Is it possible to measure countertransference?

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Abstracts
Empirical research on treatment process has long time - for good reasons - avoided to even try to measure countertransference although this dimension of psychoanalytic work has gained in momentum over the last decades.
Our paper reports on various efforts of how to approach such a methodology for measuring such an elusive concept. The distinction of habitual patterns of countertransference from situational affective reactions seem most likely a helpful way to approach the topic. Recent empirical research and measures on countertransference will be presented and discussed.

Citation from Thomä & Kächele vol. 1 chapter three:

„Freud viewed countertransference, even when he first discovered it (1910d), as connected with the patient's transference in a dynamic way. It "arises in him [the physician] as a result of the patient's influence on his unconscious feelings" (Freud 1910d, p. 144). Freud emphasizes that "no psychoanalyst goes further than his own complexes and internal resistances permit" (1910d, p. 145). Thus it is necessary for the analyst to undergo a training analysis in order to be freed of his "blind spots."

..... The fact that the analyst's "personal equation" (Freud 1926e, p.220) would still remain even after the influence of countertransference had been mastered (i.e., ideally, eliminated) was regretfully accepted as inevitable. Freud ..... hoped that training analysis would lead to such a far-reaching balancing of the personal equation that satisfactory agreement would one day be achieved among analysts (Freud 1926e, p.220).“

In this lecture we reappraise how this elusive technical concept became a topic in systematic treatment research – an scientific activity that started around the fifties in the centers of psychoanalytic empirical research.
The first attempts to catch the phenomenon of countertransference made use of clinicians´ capacity to identify countertransference issues in clinical materials. The simple strategy consisted of using rating scales that would list a number of technical concepts like transference, resistance, and countertransference to be

qualified on a non-parametric dimension ranging from zero to four. These rating could be provided by external observers like in the experimental study by Bellak & Smith (1956) or even by the treating therapists themselves like in the study of Luborsky´s research group in Philadelphia. In this study four therapist conducting psychoanalytic treatments over a long period of time had to assess weekly the degree of expression of such concepts on the Therapy Session Sheet (Graff & Luborsky 1977). Besides qualifying the patient´s capacities as reflective, receptive, anxious, depressive, hostile the degree of transference in terms of being either manifest or latent, and positive and negative, a score had to be given for the degree of resistance, the number of dreams, the kind of interpretations offered to the analysand, last not least the analysts had to qualify their own emotional reaction to the material of the past week.

One may wonder how easy or difficult it was for the participating analysts to simply summarize in one score per week an ongoing self-reflective activity which would entail the careful differentiation of their own emotinal state of mind from the assumed induced countertransference reaction. No wonder that in the same year this study was published Singer & Luborsky (1977) summarized the unsatisfying state of the art of catching the butterfly of countertransference by formal research methods.

The Ulm group on process research started with a similar kind of task. In the early seventies when Dr. Thomä provided his first tape recorded case, Christian Y, a second analyst, Dr. Rosenkötter, was listening to the tape recordings and made an analogous judgment of the materials as the analyst did. Analyzing the data set led to a rather disappointing finding. A factor analysis of the data sets showed clearly that both, treating analyst and observing analyst produced a single factor solution: sessions were either good or bad in terms of transference and countertransference. The interdepence of both clinical concepts was quite substantial. To take this findings as a corroboration of the clinical nexus between both concepts was too easy an escape. One of our early findings consisted in the observation that the treating analyst sometimes tended to produce rather lengthy interventions that the observing analyst did qualify as sign of a counter-transference due to the patient´s robust resistance to move on. At a later state of our research, when we had developed formal measures of verbal activity using computer technology we could show that indeed the tendency of being too

verbose marked sessions that were judged as difficult periods in the analysis (Kächele 1983).
In an another study we where investigated the initial interviews of five therapists we identified one therapist who initiated every second intervention by saying „ but“. Most likely this junior therapist should have talked to his supervisor!

