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Relationship between countertransference and emotional communication in the counselling process

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Abstract

Background: The negative effects of the unmanaged countertransference on session outcome are well documented, but little is known about the impact of countertransference reactions on the in-session elaboration processes. This study investigated the impact of countertransference reactions on the quality of client and counsellor's in-session work as revealed by their linguistic style, assuming that linguistic style shows the quality of speakers' referential process, i.e., their ability to translate into words and reorganize the client's emotional experiences.

Methods: To test this hypothesis twenty-three in-training psychotherapists were asked to rate their emotional reactions through the Therapist Response Questionnaire at the end of the first three counselling sessions with one of their clients, for a total of 69 sessions. These sessions were recorded, transcribed, and evaluated by three external observers who applied the Countertransference Behavior Measure. Finally, the transcripts were analyzed by applying the computerized linguistic measures of the referential process.

Results: We found that countertransference reactions were associated to clients' specific speech styles characterized by a lower referential process especially in the case of dominant, helpless, overwhelmed, and parental countertransference reactions. For the counsellors, we observed a linguistic style marked by emotional distancing.

Conclusions: This study confirms that linguistic indicators can capture the impact of countertransference reactions, which shows to hinder the emotional elaboration in the counselling sessions.

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1. Introduction

1.1 The role of countertransference

Most clinicians of any psychotherapeutic orientation consider countertransference (CT) as a critical variable that can heavily influence their relationship with patients and the effectiveness of their interventions. In the last few decades this clinical experience has been confirmed by several research findings that highlight the significant role played by CT in clinical process (Fauth, 2006; Kächele et al., 2015; Löffler-Stastka et al., 2019; Norcross & Lambert, 2018; Norcross & Wampold, 2019; Parth et al., 2017; Tishby, 2022). Research on CT has been greatly facilitated by the clearer theoretical and operational definition of the construct offered by Gelso and Hayes (2007), who conceived CT as the whole of the "internal and external reactions in which unresolved conflicts of the therapist, usually but not always unconscious, are implicated" (Hayes et al., 2018, p. 497). In this perspective CT "may—and probably should—be regarded as a pantheoretical construct. No theory 'owns' CT, just as no therapist is immune to it" (Hayes et al. 2018, p. 497). This theoretical redefinition gives CT a central role in every interpersonal psychological treatment implicating a personal significant engagement with a professional (Gabbard, 2004, 2020; Hinshelwood, 2019; Jacobs, 2019). Accordingly, CT can manifest itself from the very first session, even in a consultation intervention (Clarkin et al., 1999; Hayes et al., 1997; Laverdiere et al., 2018; Mohr et al. 2005; Sommatico et. al., 2017).

Nowadays, it is widely recognized that if CT remains outside of awareness, not understood, controlled, or managed by the therapist, it can hinder the psychotherapy process (Cartwright et al., 2021; Gelso & Hayes, 2007; Gelso & Kline, 2022), leading to negative session and treatment outcome (Gelso & Hayes, 2002; Hayes et al., 1997, 2015, 2018; Machado et al., 2014; Markin et al. 2013; Rocco et al., 2021; Singer & Luborsky, 1977). In two meta-analyses, Hayes and colleagues (2011, 2018) found a negative and moderate relationship between CT reactions and psychotherapy outcome, and a quite robust positive association between good psychotherapy outcome and successful CT management. The inability to manage CT is negatively correlated with the patients' perception of session depth (Rosenberger & Hayes, 2002), and with the counselling outcome as perceived by supervisors (Gelso et al., 2002), as well as by therapists and patients (Fuertes et al., 2015; Hayes et al., 2018; Van Wagoner, 1991). Strictly related to managing CT, even if less investigated, is the lack of CT awareness, which seems to have a negative correlation with outcome (Rocco et al., 2021) and, in addition, plays a mediating role regarding other aspects of the counselling and psychotherapy process. For instance, CT awareness was found to be correlated positively with the therapeutic alliance (Barreto et al.,

2020; Ligiéro & Gelso, 2002) and negatively with resistance (Westra et al., 2012). Regardless of whether the evaluations are performed by patients, supervisors, or clinicians themselves, empirical findings are consistent: the presence of CT seems to negatively affect the treatment process as well as the outcome, the latter evaluated mainly through questionnaires (for instance Fuertes et al., 2015; Gelso et al., 2002; Hayes et al., 2018; Rocco et al., 2021; Rosenberger & Hayes, 2002).

Although how the theoretical and clinical literature have highlighted the impact of CT on various aspects of psychotherapy and counselling, it is striking how little empirical research has been conducted to investigate the relationship between CT and the complexity of the elements at play within the treatment, whether it is a psychotherapy or a consultation. The potential impact of CT on the in-session processes can be best considered within a two-person psychology rather than a one-person psychology (Gelso & Hayes, 2007). As stated by Gabbard (2001), regardless of the scholars' specific theoretical orientation and setting, CT is widely seen as a joint creation of therapist and the patient within their interactive field, where the presence of mutual influences conceivable through concepts like projective identification, role responsiveness and CT enactment is emphasized (Gabbard, 2001). These clinical concepts, even if partially overlapping, describe different aspects of this reciprocal influence that occur in the transference/countertransference cycle (Gelso & Hayes, 2007).

A number of authors address the interplay between transference (TR) and CT: for instance, Racker (1968) applies the "law of talion" to describe the inextricable relationship between TR and CT: "every positive transference situation is answered by a positive countertransference; to every negative transference there responds, in one part of the analyst, a negative countertransference" (Racker, 1968, p. 137). Likewise, the positive or negative quality of CT influences the patient's TR reaction. The dynamics of the TR-CT cycle (Gelso & Hayes, 2007), begins with an attempt by the patient to transform the therapist into a TR object. As stated by Gabbard: "When analysts respond in an attenuated way to what they are having evoked in them by the patient, they become consciously aware of the patient's internal world and are able to help the patient understand it through interpretation" (Gabbard, 2001, p. 985). If the therapist's response is not attenuated, i.e., the CT is not made conscious or is not managed adequately, then it impedes a more complete understanding of the patient's internal world by both patient and therapist, and the TR-CT cycle hinders a positive therapeutic or counselling process.

