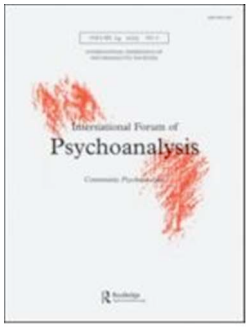


# Countertransference as Object of Empirical Research?

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# Countertransference as Object of Empirical Research?

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The concept of countertransference as a robust cornerstone of psychoanalytic work has gained in momentum over the last five decades. It is a prime example for elastic concepts covering the range from microprocess to global clinical phenomena. Empirical research on treatment process has for a long time - for good reasons - avoided to even try to measure countertransference. We report on various efforts of how to approach a methodology for measuring it. The paper organizes the various approaches in terms of stages of research.

The history of countertransference exemplifies the rediscovery of complementarity as the fundamental principle of social interaction in psychoanalysis. If we acknowledge that Heimann (1950) explicitly grounded the positive value of countertransference, then we may consider the introduction of the concept of interaction into the discussion of psychoanalytic theories as characteristic of the present stage. Of the various theories of interaction, the term "symbolic interactionism" is particularly useful in psychoanalysis. This term refers to an approach to research whose primary premise is that individuals act toward subjects and objects on the basis of what these subjects and objects mean to them. Knowledge of the theories of *intersubjectivity* make countertransference phenomena more comprehensible. One aspect of the psychoanalyst's professional role is that he is sensitive to both the patient's emotions and his own affects but - and this is the crucial point in what is called controlling countertransference - without transforming them into action.

Role and self thus take on concrete form in social interaction, which provides a basis for understanding them. Sandler et al. have accordingly pointed out "that transference need not be restricted to the illusory apperception of another person . . . , but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with others which are a concealed repetition of earlier experiences and relationships" (1973, p. 48). The same holds true for countertransference as a phenomenon that started its history in psychoanalysis as Cindarella to finally turn into a radiant princess (Thomä & Kächele 1994a, chap. 3).

And even more so. Gabbard (1995) explicitly notes that in the last decade „the understanding of countertransference has become an emerging area of common ground among psychoanalysts of diverse theoretical perspectives. This convergence can be traced to the development of two key concepts—projective identification and countertransference enactment. Projective identification has evolved from a patient's intrapsychic fantasy in Klein's original work to an interpersonal interaction between patient and analyst. The notion of countertransference enactment has been widely used to capture clinical situations in which a countertransference reaction in the analyst corresponds to the patient's attempt to actualise a transference fantasy. These ideas, in conjunction with the contributions of social constructivists and

relational theorists, as well as Sandler's conceptualisation of role-responsiveness (1976), have led to an understanding of countertransference as a 'joint creation' by analyst and patient (Gabbard 1995, p. 475).

In this paper we map out how the elusive clinical concept of countertransference has been dealt with by systematic treatment research which as a formal scientific activity started around the fifties in the centers of psychoanalytic empirical research. In order to organize the material we shall use a graphic representation for five phases of research (Kächele & Strauss 2000):

Here Figure 1

*Clinical Case Studies:*

Using the PEP-database searching for the term countertransference in the titles of papers one learns about 730 articles which use the term countertransference from 1952 til 2012; since 2000 the information provided (193 papers and books) underlines that countertransference indeed enjoys a high degree of attention. It would be a Herculean task to categories the varieties of uses. As an illustration we quote from a paper by Betan and Westen (2009) which conveys a quite typical clinical experience; any 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).*

A summary of clinical wisdom already provided by Singer and Luborsky in 1977 noted the following points:

a) Countertransference is a hindrance to effective treatment of the patient.
b) Countertransference hinders the treatment by preventing the therapist from properly identifying with the patient.
c) One of the marks of the occurence of countertransference is an inordinate intensity or inappropriateness of sexual or aggressive feelings towards the patient.
d) Countertransference can be of two kinds, acute and chronic. Acute countertransference is in response to specific circumstances and specific patients. Chronic countertransference is based on an habitual need of the therapist; it occurs with most of his patients and not in reaction to a particular conflict.
e) Countertransference can be a valuable therapeutic tool since it can help in empathizing with the patient.
f) The therapist´s emotional maturity is a deterrent to his potential countertransference needs which might interfere with the relationship.
g) Avoiding countertransference problems can be aided by self analysis or by discussing with a supervisor or colleague.

h) Countertransference can often be communicated peripherally - that is, through nonverbal cues.

(p.447-448)

From this fairly comprehensive list it may be obvious that formal studies would have a difficult time to add to clinically relevant knowledge.

*Descriptive Studies:*

Descriptive studies as a formal research activities fulfill the task to systematically describe the phenomena under scrutiny. Singer and Luborsky (1977) point out that most psychotherapy researchers feel „that a scientific orientation requires controlling certain variables even if doing so means that the phenomena studied are not in their most natural form. Consequently much psychotherapy research deals only with approximations of the actual clinical experience“ (p.438).

The first systematic attempt to catch the phenomenon of countertransference were made in the Menninger Foundation´s Psychotherapy Project. At the end of the treatment of the 42 patients the research team tried to assess the extent to which countertransference had hindered the therapy by a series of questions. Luborsky et al. (1958) concluded that it was difficult to determine the impact of countertransference feelings on the outcome.

Following the rather courageous idea of Franz Alexander to study the naturalistic evolution of countertransference feelings by recording the private association of an analyst with a separate microphone, Bergman (1966) recorded his personal reactions after each therapy session. This same idea was later implemented by Meyer (1988) studying three analyst´s emotional reactions who recorded their feeling on a note-pad while in session.