Maybe these explorations were too simple-minded to get the field closer to the phenomenon. Luckily Prof. Beckmann from the Department of Psychosomatics in Giessen presented in 1974 a true experimental study on the issue of countertransference propensities.
Applying a psychoanalytically informed, but psychometrically sound questionaire, the Giessen-Test – which had been developed by Prof. Richter and himself – he studied a group of psychoanalytic candidates who observed many patients in a psychoanalytic initial interview through a one-way-window. The patients and the candidates had to fill out the same questionaire about themselves and the candidates had to describe all patients with the instrument. Applying a lot of complicated statistics he could finally present quite strong findings. Candidates who displayed higher levels of depressive features overrated the degree of hysterical features in the patients; vice versa candidates who qualified with higher levels of hysterical features overrated the degree of depressive features in the patients; and candidates with higher levels of obsessiveness overrated the degree of obsessiveness in the patients (Beckmann 1974).
Repeating the experiments at a later stage of the candidates training the degree of overrating was conserably reduced, but the impact of personal dispositions had not disappeared (Beckmann 1988). A nice proof of Freud idea of ‚personal equation' was thus demonstrated by good experimental work.
Furthermore by this study it became clear that it would be sensible to conceive of countertransference in terms of a state-trait model. As individuals with a fairly stable personality make-up each of us shares a certain propensity to bring to the clinical encounter certain personality features that most likely tinge our way of look at clinical issues: this would be the trait aspect of every´s countertransference. In addition to it concrete clinical instances might lead to more or less actualizations of this propensity.

Now what do we know so far by formal empirical research. It will not come as a surprise to you that most of the research has not studied psychoanalytic treatments per se but as in all subject mainly psychodynamic psychotherapies. Luckily a recent review on the state of the art was provided by Hayes et al. (2011). They review three metaanalyses; the first focuses on the impact of countertransference on the outcome of treatment, the second focuses on the issue whether the capacity to manage countertransference reduces the manifestations of countertrensference feelings and the third asks whether managing the countertransference improves the outcome.

1. Metaanalysis: 10 Studies with N = 769 Patients
2. Metaanalysis: 11 Studies with N = 1065 Patients
3. Metaanalysis: 7 Studies with N = 478 Patients

The Instrument used by all included studies was the *Countertransference Factors Inventory* CFI[1] or respectively with one of the two abbreviated versions:the CFI-R[2] or the CFI-D[3]. The CFI consists of 50 items and captures features of therapists that describe the handling of countertransference respectively the functioning of a therapist in the therapeutic situation in relation to countertransference management. The CFI-R contains 27 items from the CFI and the CFI-D consists of 21 item which are specific to the therapists functioning during psychotherapy. All three versions of this measure contain five sub-scales: *self-insight* (refers to the therapist capacity to reflect their own state of mind etc.), *self-integration* (focuses on therapists healthy charactere structure), *anxiety management* (captures therapists management and coping with anxiety), *empathy* (refers to the ability to partially identify with the patient), and *conceptuality ability* (which reflects therapists ability to integrate theory and to understand the actual therapeutic situation). The CFI may be used as self rating instrument or can be applied by a rater f.e. the supervisor. What follows is a simplified presentation of the findings of the meta-analyses:

1. CT-responses show a significant negative yet numerically small correlation with treatment outcome (r = -.16, p = .002, 95% CI [-.26, -.06]) *(Tab.1)*

[1] Van Wagoner , Gelso, Hayes, & Diemer, et al. 1991 [2] Hayes et al. 1997
[3] Gelso, Latts, Gomez, & Fassinger, 2002

Tab. 1 Studies on the relationship between countertransference and outcome

Authors	Sample	Design	Setting	r
Mohr, Gelso & Hill (2005)	N = 88 P, 27 T[a]	orrelational	Lab	-0.04
Myers & Hayes (2006)	N = 224	xperimental	Lab	-0.04
Cutler (1958)	N = 5, 2 T[a]	Correlational	Field	-0.24
Rosenberger & Hayes (2002b)	N = 1 P, 1 T	correlational	Field	-0.06
Ligiero & Gelso (2002)	N = 50[a]	correlational	Field	-0.32**
Hayes, Riker & Ingram (1997)	N = 20 P, 20 T[a]	correlational	Field	-0.33*
Hayes, Yeh, & Eisenberg (2007)	N = 69 P, 69 T	correlational	Field	-0.03
Nutt, Williams & Fauth (2005)	N = 18 P, 18 T	correlational	Lab	-0.37
Yeh & Hayes (2010)	N = 116	experimental	Lab	-0.38***
Bandura, Lipsher & Miller (1960)	N = 12 P, 17 T	correlational	Field	-0.53*