To go deeper into the intersubjective dynamics paving the TR-CT relationship, we draw on a recent theory of emotional communication and therapeutic change developed by Bucci (1997, 2021a).

1.2 The emotional communication as a referential process

Bucci (1997, 2021a) has proposed a general theory of emotional information processing, grounded on some recent advances in psychoanalysis, cognitive psychology, and affective and social neurosciences, with the intent to understand and operationalize some core processes of therapeutic communication and change. This theory assumes that human beings experience the physical and interpersonal world through multiple codes and systems that operate in different ways and only incompletely are connected and integrated with each other. Specifically, the theory foresees three different processing and communication systems: *nonverbal subsymbolic, nonverbal symbolic, and verbal symbolic.*

The *nonverbal subsymbolic* systems operates along multiple parallel sensory channels and performs rapid and intuitive computations of the unceasing flow of sensory and bodily experience. This processing is sensory-specific and takes form in as many codes as the number of modalities for the reception of information (e.g., sensorial, visceral, kinaesthetic). The *nonverbal symbolic system* operates on discrete entities or symbols by conglomerating certain aspects of subsymbolic experience to form prototypes, images, patterns, and memories that can be thought of, and can be distinguished one from another. Finally, through the *verbal symbolic system – i.e. language* – the individual can connect nonverbal images and symbols to the words that represent them. This system, thus, allows to think of, reflect on, mentally manipulate, and communicate some aspects of the individual's sub-symbolic and symbolic experience.

To ensure a functional and unitary sense of self a substantial integration between the individual's processing systems is required. A such integration is therefore necessary when people communicate each other thorough the three systems because the speakers need to connect others' words with their own experiences. This interpersonal connection allows them also to reflect and transform the meanings of their own experiences, as in a counselling and therapeutic setting. This competence of translating nonverbal experience into words (and vice versa) is usually ensured by the Referential Process (RP) i.e., an overarching integrating function that builds and continually rebuilds links between the three formats of processing. However, the elaboration processes of subsymbolic experience and its translation into symbolic levels lead to a progressive abstraction and selection of information. For this reason, the connection between the three systems can only be partially accomplished, even when factors of resistance or defence

do not interfere. Thus, a certain degree of disconnection always remains between what people feel and what they can think and verbally communicate of their experience. If, in addition, the individual's emotional experience includes painful or overwhelming affective states, the ability to connect emotions to words is further compromised. This is the case in which a painful emotion of someone who is talking makes difficult to speech fluently and to put into words what they are experiencing; or it is the case of people suffering from emotional or mental disorders that are rooted in painful emotion schemas that are continuously reactivated in interpersonal relationships.

Bucci (1997) has defined emotion schemas, as "prototypic representations of the self in relation to others, build up through repetitions of episodes with shared affective state" (p. 195). The emotion schemas include components of all three processing systems, but they are strongly dominated by sensory and bodily components of the experience (Bucci, 2021a). Moreover, if the schema incorporates traumatic or painful components, it is likely to remain dissociated from the symbolic systems and experienced only at the subsymbolic level. For this reason, one of the crucial aims of psychological treatments is to relive these dissociated schemas within the therapeutic relationship and reactivate the RP connecting the levels of experience processing. Counselling and psychotherapy interventions became in this way potentially transformative of affective as well as the bodily domain, even if they take form mainly through language (Bucci et al., 2015).

A corollary of Bucci's theory is that language used by people to communicate reveals the quality of their RP. In fact, the ability to vividly convey the emotional experience through words can be measured and it is an indication of the degree of connection between the processing systems of the individual at that moment. Over the last decades several manual, self-report and computerized instruments have been developed and validated to measure the RP (Bucci, 2021b; Maskit, 2021; Maskit & Murphy, 2011; Maskit et al. 2012; Mariani et al. 2013; Negri et al. 2019, 2020; see also the method section); it is possible therefore to measure the emotional communication and elaboration process put in place in the therapeutic conversation. In particular, the more important computerized linguistic measures of the RP are the Referential Activity (RA) and the Reflection and Reorganization Function (RRF). RA can be defined as the degree to which the speaker or writer is able to translate their emotional, visceral, and relational experience into words, so as to evoke corresponding experiences in the listener or reader (Bucci, 1984; Bucci & Freedman, 1978; Bucci et al., 2004). The more concrete, clear, specific, and imaginative a speech is, the more it is able to translate subsymbolic experience in an immediate way for interlocutors. Conversely, the more language remains abstract, vague, and generic the

higher the likelihood that speaker will remain disconnected to their own experience, and the more difficulties in engaging a listener (Bucci, 1997). The Reflection and Reorganization Function is defined as the degree to which the speaker is trying to recognize and understand the emotional significance of an event or set of events in their own or someone else's life, or in a dream or fantasy (Negri et al., 2018; Zhou et al., 2021). It is not an abstract and logical reasoning but an active searching for subjective meanings of a memory in which the speaker is emotionally engaged. In addition to these the measures described above, there are other features and complementary measures – described below in the method section – that have also been developed in order to assess and monitor the referential process. These linguistic measures have been applied in a variety of empirical studies, including studies on storytelling, emotional engagement, differential diagnosis, therapeutic emotional change, and psychotherapy outcome (Christian et al., 2021; Fertuck et al., 2021; Gennaro et al., 2022; Kahn & Hoffman, 2021; Mariani et al., 2020; Maskit et al., 2021; Murphy et al., 2021; Negri & Ongis, 2021; Negri et al., 2019; Nelson et al. 2021; Rocco et al., 2018; Zhang & Bucci, 2021). To the best of our knowledge, no studies have been conducted to investigate the relationship between RP and CT. One study (Dubé & Normandin, 2007) used the referential activity measure for the methodological purpose of validating the Countertransference Rating System. In our study we sought to conduct an in-depth analysis of the emotional communications of the therapeutic dyad in conjunction with the manifestation of CT reactions.

