D. (2003). *The therapist response questionnaire*. Departments of Psychology and Psychiatry and Behavioral Sciences, Emory University, Atlanta, Georgia.

Table 1

Factor Structure of the Therapist Response Questionnaire's Current Version (N 166)[a]

Factors and items[b]	1	2	3	4	5	6	7	8	9
Factor 1. Helpless/Inadequate									
I feel I am failing to help him/her or I worry that I won't be able to help him/her. (31)	**.92**	.02	.02	.06	.03	.06	.02	.08	.08
I feel hopeless working with him/her. (52)	**.82**	.07	.10	.04	.03	.07	.14	.03	.02
I think s/he might do better with another therapist or in a different kind of therapy. (54)	**.81**	.14	.01	.01	.18	.03	.09	.01	.08
I feel incompetent or inadequate working with him/her. (36)	**.80**	.02	.05	.10	.14	.07	.06	.05	.05
I feel less successful helping him/her than other patients. (68)	**.75**	.02	.05	.01	.01	.07	.05	.10	.12
I feel frustrated in sessions with him/her. (22)	**.65**	.09	.09	.14	.03	.11	.06	.12	.04
I feel like my hands have been tied or that I have been put in an impossible bind. (59)	**.61**	.03	.05	.07	.07	.11	.07	.13	.09
I feel depressed in sessions with him/her. (18)	**.58**	.05	.08	.03	.20	.06	.09	.10	.05
I feel interchangeable—that I could be anyone to him/her. (38)	**.57**	.07	.07	.05	.10	.09	.08	.00	.17
Factor 2. Overwhelmed/Disorganized									
When checking my phone messages, I feel anxiety or dread that there will be one from him/her. (60)	.27	**.87**	.09	.02	.05	.05	.06	.03	.28
I talk about him/her with my spouse or significant other more than my other patients. (79)	.21	**.79**	.08	.13	.07	.17	.06	.02	.10
I feel overwhelmed by his/her strong emotions. (26)	.04	**.78**	.19	.09	.10	.09	.08	.05	.09
I find myself discussing him/her more with colleagues or supervisors than my other patients. (73)	.08	**.69**	.08	.06	.03	.17	.01	.21	.02
I worry about him/her after sessions more than other patients. (66)	.14	**.62**	.11	.03	.08	.05	.02	.11	.04
S/he tends to stir up strong feelings in me. (29)	.07	**.58**	.09	.21	.09	.06	.24	.11	.18
I feel confused in sessions with him/her. (10)	.25	**.57**	.09	.04	.02	.06	.06	.16	.12
I feel anxious working with him/her. (30)	.29	**.56**	.07	.04	.07	.10	.10	.20	.16
I feel used or manipulated by him/her. (33)	.01	**.55**	.11	.16	.03	.09	.16	.06	.15
I feel overwhelmed by his/her needs. (51)	.07	**.54**	.23	.11	.02	.14	.13	.09	.05
I feel pushed to set very firm limits with him/her. (55)	.14	**.52**	.15	.14	.05	.01	.04	.01	.03
Factor 3. Positive/Satisfying									
I feel pleased or satisfied after sessions with him/her. (53)	.15	.09	**.84**	.06	.02	.03	.04	.02	.15
S/he is one of my favorite patients. (74)	.14	.15	**.76**	.21	.07	.01	.05	.10	.02
I find it exciting working with him/her. (3)	.05	.09	**.75**	.13	.09	.09	.11	.03	.23
I am very hopeful about the gains s/he is making or will likely make in treatment. (1)	.24	.09	**.71**	.16	.09	.07	.06	.02	.06
I like him/her very much. (65)	.08	.08	**.71**	.06	.08	.03	.10	.00	.05
S/he makes me feel good about myself. (23)	.11	.07	**.71**	.06	.09	.07	.01	.06	.13
If s/he were not my patient, I could imagine being friends with him/her. (7)	.07	.12	**.63**	.17	.10	.08	.06	.18	.03
I feel like I understand him/her. (40)	.14	.09	**.56**	.08	.24	.24	.13	.10	.07
Factor 4. Hostile/Angry									
I feel annoyed in sessions with him/her. (8)	.05	.10	.03	**.82**	.03	.06	.05	.01	.04
I get enraged at him/her. (27)	.05	.07	.06	**.82**	.06	.01	.06	.10	.04
I tell him/her I'm angry at him/her. (41)	.14	.14	.04	**.75**	.06	.16	.09	.04	.02
At times I dislike him/her. (2)	.06	.04	.04	**.72**	.21	.07	.06	.08	.09
I feel angry at him/her. (15)	.09	.16	.04	**.67**	.04	.01	.08	.06	.22
I have to stop myself from saying or doing something aggressive or critical. (39)	.19	.18	.03	**.52**	.11	.07	.02	.18	.12
I lose my temper with him/her. (48)	.12	.08	.05	**.46**	.16	.13	.07	.13	.03
Factor 5. Criticized/Devalued									
I feel dismissed or devalued. (6)	.04	.05	.08	.17	**.81**	.04	.06	.05	.04
I feel criticized by him/her. (12)	.16	.07	.03	.16	**.79**	.05	.03	.02	.03
I feel repulsed by him/her. (62)	.14	.07	.09	.11	**.79**	.03	.04	.05	.19
I dread sessions with him/her. (13)	.04	.17	.18	.01	**.66**	.07	.08	.06	.10
I feel unappreciated by him/her. (63)	.02	.18	.07	.03	**.66**	.03	.01	.11	.02

