

IS IT POSSIBLE TO MEASURE COUNTERTRANSFERENCE?

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Résumé

La recherche empirique du processus thérapeutique a longtemps évité - justement - même d'essayer à mesurer le contretransfert bien que cette dimension du processus psychanalytique ait pris de l'élan les dernières décennies. Notre article met en évidence les divers efforts entrepris dans la direction de l'approche d'une telle méthodologie de mesure d'un concept si flou. La distinction entre les patterns habituels de contre-transfert et les réactions affectives situationnelles semble être la plus utile modalité d'approche de ce sujet. On présentera et on discutera des études empiriques récentes et des mesures relatives au contre-transfert.

Mots-clés: recherche empirique, contre-transfert, pattern, mesure du contre-transfert

Abstract

Empirical research on the treatment process has long time - for good reasons - avoided to even try to measure countertransference, although this dimension of the 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 between habitual patterns of countertransference and situational affective reactions seems most likely a helpful way to approach the topic. Recent empirical research and measures on countertransference will be presented and discussed.

Key words: empirical research, countertransference, pattern, measures on countertransference

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"Freud viewed countertransference, even when he first discovered it [9], 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" [9]. Freud emphasizes that "no psychoanalyst goes further than his own complexes and internal resistances permit" [9]. 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'" [10], 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" [10].

In this lecture we reappraise how this elusive technical concept became a topic in systematic treatment research – a 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 the 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. This rating could be provided by external observers like in the experimental study by Bellak & Smith [4] or even by treating therapists themselves like in the study of Luborsky's research group in Philadelphia. In this study, four therapists conducting psychoanalytic treatments over a long period of time had to weekly assess the degree of expression of such concepts on the Therapy Session Sheet [11]. Besides qualifying the patient's capacities as reflective, receptive, anxious, depressive, hostile, the degree of transference in terms of being either manifest or latent, 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 and last but 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 was it 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 emotional state of mind from the assumed induced countertransference reaction. No wonder that in the same year this study was published; Singer & Luborsky [19] 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 rather disappointing findings. A factor analysis of the data sets showed clearly that both, the treating analyst and the observing analyst produced a single factor solution: the sessions were either good or bad in terms of transference and countertransference. The interdependence of both clinical concepts was quite substantial. To take the 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 a sign of countertransference 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 the sessions that were judged as difficult periods in the analysis [16].

In another study, where we 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 a true experimental study on the issue of countertransference propensities in 1974.

Applying a psychoanalytically informed, but psychometrically sound questionnaire, 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 questionnaire about themselves and the candidates had to describe all patients with the instrument. Applying a lot of complicated statistics he could finally present solid findings. The candidates who displayed higher levels of depressive features overrated the degree of hysterical features in the patients; vice versa, the candidates who qualified with higher levels of hysterical features overrated the degree of depressive features in the patients; and the candidates with higher levels of obsessiveness overrated the degree of obsessiveness in the patients [3].

Repeating the experiments at a later stage of the candidates' training, the degree of overrating was considerably reduced, but the impact of personal dispositions had not disappeared [2]. A nice proof of Freud's 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 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 looking 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 from 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 subjects mainly psychodynamic psychotherapies. Luckily, a recent review on the state of the art was provided by Hayes et al. [13].

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 countertransference feelings and the third rises the question whether managing countertransference improves the outcome.

Metaanalysis: 10 Studies with N = 769 Patients

Metaanalysis: 11 Studies with N = 1065 Patients

Metaanalysis: 7 Studies with N = 478 Patients

The Instrument used by all included studies was the Countertransference Factors Inventory CFI or, respectively, with one of the two abbreviated versions: the CFI-R or the CFI-D. The CFI consists of 50 items and captures therapists' features 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 items 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's capacity to reflect their own state of mind etc.), self-integration (focuses on therapists' healthy character 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 understand the actual therapeutic situation). The CFI may be used as a 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:

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

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	correlational	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; $p \leq .05^*$; $p \leq .01^{**}$; $p \leq .001^{***}$ (1-tailed)

The 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 Williams, Hurley, & O'Brian, Degregorio (2003)	N = 301	correlational	Field	0.29*
Nutt Williams & 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***

$p \leq .05^*$; $p \leq .01^{**}$; $p \leq .001^{***}$ (1-tailed)

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

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***

$p \leq .05^*$; $p \leq .01^{**}$; $p \leq .001^{***}$ (1-tailed)

The handling and respectively the management of CT depend mainly on the therapists' personal qualities. 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 characteristics 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 the 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 one's countertransference responses in a reflective way supports a positive result of the therapeutic efforts. The empirical confirmation of the countertransference-interaction hypothesis as stated by Gelso & Hayes [12], which states that the patient and therapist variable contributes to countertransference, shows that specific patient variables interact with certain conflicts of the therapist. Thus, the key for therapeutic usefulness of countertransference resides in the connection of theory and personal knowledge [18].

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 [6] starts with a quite typical clinical illustration where any experienced clinicians will recognize the countertransference issues involved:

"From the start, the 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. The interpretations of Mario's need to control the interaction and his fears of difference, along with the 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" [6].

In this paper, Betan and Westen point out that in the research related to countertransference, 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 the therapist's avoiding 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 the therapists' involvement they have designed the Countertransference Questionnaire [5] 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' countertransference 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 about 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, and 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 understanding 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 a 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 a way that I don't do for other patients .52
I feel guilty when s/he is distressed 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 a 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, being unable to tolerate her becoming merely an “impersonal function” [17] that parrots the patient’s words to confirm his sense of himself [6].

This report on research on countertransference cannot end till we have returned to the microscopic level of therapeutic interaction. The New York research psychoanalyst Hartvig Dahl and his coworkers wrote about “countertransference examples of the syntactic expression of warded-off contents” [7]. There are indeed myriad possibilities about how the unconscious mind with its emotional and cognitive components can impact on the production of spoken language especially (‘parole’ in de Saussure sense). In his seminal work on the „Psychopathology of everyday life“ [8] gave a 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 – is that diverse countertransference responses are unavoidingly part and parcel of the work with patients.

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