1.3 The relationship between countertransference and referential process

According to Bucci (2021a), Freud's concept of transference may be seen as a precursor of the concept of emotion schema. "The structure of schema provides the conceptual basis for the process of transference (and countertransference). The patient plays out with the analyst the expectations and responses encapsulated in the emotion schema (as the analyst necessarily does-perhaps in different way-with the patient)" (Bucci, 2021a, p. 162). During the therapeutic exchange, communication takes place both at the subsymbolic and symbolic levels. When a disconnected emotion schema of either patient or therapist is activated, they are predominantly communicated and acted out at the level of subsymbolic nonverbal communication, limiting their translation into images and words (Figure 1). "The analyst, like the patient, view all things through the lens of his emotion schema; there is no other way. Countertransference is ubiquitous–as is transference–in this sense. The analyst will bring their own self, with their dissociated as well as integrated schema into the therapeutic encounter" (Bucci, 2021a, p. 188).

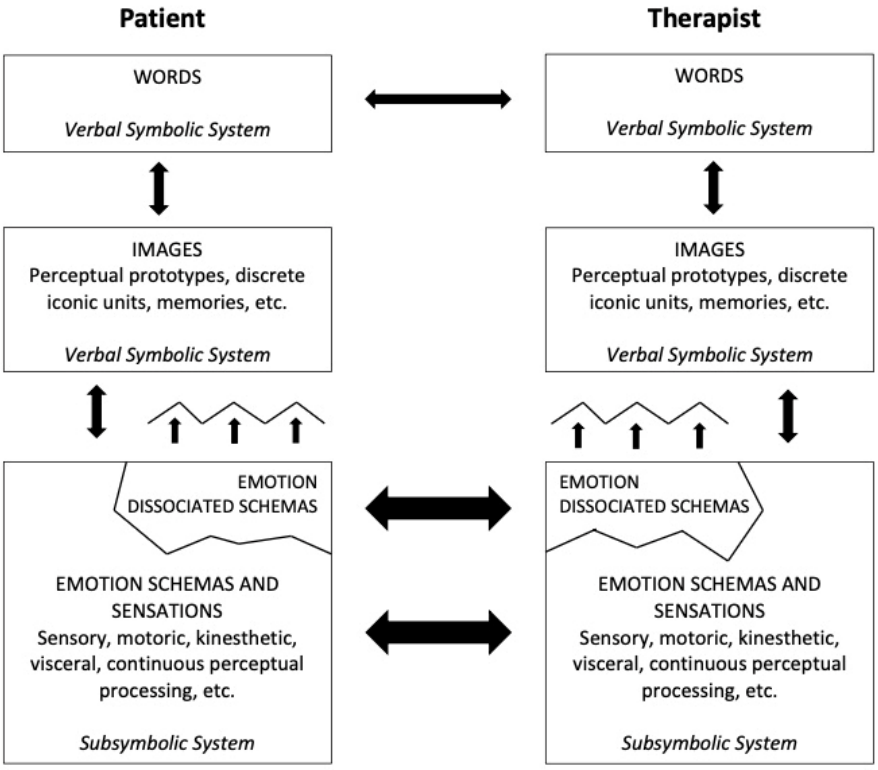

Figure 1. Emotional communication in the therapeutic exchange. From *Emotional communication and therapeutic change* (p. xxxviii), by W. Bucci, 2021, Routledge. Copyright [2021] by Wilma Bucci. Adapted with permission.

In more general terms, "countertransference results from the interaction of particular patient actions or triggers (words, intimations, characteristics, behaviours) with particular therapist conflicts and vulnerabilities" (Gelso & Hayes, 2007, p. 131–132). CT, thus, it is always a co-construction of both patient and therapist where, "although the therapist must have a hook (indicative of unresolved conflict and vulnerability) for countertransference to occur, usually something expressed (verbally or nonverbally) by the patient serves as a precipitant. Such patient triggers touch the therapist in a sore area, and if the therapist is unable to understand or control consciously his or her reactions, countertransference is likely to be acted out" (Gelso & Hayes, 2007, p. 131). In term of Bucci's theory we assumed that CT reactions, especially when the therapist is partially or completely unaware of them, are the result of the interactive arousal of disconnected emotion schemas of patients and therapists. The CT reactions would be triggered within the reciprocal verbal and nonverbal communication by a therapeutic dyad that is not able to clearly translate into words the emotions that they are experiencing. "In such cases, the affective core of sensory and somatic experience is not connected to the source of activation and the connection is avoided; thus, both participants may be aroused in particular ways and may not know why. This interactive arousal, which is largely unsymbolized – feelings of rage or humiliation or despair, whose meaning is not known or is wrongly known – is the potential

source and content of the therapeutic work; it is also the potential threat" (Bucci, 2021a, p. 150). This hypothesis allows also to consider the language used by both patient and therapist during the session as a CT trigger and at the same time as influenced by CT reactions. It is possible to measure the quality of the RP in conjunction with the emergence of certain CT reactions. The computerized linguistic measures developed by Bucci and colleagues allows us in fact to measure the degree to which the language communicates in a vivid and concrete way the emotional experience of the speaker or the degree to which prevails a reflexive and reorganizing style, in the presence of specific CT reactions.

1.4 Purpose of the present study

This study explored the relationship between RP and CT by analysing whether and when CT reactions were associated to counsellor's as well as client's reduced ability to verbalize and reorganize their emotion schemas. We sought to investigate this association through the analysis of the linguistic qualities of their verbal production.

According to Bucci's theory we expected that, in general, when some CT reactions are experienced and enacted the therapeutic dyad would show poorer RP, i.e., the counsellor and patient would be less able to put into words (low RA) and reflect on the emotional experience (low RRF) being activated in the here-and-now of the interpersonal relationship (Bucci, 1984; Bucci, 2021a, 2021c; Bucci & Freedman, 1978; Bucci et al., 2016; Negri et al., 2019, 2020; Zhou et al., 2021). In other words, the more the counsellor experiences CT reactions, the more the therapeutic dyad tends to act out their emotions instead of verbalizing them and comprehending them within the clinical situation. However, since CT reactions vary widely from each other and have a different impact on the interpersonal communication, we expect these configurations to vary according to the specific CT dimensions present in the session. The present study in this sense had this explorative aim: to analyse the complex relationship between the specific CT reactions and the linguistic qualities of RP.