[a] Therapists were trainees [or students] in psychotherapy training]; P = Patient, T = Therapist, S = Supervisor; p ≤ .05*; p ≤ .01**; p ≤ .001*** (1-tailed)

2. Factors of countertransference managment play a little or no role in the mitigation of countertransference reactions (r = - .14, p = .10, 95% CI [-.30, 0.3]) *(Tab.2)*

Tab.2 Studies on the relationship between countertransference management and countertransference

Autoren	Stichprobe	Design	Setting	r
Gelso, Fassinger, Gomez & Latts (1995)	N = 68 [a]	experimental	Lab	-0.04
Robbins & Jolkovski (1987)	N = 58 [a]	correlational	Lab	-0.04
Forester (2001)	N = 96	correlational	Field	-0.10
Kholocci (2007)	N = 203	correlational	Field	-0.15
Hayes, Riker & Ingram (1997)	N = 20, 20 T[a]	correlational	Field	-0.18
Peabody & Gelso (1982)	N = 20 P, 20 T[a]	correlational	Field	-0.24
Nutt Willians, Hurley, & O'Brian, Degregorio (2003)	N = 301	correlational	Field	0.29*
Nutt Willians & Fauth (2005)	N = 18 P, 18 T	correlational	Lab	-0.43***
Latt & Gelso (1995)	N = 47[a]	correlational	Lab	-0.45***
Hofsess & Tracey (2010)	N = 35 T[a], 12 S	correlational	Field	-0.57***
Friedmann & Gelso (2000)	N = 149	correlational	Field	-0.59***

p ≤ .05*; p ≤ .01**; p ≤ .001*** (1-tailed)

3. Successful managment of countertransference correlates significantly with better treatment outcome (r = .56, p = .000, 95% CI [.40, .73]) *(tab)*

Tab.3 Studies on the relationship between zwischen CT-Management and Outcome

Authors	Sample	Design	Setting	r
Rosenberger & Hayes (2002b)	N = 1 P, 1 T	corr.	Field	0.38***
Fauth & Williams (2005)	N = 17 P, 17 T [a]	corr.	Lab	0.17***
Nutt Williams & Fauth (2005)	N = 18 P, 18 T	corr.	Lab	0.18
Gelso, LAtts, Gomes & Fassinger (2002)	N = 63 P, 32 T[a]	corr.	Field	0.39**
Peabody & Gelso (1982)	N = 20 P, 20 T[a]	corr.	Lab	0.42*
Van Wagoner, Gelso, Hayes & Diemer (1991)	N = 122	experim.	Lab	0.55***
Latts (1996)	N = 77 P, 77 T[a]	corr.	Field	0.89***

p ≤ .05*; p ≤ .01**; p ≤ .001*** (1-tailed)

The handling respective the managment of CT depends mainly on personal qualities of therapists. If they show certain features (f.e. self-awareness) or are able to implement certain exercises (f.e. meditation) they are more likely to handle their countertransference. However certain characteristica of patients play also a role. Some patients (f.e. borderline patients) generate countertransference reactions that are more likely to be difficult to handle. Therefore the demonstrated negative correlation between CT and outcome could be mediated by patients features.

It is quite clear – even in the realm of formal treatment research – that acting out countertransference feelings is not fertile for the treatment outcome. The capacity to manage ones countertransference responses in a reflective way supports a positive results of therapeutic efforts. The empirical confirmation of the countertransference-interaction hypothesis as stated by Gelso & Hayes (2007), which states that patient and therapist variable contribute to countertransference, shows that specific patient variables interact with certain conflicts of therapist. Thus the key for therapeutic usefulness of countertransference resides in the connection of theory and personal knowledge (Polany 1958).