I feel I am 'walking on eggshells' around him/her, afraid that if I say the wrong thing

Factors and items	1	2	3	4	5	6	7	8	9
s/he will explode, fall apart, or walk out. (34)	.21	.10	.09	.07	**.62**	.03	.11	.09	.05
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. (77) Factor	.14	.24	.08	.05	**.53**	.03	.03	.15	.03
6. Special/Overinvolved									
I disclose my feelings with him/her more than with other patients. (71)	.08	.02	.01	.06	.02	**.83**	.01	.02	.02
I tell him/her I love him/her. (50)	.03	.10	.04	.20	.13	**.80**	.06	.20	.03
I self-disclose more about my personal life with him/her than with my other patients. (76)	.05	.09	.07	.04	.04	**.80**	.04	.09	.06
I call him/her between sessions more than my other patients. (72)	.02	.17	.04	.13	.04	**.72**	.09	.06	.07
I look forward to sessions with him/her. (19)	.09	.11	.25	.06	.05	**.52**	.19	.04	.08
I end sessions overtime with him/her more than with my other patients. (67) Factor	.19	.23	.05	.02	.16	**.45**	.05	.08	.12
7. Parental/Protective									
I feel like I want to protect him/her. (42)	.05	.01	.06	.07	.04	.09	**.85**	.00	.03
I feel nurturant toward him/her. (47)	.03	.02	.12	.06	.04	.09	**.78**	.15	.10

(table continues)

Table 1 (*continued*)

Factors and items[b]	1	2	3	4	5	6	7	8	9
I feel angry at people in his/her life. (14)	.04	.15	.11	.01	.02	.14	**.77**	.06	.05
I wish I could give him/her what others never could. (21)	.05	.05	.19	.10	.10	.04	**.69**	.19	.01
I have warm, almost parental feelings toward him/her. (64)	.07	.19	.21	.02	.15	.18	**.68**	.14	.03
Factor 8. Sexualized									
I feel sexually attracted to him/her. (17)	.07	.10	.07	.06	.10	.11	.14	**.83**	.06
I feel sexual tension in the room. (61)	.04	.00	.07	.05	.08	.01	.11	**.81**	.05
I find myself being flirtatious with him/her. (56)	.04	.09	.19	.03	.05	.10	.08	**.80**	.09
His/her sexual feelings toward me make me anxious or uncomfortable. (32)	.02	.26	.20	.11	.07	.02	.23	**.62**	.05
Factor 9. Disengaged									
I begin sessions late with him/her more than with my other patients. (78)	.06	.17	.14	.07	.06	.09	.01	.09	**.70**
I feel bored in sessions with him/her. (16)	.19	.07	.13	.08	.08	.08	.02	.11	**.69**
My mind often wanders to things other than what s/he is talking about. (25)	.02	.12	.10	.06	.04	.12	.08	.06	**.61**
I don't feel fully engaged in sessions with him/her. (9)	.12	.12	.06	.05	.07	.08	.06	.02	**.61**
I watch the clock with him/her more than with my other patients. (75)	.12	.03	.10	.02	.16	.10	.03	.02	**.55**