2. Method

2.1 Participants

Twenty-three clients/counsellor dyads were enrolled from a psychological counselling service, whose mission is to help students who experience transitory or persistent psychological distress at a university in northern Italy. Students' psychological problems are most often related to relational issues (e.g., disengagement from family or conflicts with friends or partners), specific symptoms (e.g., addiction, eating disorders, panic attacks, depression, and self-esteem problems) or academic or vocational difficulties (e.g., confusion related to exams or fears about entering

the job market after graduation that are not linked to cognitive issues). The service offers students three free counselling sessions, followed by a feedback session.

Counsellors

The 23 counsellors (20 women and three men) were psychotherapy trainees conducting the counselling sessions as interns of a school of psychotherapy with various clinical orientations (73.9% psychodynamic, 17.5% constructivist, 4.3% cognitive and behavioural and 4.3% psychoanalytic). Their ages ranged from 27 to 65 (M = 31.2, SD = 8.37). They were free to accept or refuse participation in the study without penalization.

Clients

The 23 clients were students (17 women and six men) who received three counselling sessions and consented to participate to the study. Their average age was 22.5 (range = 19–26; SD = 1.93) and were enrolled in various academic majors (21.7% medicine, 17.4% mathematics and physics, 17.4% engineering, 13.0% educational science, and other various majors for the remaining 30.5%). They requested counselling for relational and affective problems (26.1%), mood disorders (26.1%), anxiety disorders (21.7%), self-esteem issues (17.4%), and family problems (8.7%). Out of the 23 counselees, 13 presented personality disorders (Millon et al., 1997; Zennaro et al., 2008): five dependent, four depressive, three avoidant, and one borderline. Concerning clinical syndrome scales, 11 students reported generalized anxiety and five reported persistent depression.

2.2 Instruments

Measures of countertransference

Countertransference Behaviour Measure. The Countertransference Behaviour Measure (CBM; Mohr et al., 2005) is a 10-item questionnaire conceived to measure CT behaviour in supervisees as perceived by their supervisors. Because the items refer to overt manifestations of CT, CBM is an optimal instrument for observer-based detection of CT-related behaviour. All CBM items were rated by experts in psychodynamic psychotherapy as being at least moderately indicative of CT (Friedman & Gelso, 2000). CBM is comprised of three subscales: (a) The *Dominant Countertransference Behaviour* subscale*,* composed of five items referring to therapist's inappropriate controlling, structuring, and dominating behaviour (e.g., "The therapist provided too much structure in the session"); (b) the *Distant Countertransference Behaviour* subscale*,* consisting of two items concerning a therapist's lack of involvement (e.g., "The therapist behaved as if they were 'somewhere else' during the session"); (c) the *Hostile Countertransference Behaviour* subscale*,* containing three items concerning a therapist's hostility toward client or the

therapist's rejection of the client (e.g., "The therapist was critical of the client during the session"). When completing the CBM, raters indicated the extent to which a behaviour has occurred in a given counselling session using a 5-point scale ranging from 1 (*to no extent*) to 3 (*to a moderate extent*) to 5 (*to a great extent*). A validation study (Mohr et al., 2005) reported a high internal consistency (α = .89, .82, .82 respectively for dominant, distant, and hostile countertransference behaviour) and a confirmatory factor analysis supporting the three-factor structure.

Therapist Response Questionnaire. The Therapist Response Questionnaire (TRQ; Betan et al., 2005; Tanzilli et al., 2016) is filled out by clinicians to assess their CT in psychotherapy sessions. It consists of 79 items measuring a wide range of thoughts, feelings, and behaviours expressed by therapists toward their patients. The statements are written in everyday language so that clinicians of any theoretical approach can use the tool without bias. Every item is rated on a 5-point Likert scale, ranging from 1 (*not true*) to 5 (*very true*). The TRQ comprises nine CT dimensions derived by factor analysis: (1) *Overwhelmed/disorganized* indicates a desire to avoid the patient and strong negative feelings, including dread, repulsion, and resentment (e.g., "I feel mistreated or abused by him/her"); (2) *Helpless/inadequate* describes feelings of inadequacy, incompetence, hopelessness, and anxiety (e.g., "I feel incompetent or inadequate working with him/her"); (3) *Positive* indicates the experience of a positive working alliance and close connection with the patient (e.g., "I am very hopeful about the gains she/he is making in treatment"); (4) *Special/overinvolved* describes a sense of the patient as special relative to other patients and includes "soft signs" of problems maintaining boundaries—including self-disclosure, not ending sessions on time, and feeling guilty, responsible, or overly concerned about the patient (e.g., "I do things for him/her, or go the extra mile for him/her, in way that I don't do for other patients"); (5) *Sexualized* describes sexual feelings toward the patient or experiences of sexual tension (e.g., "I find myself being flirtatious with him/her"); (6) *Disengaged* is marked by feeling distracted, withdrawn, annoyed, or bored in sessions (e.g., "I feel bored in sessions with him/her"); (7) *Parental/protective* is marked by a wish to protect and nurture the patient in a parental way, above and beyond normal positive feelings (e.g., "I wish I could give him/her what others never could"); (8) *Criticized/mistreated* describes feelings of being unappreciated, dismissed, or devalued by and hostility with the patient (e.g., "I feel criticized by him/her"); and (9) *Hostile/angry* marked by a feeling of anger, hostility and irritation toward the patient (e.g., "I have to stop myself from saying or doing something aggressive or critical"). TRQ factors had previously registered a good internal consistency (Betan et al., 2005), confirmed in the Italian validation of the instrument (α values ranged from .75 to .90; Tanzilli et al., 2016).