This idea of a form of habitual countertransferences was recently taken up by Drew Westen´s research group in Atlanta. The paper by Betan and Westen (2009) starts with a quite typical clinical illustration where any experienced clinician will recognize the countertransference issues involved:

„*From the start, patient criticized his therapist's therapeutic style, choice of words, and efforts to explore his reactions. Most times the therapist ventured to speak, her words triggered the patient's angry outbursts. He demanded the therapist repeat verbatim the words he wanted to hear, and it seemed he could not tolerate anything but perfect and absolute mirroring. Paraphrasing, using synonyms, pointing out the controlling quality of his demands brought an onslaught of criticism of the therapist's personhood with accusations that the therapist was inhumane, disingenuous, and even nonhuman. The patient's efforts to dehumanize and annihilate the therapist intensified during periods of consistent attendance. Normally, however, the patient arrived 30 min late if he arrived at all. Interpretations of Mario's need to control the interaction and fears of difference, along with attempts to articulate the therapist's understanding of the links between Mario's early experiences and presentation in the treatment, sometimes seemed to quiet his anger and promote collaboration. However, at other times, he experienced these interventions as the therapist's withdrawal and abandonment, intensifying his anxiety and rage.*
In the face of ongoing interpersonal assaults, it became increasingly difficult for

the therapist to think her own thoughts. She felt stilted and stifled, as well as angry in response to what she experienced as Mario's effort to control her. At each appointment, waiting to see if Mario would arrive, the therapist hoped he would miss, dreaded that he would attend, and worried about his well-being" (Betan & Westen, 2009, p. 179).

In this paper Betan and Westen point out that in research specific to counter-transference, a series of analogue studies have defined countertransference as the therapist's reactions to a patient that are based solely on the therapist's unresolved conflict and as a result, have operationalized countertransference in terms of a therapist's avoidant behaviors (i.e., disapproval, silence, ignoring, mislabeling, and changing the topic). These studies focus on negative countertransference and are limited to what countertransference tells us about the therapists. Furthermore, the studies do not investigate the specific internal emotional responses or thoughts associated with countertransference reactions. In order to catch the specifics of therapists´ involvement they have designed the *Countertransference Questionnaire* (Betan et al. 2005) in order to assess the range of cognitive, affective, and behavioral responses therapists have to their patients. They claim that this is the only broad measure of countertransference with ecological validity in its application to directly studying clinicians' counter-transference reactions in treating patients.

The *Countertransference Questionnaire* is an empirically valid and reliable measure of countertransference responses that can be applied to a range of diagnostic and clinical populations. The developers of this instrument were especially interested in studying the relationship between patients' personality pathology and countertransference reactions in order to test clinically derived hypotheses that have never been put to empirical investigation.
To render some concrete feelings how an instrument works, we report some details on the most salient factors that Betan and Westen have identified:

> **Factor 1, Overwhelmed/Disorganized** (coefficient alpha = .90), involves a desire to avoid or flee the patient and strong negative feelings including dread, repulsion, fand resentment.

I feel resentful working with him/her .72
I wish I had never taken him/her on as a patient .71
When checking phone messages, I feel anxiety or dread that there will be one from him/her .69
S/he frightens me .67
I feel used or manipulated by him/her .62

I return his/her phone calls less promptly than I do with my other patients .61
I call him/her between sessions more than my other patients .60
I think or fantasize about ending the treatment .59
I feel mistreated or abused by him/her .55
I feel pushed to set very firm limits with him/her .54
I feel angry at him/her .52
I feel repulsed by him/her .50

Factor 2, Helpless/Inadequate (coefficient alpha=.88), was marked by items capturing feelings of inadequacy, incompetence, hopelessness, and anxiety.