Note. Main differences between the Therapist Response Questionnaire's current and original versions in the factor composition of all the scales were as follows: Items of the original Criticized/Mistreated scale were split in the current scales: the Criticized/Mistreated and Hostile/Angry; Items 72, 19, and 50 belonging, respectively, to the original Overwhelmed/Disorganized, Positive/Satisfying, and Sexualized scales were included in the current Special/ Overinvolved scale; Items 30 and 10 belonging to the original Helpless/Inadequate scale were included in the current Overwhelmed/Disorganized scale; Some items that did not load strongly on the factors of the original version were included in the TRQ's current version (for example, item 78 in the Disengaged scale; item 29 in the Overwhelmed/Disorganized scale; item 77 in the Criticized/Mistreated scale; and item 18 in the Helpless/Inadequate scale). [a] Based on data provided by a national sample of psychiatrists and clinical psychologists (N 166) who were asked to describe a selected nonpsychotic therapy patient at least 18 years old whom they had treated for at least eight sessions and a maximum of 6 months (one session per week). [b] Items with high loadings (|.45| on one factor and |.30| on all other factors) or, in other words, with greater factor saturation (see the values in bold) are listed. As is standard in factor-analytic studies, a number of items (N 17) did not load strongly on the factors (according to the strict criteria of this study) and hence are not listed here. These unlisted items were not deleted from the Therapist Response Questionnaire's current version because they could be useful in creating empirically founded patterns of countertransference in specific clinical populations.

Table 2

Bivariate Correlations Between the Factors of the Therapist Response Questionnaire Original Version and Factors of the Current Version (N 332)

Countertransference factors of TRQ Current Version[b]	Countertransference factors of TRQ Original Version[a]							
	Helpless/Inadequate	Overwhelmed/Disorganized	Positive/Satisfying	Criticized/Mistreated	Parental/Protective	Special/Overinvolved	Sexualized	Disengaged
Helpless/Inadequate	.96	.47	.16	.53	.25	.12	.18	.43
Overwhelmed/Disorganized	.54	.91	.17	.48	.22	.16	.06	.23
Positive/Satisfying	.17	.18	.98	.25	.27	.04	.15	.39
Hostile/Angry	.42	.23	.24	.81	.11	.13	.17	.27
Criticized/Devalued	.53	.44	.11	.79	.12	.21	.14	.12
Parental/Protective	.24	.25	.27	.18	.97	.28	.17	.10
Special/Overinvolved	.14	.32	.09	.14	.16	.78	.16	.21
Sexualized	.14	.09	.08	.12	.10	.16	.93	.22
Disengaged	.40	.14	.22	.39	.12	.11	.22	.98

[a] Therapist Response Questionnaire Original Version (Betan et al., 2005). p .05. p .01. p .001.
[b] Therapist Response Questionnaire Current Version.

Table 3

Partial Correlations Between the Factors of the Therapist Response Questionnaire Current Version[a] and SWAP–200 Personality Disorder Scales[b] (N 332)

Personality Disorder	Countertransference factors of TRQ Revised Version[a]								
	Helpless/Inadequate	Overwhelmed/Disorganized	Positive/Satisfying	Hostile/Angry	Criticized/Devalued	Parental/Protective	Special/Overinvolved	Sexualized	Disengaged
Paranoid	.06	.03	.15	.23	.21	.10	.04	.03	.06
Schizoid	.16	.03	.03	.02	.08	.10	.04	.08	.15
Schizotypal	.10	.08	.09	.04	.01	.02	.06	.04	.20
Antisocial	.08	.10	.10	.21	.18	.08	.06	.03	.09
Borderline	.25	.38	.02	.10	.11	.07	.14	.03	.04
Histrionic	.03	.07	.09	.03	.02	.07	.07	.18	.10
Narcissistic	.02	.01	.03	.15	.16	.10	.08	.04	.13
Avoidant	.03	.03	.15	.01	.04	.26	.14	.03	.10
Dependent	.16	.01	.05	.02	.02	.19	.12	.09	.08
Obsessive	.04	.07	.06	.03	.07	.08	.04	.04	.15

[a] Therapist Response Questionnaire Current Version.   [b] SWAP–200 Shedler-Westen Assessment Procedure-200. The table lists partial r, two-tailed.
p .05. p .01. p .001.