Linguistic measures of referential process

Bucci and colleagues (Bucci, 2021b; Maskit, 2021; Mariani et al. 2013; Negri et al., 2020; Zhou et al., 2021) developed and validated in various languages several computerized linguistic measures of the core characteristics of the RP as it appears in therapeutic conversations. These measures consist of lists of words or dictionaries that are compared to texts. They allow for the assessment of various components of linguistic style of the speakers. The analysis is performed by the Discourse Attribute Analysis Program (DAAP; Maskit, 2021) and the output are counts and average weights indicating the proportion or the degree of presence of the lists of words in the text. For this study we applied the Italian version (Mariani et al., 2013) of the following linguistic measures of the RP:

Weighted Referential Activity Dictionary (WRAD). WRAD is a measure of the RA that can be defined as the degree to which the speaker or writer is able to translate their emotional, visceral, and relational experience into words, so as to evoke corresponding experiences in the listener or reader (Bucci, 1984, 2021b; Bucci & Freedman, 1978; Bucci et al., 2004; Mariani et al., 2013; Maskit, 2021). The higher the concreteness, clarity, specificity, and imagery of a narrative, the more that narrative works to translate emotional experience in an immediate way for the interlocutor. WRAD scores range from 0 (lowest) to 1 (highest RA) with .5 as the neutral value.

Weighted Reflection and Reorganization List (WRRL). The WRRL is a measure of the RRF that can be defined as the degree to which the speaker is trying to recognize and understand the emotional significance of an event or set of events in their own or someone else's life, or in a dream or fantasy; it is not about abstract reflection but rather a person's reasoning related to an event that has been vividly experienced (Bucci, 2021b; Maskit, 2021; Negri et al., 2018; Zhou et al., 2021). WRRL is an index of personal elaboration of emotional experiences and its scores range from 0 (lowest) to 1 (highest RRF) with .5 as the neutral value.

Reflection Dictionary (RefD). The RefD is a measure of the abstract reflection present in speech. It consists of a list of words that refer to cognitive or logical functions, or to communication processes that imply the use of cognitive functions; if it is not associated to narrative with high RA the RefD is often indicative of an intellectualizing and defensive style of the speaker (Bucci, 2021b; Mariani et al., 2013; Maskit, 2021).

WRAD_RefD Covariation (WRAD_RefD). The WRAD_RefD is a measure of the quality of the therapeutic elaboration the speaker is carrying out. It is an index of covariation between WRAD and RefD scores. The more negative values the covariation shows, the better is the elaboration process as the speaker is separating the two functions, telling a story (high WRAD) and

reflecting on it (high REF); the more negative the covariation, the greater the separation (Bucci, 2021b, 2021c; Mariani et al., 2013; Maskit, 2021).

Disfluency Dictionary (DfD). The DfD indicates the proportion of disfluency words present in a speech, namely a small set of words as well as repetitions of words, incomplete words and filled pauses that people tend to use when struggling to communicate; high scores of DfD characterize the initial phase of the activation of an emotion schema or moments of confusion and dissociation (Bucci, 2021b; Mariani et al., 2013; Maskit, 2021).

Affects Dictionary (AffD). The AffD indicates the degree to which the speaker uses words to name and label feelings and emotions; it is a measure of the emotionality present in the discourse but also a defensive and distancing action toward the emotional engagement because the speaker uses abstract words to name affects, rather than describing the emotional experience in a vivid, specific, and concrete way (Bucci, 2021b; Bucci et al. 2016; Mariani et al., 2013, 2020; Maskit, 2021; Negri & Ongis, 2021). AffD are further subclassified as Positive Affect Dictionary (PAffD), Negative Affect Dictionary (NAffD), and Neutral Affect Dictionary (ZAffD).

Sensory Somatic Dictionary (SenSD). The SensSD is a measure of the arousal of bodily subsymbolic aspects of emotion schemas as it is a list of words related to the body and bodily activities, and to sensory processes and/or descriptions of symptoms (Bucci, 2021b; Mariani et al., 2013; Maskit, 2021).

2.3 Procedure

After finishing the third consultation session, the in-training psychotherapists filled out the TRQ considering all three sessions when assigning the values.

Three external raters (average age = 46.7 years), corresponding to three of the authors of this study, verified their reliability in using the CBM on a set of audio-recorded psychotherapy sessions conducted by therapists who were not included in this study. These raters achieved a good interrater reliability (ICC = .751). Subsequently, without having access to any other participant-related data, the three raters separately listened to the 69 counselling sessions (three for each of the 23 consultations) and applied the CBM to each of them. The raters were experienced psychologists and psychotherapists with a psychoanalytical and psychodynamic approach. Moreover, they were supervisors and researchers in psychotherapy (average years of experience as psychotherapists = 18.3; average years of experience as supervisors = 13).

Finally, the 69 counselling sessions were transcribed verbatim to apply the linguistic measures of the RP and to explore the association of CT reactions and the linguistic style adopted by client and counsellor during the session.

3. Results

3.1 Preliminary analyses

Interrater reliability on CBM

To estimate interrater agreement for each CBM dimension, we calculated the interclass correlation coefficient (ICC; Shrout & Fleiss, 1979). The ICC was .79 for the Dominant dimension, .78 for the Distant, and .88 for the Hostile. These values, according to Fleiss and Cohen (1973) and Fleiss (1981), represent excellent interrater reliability levels, while the ICC value of .88 is, according to Cicchetti and Sparrow (1981) and Cicchetti (1994), nearly perfect.

Consistency of CBM Evaluations and Linguistic Measures on the Three Counselling Sessions

To evaluate the consistency of the CBM ratings and the linguistic measures of the three counselling sessions of each of client/counsellor dyad, we ran a non-parametric test (Friedman) with repeated measures. The results were not significant, making it appropriate to run all the statistical analyses on the average values of the three counselling sessions.

3.2 Countertransference reactions

The external judges acknowledged as present some low intensity CT reactions from the counsellors' interventions. On a scale of from 1 to 5 the highest average score on CBM dimensions was for the Distant CT, $M = 1.78$, $SD = 0.89$, the lowest for the Hostile CT, $M = 1.10$, $SD = 0.15$, the intermediate for Dominant CT, $M = 1.50$, $SD = 0.53$.