I feel I am failing to help him/her or I worry that I won't be able
to help him/her .84
I feel incompetent or inadequate working with him/her .80
I feel hopeless working with him/her .78
I think s/he might do better with another therapist or in a different kind of therapy .67
I feel overwhelmed by his/her needs .62
I feel less successful helping him/her than other patients .62
I feel anxious working with him/her .61
I feel confused in sessions with him/her .52

Factor 3, Positive (coefficient alpha = .86), characterizes the experience of a positive working alliance and close connection with the patient.

I look forward to sessions with him/her .69
S/he is one of my favorite patients .67
I like him/her very much .67
I find it exciting working with him/her .58
I am very hopeful about the gains s/he is making or will likely make in treatment .52
I have trouble relating to the feelings s/he expresses _.48
If s/he were not my patient, I could imagine being friends with him/her .44
I feel like I understand him/her .43
I feel pleased or satisfied after sessions with him/her .43

Factor 4, Special/Overinvolved (coefficient alpha=.75), indicates a sense of the patient as special relative to other patients, and ''soft signs'' of problems maintaining boundaries, including self-disclosure, ending sessions on time, and feeling guilty, responsible, or overly concerned about the patient.

I disclose my feelings with him/her more than with other patients .64
I self-disclose more about my personal life with him/her than with
my other patients .64
I do things, or go the extra mile, for him/her in way that I don't do
for other patients .52
I feel guilty when s/he is distress or deteriorates, as if I must be
somehow responsible .39
I end sessions overtime with him/her more than with my other patients .39

The factor structure offers a complex portrait of countertransference processes that highlight the nuances of therapists' reactions toward their patients. The dimensions are distinct and go beyond the cursory divisions between ''positive'' and ''negative'' countertransference. For example, they identified distinct experiences of negative countertransference – i.e., feeling overwhelmed and disorganized,

helpless and inadequate, disengaged, or mistreated with a patient.
Similarly, the sexualized, special/overinvolved, and parental/protective factors all suggest affiliation or closeness, but with distinct clinical roots and implications for treatment.

In addition, to illustrate the potential clinical and empirical uses of the instrument, they report on prototypes of the ‘‘average expectable’’ countertransference responses to patients with a personality disorder. Delineating the specific content and domains of countertransference may help therapists understand and anticipate their reactions toward patients, as well as further clarify how countertransference influences clinical work and can have diagnostic value.

Although the clinical literature is rich in cogent descriptions of therapist reactions, empirical investigation of countertransference as it occurs in clinical practice avoids the subjectivity of clinical observation that is generally based on a single author’s clinical experience with a limited number of cases. The *Countertransference Questionnaire*, used with a practice network approach, allowed them to pool the experience of dozens of clinicians and thereby identify common patterns of countertransference reactions that are not readily apparent to an individual observer or from even an in-depth review of the clinical literature. Delineating the specific domains of countertransference may aid therapists in increasing awareness of and management of the myriad reactions we have toward patients.

What kinds of use will such research instrumentation have for training of younger less experienced therapists? Most likely it may help the unexperienced, the novice, to identify his or her emotional responses to difficult-to-treat patients. It could be used in supervision directing the attention to the plethora of potential responses.
Returning to their clinical example, they state:

„Mario’s therapist is beset by feelings similar to those captured in our prototype of countertransference responses to narcissistic patients. Frustrated with and resentful of Mario’s inability to acknowledge the therapist as a separate being, the therapist found herself withdrawing: she consciously wished Mario would leave treatment, lamenting that she ever took him on as a patient and feeling relieved when he would miss a session. In the moments she could not think her own thoughts, she had disengaged from the patient and the treatment. In the moments she could not bring herself to repeat Mario’s words, she had rejected his mirroring transference needs,

unable to tolerate becoming merely an ‘‘impersonal function’’ (Kohut 1959) that parrots the patient’s words to confirm his sense of himself (Betan & Westen 2009, p.191).