Also, the counsellors themselves assessed through the TRQ indicated that they had experienced some CT responses, at medium/low level of intensity. From highest to lowest the average scores on a 1-5 Likert scale were: Positive, $M = 2.28$, $SD = 0.67$, Parental, $M = 2.03$, $SD = 0.68$, Helpless, $M = 1.98$, $SD = 0.72$, Disengaged, $M = 1.84$, $SD = 0.56$, Overwhelmed, $M = 1.80$, $SD = 0.60$, Criticized, $M = 1.60$, $SD = 0.57$, Special, $M = 1.20$, $SD = 0.30$, and Sexualized, $M = 1.12$, $SD = 0.32$.

In sum, the CBM and TRQ scores showed that avoidance and withdrawal or overinvolvement and excessive client nurturing were the highest CT dimensions for counsellors.

3.3 Linguistic Markers Associated to Countertransference

To evaluate the association between CT and RP, we conducted a correlation analysis between the RP measures applied to session transcripts and the evaluations of CT reactions as performed by both the external observers and counsellors. Because the scores of some variables were not normally distributed and the number of participants was low, we calculated the Kendall's Tau-B correlation coefficients as the most suitable and reliable association indices. We considered

counsellors and clients' interventions separately to detect the specific influence of CT on the language use by the two sides of the interpersonal exchange.

Associations between countertransference and referential process measures in counsellors' speech

CT average scores as measured through the CBM by external observers on counsellors' speech correlated positively with the use of words related to negative affects (NAffD), $\tau_b = .330$, $p = .030$, and to bodily and sensory processes (SensSD), $\tau_b = .330$, $p = .030$, and negatively with the disfluency dictionary (DfD), $\tau_b = -.298$, $p = .050$. Considering the specific CT dimensions, the higher the Dominant CT scores, the more frequent the use of words referring to negative affects (NAffD), $\tau_b = .456$, $p = .003$, and the higher the Distant CT scores, the lower the disfluency (DfD) of clinicians, $\tau_b = -.315$, $p = .042$ (Figure 2).

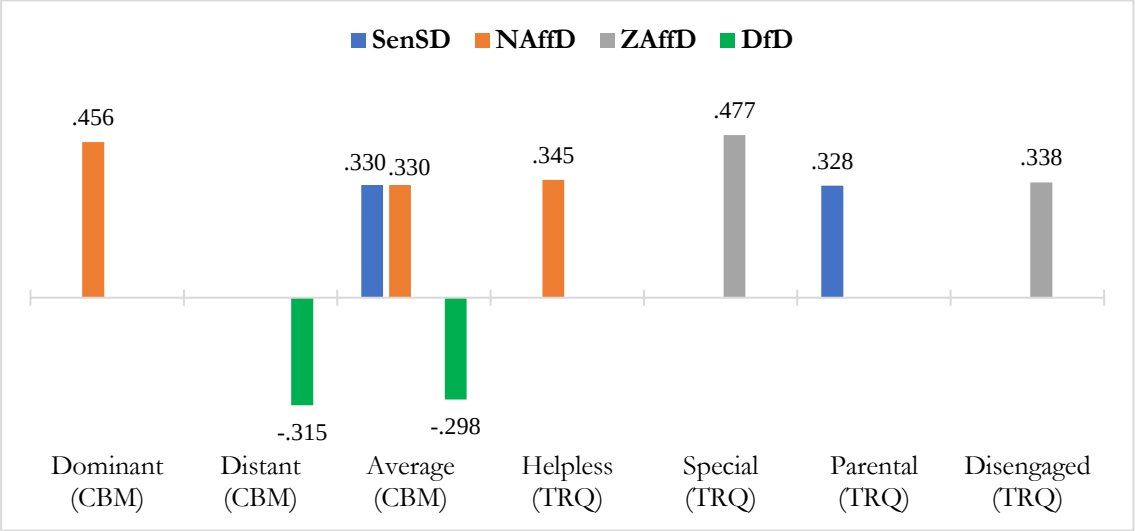

Figure 2. Significant Kendall's Tau-B coefficients between CT dimensions and the linguistic measures of RP of counsellors' speech

Note. CBM = Countertransference Behaviour Measure; TRQ = Therapist Response Questionnaire; SensD = Sensory and Somatic Dictionary; NAffD = Negative Affect Dictionary; ZAffD = Neutral Affect Dictionary; DfD = Disfluency Dictionary.

When we considered counsellors' evaluation of their CT through the TRQ, the proportion of body and sensations-referred words (SenSD) in their speech positively correlated with the Parental/Protective CT, $\tau_b = .328$, $p = .036$; the Helpless CT dimension positively correlated with the negative affect index (NAffD), $\tau_b = .345$, $p = .023$, the Special/Overinvolved and Disengaged CT dimension positively correlated with the neutral affects dictionary (ZAffD), respectively $\tau_b = .477$, $p = .003$ and $\tau_b = .338$, $p = .029$ (Figure 2).

Overall, when we considered the counsellors' speech, the CT reactions were associated with words labelling emotions and affects–especially the negative and neutral ones–and words

referring to sensory and somatic elements, that are, as expected, measures of the arousal of bodily subsymbolic aspects of emotion schemas. In general, moreover, when counsellors show CT reactions their interventions are less disfluent, and particularly when they show a distancing CT reaction. In contrast to our expectations, however, no association was found between CT reactions and RA and RRF measures.

Associations between countertransference and referential process measures in clients' speech

The CT scores expressed by external observers through the CBM correlated with several linguistic measures when applied on clients' speech (Figure 3). The Dominant CT dimension positively correlated with dysfluencies (DfD), τ_b = .302, p = .047, and WRAD_RefD covariation, τ_b = .302, p = .047, and negatively with the RRF measure (WRRL), τ_b = -.351, p = .021, and positive affects dictionary (PAffD), τ_b = -.335, p = .028; the Hostile CT dimension positively correlated with the reflection dictionary (RefD), τ_b = -.356, p = .033; the Distant CT dimension had a negative correlation with the dysfluency dictionary (DfD), τ_b = -.531, p < .001, and a positive correlation with the positive affects index (PAffD), τ_b = .340, p = .028.

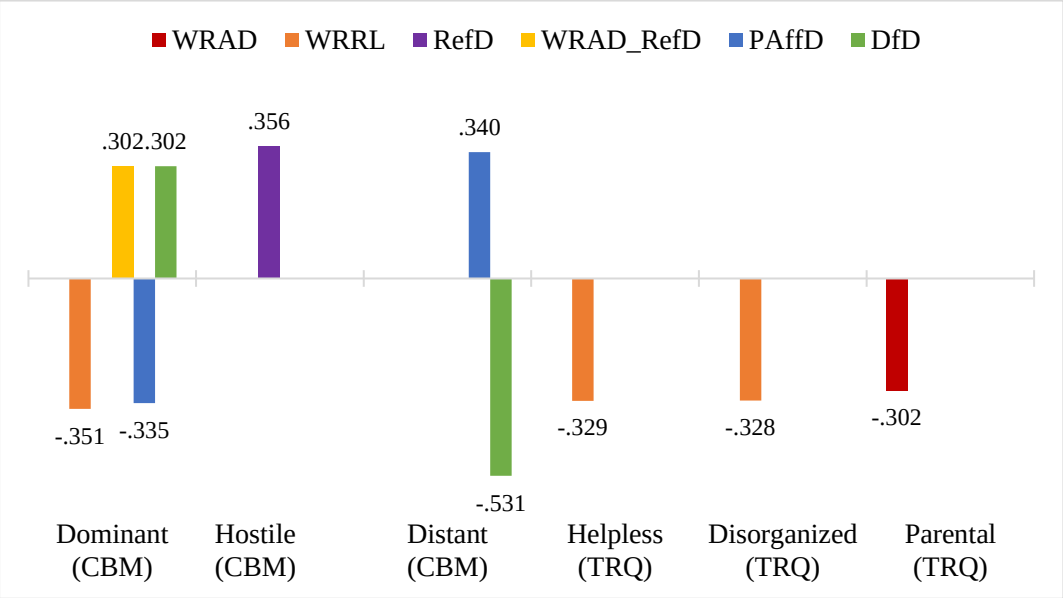

Figure 3. Significant Kendall's Tau-B coefficients between CT dimensions and the linguistic measures of RP of clients' speech

Note. CBM = Countertransference Behaviour Measure; TRQ = Therapist Response Questionnaire; WRAD = Weighted Referential Activity Dictionary; WRRL = Weighted Reflection and Reorganization List; RefD = Reflection Dictionary; WRAD_RefD = covariation between WRAD and RefD; PAffD = Positive Affect Dictionary; DfD = Disfluency Dictionary.

The evaluation of CT performed by counsellors through the TRQ showed four CT dimensions associated to the linguistic measures of clients' speech (Figure 3): the RRF measure (WRRL) negatively correlated with the Helpless and Disorganized CT scores, respectively τ_b = -.329, p = .030, τ_b = -.328, p = .031; the clients' RA (WRAD) showed a negative correlation with the Parental/Protective CT scores , τ_b = -.302, p = .050.

In sum, CT correlated, as expected, to clients' speech with lower RRF, especially when counsellor showed Dominant CT behaviours or experienced Helpless and Disorganized CT reactions; the hypothesized association between CT and clients' RA was significant for only one type of CT reaction: the more Parental/Protective CT was experienced by the counsellors, the lower the degree of RA in the client's speech tended to be; Dominant and Distant CT showed an opposite pattern in terms of disfluency and positive affects: more disfluencies and less positive affects associated with the first type of CT reaction, less disfluencies and more positive affects associated with the second type of CT reaction; finally, the Hostile CT matches with clients' speech showing higher defensive abstract reflection.

4. Discussion

The analysis of the correlations between CT and linguistic measures of the referential process seems to partially support the hypothesis that counsellor's CT reactions are associated with specific linguistic markers indicating a lower capacity for emotion elaboration in the counselling dyad. The long-standing notion shared by many scholars and clinicians that CT reactions introduce hurdles hindering the intervention process (Bucci, 2021a; Gabbard, 2020; Gelso & Hayes, 2007; Tishby & Wiseman, 2020) received partial empirical evidence through this study for some of the many CT reactions that a counsellor may experience. We believe that these findings are novel compared to what has been published in the literature to date as they show that a reduced capacity for translating the emotions into words and reflect on them is associated with some CT reactions. This may better elucidate how and why CT negatively impacts treatment outcome as highlighted in several studies (Hayes et al., 2011, 2018).

The hindering effect of CT manifests itself in different ways in the verbal production of the client and the counsellor. When we considered the linguistic markers of counsellors' interventions we found that CT reactions were not associated with a diminished ability to translate thoughts and emotions into words (RA) and to reflect on and reorganize meanings (RRF), but they were associated with a more frequent use of words referring to negative affects (for CBM Dominant and average score) and to other indexes generally related to it: the proportion of words referred to sensory and somatic aspects (for CBM average score and

Parental/Protective TRQ dimension) and to neutral affects (for TRQ Special and Disengaged dimensions). All these indexes are considered measures of the arousal of the bodily and subsymbolic aspects of speaker's emotion schemas (Bucci, 2021a, 2021c; Mariani et al., 2013, 2020; Maskit, 2021; Negri & Ongis, 2021). High values of these indices, when not accompanied by high values of RA, indicate that speakers are only trying to label the feelings they are experiencing, but are struggling to describe them vividly and concretely. This is a sign of a temporarily more pronounced disconnection between the subsymbolic and symbolic processing systems of emotional experience. In other words, this difficulty in describing emotions in a non-abstract way is a process of distancing from the ongoing emotional experience (Bucci et al. 2016; Izard et al. 2008; Lieberman et al. 2007; Tabibnia et al. 2008). Also, the lower presence of disfluencies in the interventions of counsellors with higher scores in CBM Distant and average scores may indicate less uncertain speech but because they were less manifestly involved in the interpersonal process. In other words, the language of counsellors who experience CT reactions highlights the activation of important emotional components that are only named and labelled, perhaps as a first attempt at their management and distancing. Not having found negative correlations between RA and RRF in association with CT reactions, as hypothesized, is probably due to the counsellor's very brief and often directive interventions during the first three consultation sessions. However, the linguistic markers indicate, even in these early consultation sessions, that the CT reactions activate relevant emotional processes that emerge in the counsellor's discourse associated with attempts to manage them defensively. Despite different results from those expected, we can say that the CT's reactions had an impeding effect on the processes of verbalizing and reflecting emotion of counsellors.