This report on research on countertransference cannot end before we wouldn´t have returned to the microscopic level of therapeutic interaction. The New York research psychoanalyst Hartvig Dahl and his coworkers wrote about „counter-transference examples of the syntactic expression of warded-off contents“ (Dahl et al. 1978). There are indeed myriad possibilities how the unconcious mind with his emotional and cognitive components can impact on the production especially of spoken language (‚parole’ in de Saussure sense). Freud in his seminal work on the „Psychopathology of everyday life“ (1901) gave beautiful example that can lead our attention to the smaller examples of countertransference responses. One of my beloved examples of such a small countertransference incident is the following: A well know therapist had offered to a patient that she could call him when in trouble. When she rang him he immediately responded: „What is going wrong again“ – I think he was unconsciously deceiving himself when he had offered to be contacted again. In all likelihood, what we have learned – from clinical work and scientific studies that diverse countertransference responses are unavoidingly part and parcel of work with patients.

Bibliography

Beckmann D (1974) Der Analytiker und sein Patient. Untersuchungen zur Übertragung und Gegenübertragung. Huber, Bern Stuttgart Wien

Beckmann D (1988) Aktionsforschungen zur Gegenübertragung. Rückblick auf ein Forschungsprogramm. In: Kutter P, Beckmann D (Eds) Die psychoanalytische Haltung. Verlag Internationale Psychoanalyse, München, pp 231-244.

Beckmann D, Richter H-E (1972) Gießen-Test. Ein Test für Individual- und Gruppendiagnostik. Huber, Bern

Bellak L, Smith MB (1956) An experimental exploration of the psychoanalytic process. Psychoanal Quart 25: 385-414

Betan E, Heim AK, Conklin CZ, Westen D. (2005) Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. American Journal of Psychiatry 162: 890–898

Betan EJ, Westen D (2009) Countertransference and personality pathology: Development and clinical application of the Countertransference Questionaire. In:

Levy RA, Ablon JS (Eds) Handbook of Evidence-Based Psychodynamic Psychotherapy. Bridging the Gap Between Science and Practice. Humana Press, New York, pp 179-198

Dahl H, Teller V, Moss D, Trujillo M (1978) Countertransference examples of the syntactic expression of warded-off contents. Psychoanalytic Quarterly 47: 339-363

Freud S (1901) Psychopathology of Everyday Life. Standard Edition 6

Freud S (1910d) The future prospects of psychoanalytic therapy. Standard Edition 11: 139-151

Freud S (1926e) The question of lay analysis. Standard Edition 20: 183-250

Graff H, Luborsky L (1977) Long-term trends in transference and resistance: A quantitative analytic method applied to four psychoanalyses. Journal of the American Psychoanalyic Association 25: 471-490

Gelso CJ, Latts M, Gomez M, & Fassinger RE (2002). Countertransference management and therapy outcome. Journal of Clinical Psychology 58: 861-867

Hayes JA, Gelso JCh, & Hummel AM (2011) Managing countertransference. Psychotherapy 48 (1): 88-97

Hayes JA, Riker JB & Ingram KM (1997) Countertransference behavior and management in brief counseling: A field study. Psychotherapy Research, 7:145–154

Heimann P (1950) On countertransference. International Journal of Psychoanalysis, 31: 81-84

Kächele H (1983) Verbal activity level of therapists in initial interviews and long-term psychoanalysis. In: Minsel W, Herff W (Eds) Methodology in psychotherapy research. Lang, Frankfurt, pp 125-129

Kohut H (1968) The psychoanalytic treatment of narcissistic personality disorders: Outline of a systematic approach. Psychoanalytic Study of the Child 23:86–113.

Polanyi M (1958) Personal knowledge. Towards a post-critical philosophy. Routledge & Kegan Paul, London

Singer BA & Luborsky L (1977) Countertransference: The status of clinical versus quantitative research. In: Gurman AS, Razin AM (Eds) Effective Psychotherapy. Pergamon Press, Oxford, pp 433-451

Thomä H & Kächele H (1987) Psychoanalytic Practice. Vol.1 Principles. New York: Springer; 1994 paperback edition Aronson, New York; romanian Tratat de Psihanaliza contemporana. Fundamente. Editura Trei, Bukarest, 1999

Van Wagenor SL, Gelso CJ, Hayes JA, Diemer R (1991). Countertransference and the reputedly excellent psychotherapist. Psychotherapy, 28: 411-421

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