The hypotheses regarding the association of RA and RRF with CT reactions found more robust support in the analysis of the clients' language. The ability of clients to reflect on the meanings that emerged from their narrative and to reorganize the emotional meanings attributed to their experience (RRF) negatively correlated with Dominant, Helpless, Disorganized CT reactions in the counsellors; clients' ability to vividly, concretely, and specifically narrate their emotional experience (RA) showed negative correlation with counsellors' Parental/Protective CT reactions. These results highlight how counsellors' specific CT reactions were associated with poorer emotion elaboration of the dyad – mainly, a diminished ability in their clients to translate thoughts and emotions into words and to reflect on them. Interestingly, these associations between the counsellors' CT reactions and the quality of the clients' elaboration processes confirm the clinical evidence that CT cannot be isolated and is to be understood as a part of complex intersubjective processes involving both partners of the relationship. The activation of

the client's emotion schemas activated corresponding schemas in the counsellor and vice versa, giving rise to what many authors highlight as an indivisible dynamic of TR-CT (Bucci, 2021a; Gelso & Hayes, 2007; Mitchell, 1997; Racker, 1968; Settineri et al. 2019; Situmorang, 2020).

Other linguistic markers were found to be associated with CT reactions and clients' speech, although not predicted by the hypotheses, and were consistent with the previous results. Clients mentioned more positive affects as their counsellors experienced Distant CT reactions and less when their counsellors showed Dominant CT reactions; clients were less disfluent in response to their counsellors' Distant CT; Hostile CT was associated with clients' speech showing higher abstract reflection (RefD) that is considered a defensive distancing process (Bucci, 2021b, 2021c; Maskit, 2021); and lastly, Dominant CT reactions were accompanied by a positive covariance between WRAD and RefD, which indicates a lack emotion elaboration as the client defensively produces a very emotionally charged speech surrounded by abstract and non-personalized reflections (Bucci, 2021b, 2021c; Maskit, 2021). All these results make sense from the clinical point of view, and all further indicate how much the presence of the various therapist's CT reactions is associated with a poorer quality of clients' RP.

This preliminary study opens a new research perspective on the role played by CT in the session processes, but the results need to receive further and more robust confirmation in order to be generalized. For example, it would be necessary to verify whether the findings in the first three consultation sessions are confirmed and reinforced as we study the more advanced segments of therapy and the impact on treatment outcome. It would also be useful to apply the analysis to more patient-therapist dyads, having a more homogeneous sample concerning the therapists' clinical orientation in order to verify the relationship between CT and the clinical approaches. On the other hand, we consider a strength of the study to have used multiple CT detection tools and computerized measures of language. In particular, the CT evaluation by external observers and the automated linguistic analysis of texts avoids the peril of subjective biases in the evaluation of very complex clinical processes. Moreover, the CT evaluation by external observers compared with the counsellors' self-observation, probably highlights the role played by the unacknowledged part of CT (Rocco et al., 2021) on counselling process and outcome. In this study we have considered only the counsellors' verbal behavior as expression of their CT, not considering their nonverbal and paraverbal behavior (Gabbard, 2001; Kiesler, 2001). Future research should also investigate these aspects, using a methodology that has already shown the strict relationship between paraverbal behavior and change process (Griffero, 2017; Rocco et al., 2013, 2018).

The results described above put the role of the counsellor back at the center of counselling intervention as well as that of the client (Esposito et al., 2020; Sommatico et al., 2017). From a methodological point of view, but above all from a theoretical point of view, it is not possible to affirm that CT reactions have a negative causal effect on the quality of the in-session elaboration processes. Instead, we are more inclined to believe that there is a reciprocal influence between the client' and counsellor's emotional experience. This inextricable interconnection makes it even more necessary for the therapists and counsellors to become aware of and manage their own CT reactions in order to use them to improve the elaborative process in their interventions. For this reason, fostering the practitioners' ability to became aware of their CT reaction should assume a central role in supervision, counselling, and psychotherapy training (Cartwright et al., 2014, 2018, 2021; Clarke et al., 2022).

Conclusion

The picture that emerges from these findings highlights the crucial and complex role played by the CT in the counselling sessions: if the counsellor is able to become aware of CT, handle it and use it to understand what is happening in the interpersonal relationship, then the CT becomes a valuable tool that promotes change in the client; if, on the other hand, the counsellor acts out the CT that is activated in turn by the client's dissociated transferential experiences, then the CT is associated with a poorer emotion elaboration process. Linguistic analysis makes it possible to monitor when the TR-CT dynamics are activated without the counselling dyad being able to translate these experiences into words, reflect on them, and reorganize the client's experiential meanings. This study thus suggests the mediation role that in-session elaboration processes have on the good or bad outcome of treatment and highlights the crucial responsibility that the practitioner has in promoting or hindering in-session elaborative processes.

Ethical approval: All aspects of the research design were approved by the Institutional Review Board and the study complied with relevant ethical standards for human subjects' protections.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data supporting the results showed in the paper will be available from the corresponding author on request.

Conflict of interest statement: No potential conflict of interest was reported by the authors.

Author Contributions:

Conceptualization, A.N., F.D.B, and D.R.; Data curation, A.N., F.D.B. and D.R.; Methodology: A.N., F.D.B, D.R and C.C.; Formal Analysis, A.N.; Writing – original draft: A.N.; Writing – final draft: A.N., F.D.B, D.R., and C.C.; Supervision, A.N., D.R., and C.C.

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