In the early seventies the Ulm group on single case process research analyzed the formal judgment of degree of transference and countertransference by analyst and of a second particpant observer who listened to the first recording of a psychoanalysis in Germany. A factor analysis of the twofold 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 (Kächele 1971).

Sometimes the non-inclusion of countertransference as an object of study is also informative. Graff & Luborsky (1977) applied a quantitative analytic method to four psychoanalyses and reported on long-term trends in transference and resistance. It comes as a surprise that their instrument, the Luborsky Session Sheet, did not mention countertransference at all.

More recent descriptive studies using recorded sessions try to catch the disruptive emotional involvement of a therapist. For example, the Psychotherapy Process Q-Set (Jones 2000) identifies if a therapists emotional response (the countertransference reaction) intrudes in the patient-therapist relationship or not (PQS item 24). In a comparison of three psychotherapy samples, Seybert (2011) found that emotional conflicts intruded less in the short-term psychodynamic psychotherapy sample than among the longer forms of treatments. Among the longer treatments, the emotional conflicts were seldom observed or even considered irrelevant by the observers. Here one may question how accurate can be the observation of therapists emotional response from the outside. Not only is it difficult for a observer to determinate if a therapists response derives from the therapist's own emotional or psychological conflicts or not, but also it maybe be the case that disruptive responses are easier to capture than emotional responses that do not intrude in the therapy relationship inappropriately. The later may also be the case in therapeutic practice.

While being aware of the limitations of countertransference observation (PQS rater is different from a supervisor that knows about therapists inner processes) one might suggest a group of items that might describe aspects around the process of countertransference in a therapy session. For example the observation of therapist's self-disclosure (Item 21) might make this process explicit as the therapist/ analyst shares his countertransference with the patient as a technical intervention. Another relevant indicator might be the therapist being confident and self-assured or being uncertain and defensive (Item 86). The therapist showing extremely positive regard or lacking acceptance towards the patient (Item 18) can be an important indicator of acting out negative countertransference.

Here we can see that the PQS can highly contribute to the recognition of the context in which clinical phenomena as countertransference reactions occur. Many PQS

items capture the nature of the therapeutic dyad and specific therapist and patient items can characterize their interaction. To interprete the context of the relevant process items which describe the interaction within the dyad is necessary. A therapist who demonstrates condescending or patronizing behavior (Item 51) or tactless (Item 77) towards the patient in the context with a patient who is controlling within the session (Item 87) and/ or who tests the boundaries of the relationship (Item 20) is different than with a patient who is compliant and collaborating etc.

Not only for clinical but also for research purposes it is relevant to identify the interpersonal context in which countertransference reactions occur. The PQS captures the nature of the patient-therapist-interaction by describing the " interaction structures" (Jones 2000, p. 16) of the dyad within the session.

One would expect that in this field qualitative studies would excell the often rather crude quantitative approaches. However as we shall detail later in the special section on qualitative research the very phenomenon of countertransference is dissolved in notions of affective interpersonal patterns (Rasting & Beutel 2005).

*Experimental Analogue Studies*

In the fifties and sixties of the last century a number of researchers generated truely experimental approaches to study the subject of countertransference (e.g. Bandura 1956; Fiedler 1951; Strupp 1960). Many of these studies can rightfully be criticized as lacking ecological validity.

A fairly ecologically valid experimental study on the issue of countertransference propensities was performed by Beckmann (1974). Applying a psychoanalytically informed, but psychometrically sound questionaire, the Giessen-Test (Beckmann & Richter 1972) 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. Beckmann´s (1974) findings were quite strong: Candidates who qualified with 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.
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 (Beckmann 1988). 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 of countertransference in terms of a state-trait model. As individuals with a fairly stable personality make-up therapists share a certain propensity to bring to the clinical encounter certain personality features that most likely tinge their 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.

*Randomized –Controlled Studies*

In the present era of evidence-based psychotherapy one might be tempted to ask for true experimental manipulation of countertransference in clinical settings. Why not? may be a question as transference interpretation has been made the object of a RCT (Høglend et al. 2006). Yet it would be very difficult to construct a design where meaningful experimental manipulation with real patients could be performed. It might be feasible to conceive a study where therapists with low or high habitual countertransference propensity could be randomized.

*Naturalistic Studies*

This stage of treatment research has turned out a fair number of studies with real patients in clinical settings. It will not come as a surprise that most of the research has not studied high frequency psychoanalytic treatments but psychodynamic psychotherapies. A recent review on the state of the art concerning countertransference was provided by Hayes, Gelso, & Hummel (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 actualization of countertransference

feelings and the third asks whether managing the countertransference improves the outcome.

The instrument used by all included studies was the *Countertransference Factors Inventory (CFI)* that exists in three versions: CFI (Van Wagenor et al. 1991) with 50 items and two shorter versions, the CFI-D (Gelso et al. 2002) with 21 items and the CFI-R (Hayes et al. 1997) with 27 items.
The CFI captures features of therapists that describe the handling of counter-transference respectively the functioning of a therapist in the therapeutic situation. The instrument consists of five sub-scales: self-insight, self-integration, anxiety management, empathy, conceptualizing ability. The CFI may be used as self-rating instrument or can be applied by a rater e.g. the supervisor. What follows is a simplified presentation of the findings of the meta-analyses:

a) Countertransference responses show a negative yet numerically small correlation with treatment outcome ($r$ = -.16, $p$ = .002, 95% *CI* [-.26, - .06], $N$ = 769 participants; $k$ = 10 studies)

here Table 1

b) Factors of countertransference managment play only a small role in the mitigation of countertransference reactions ($r$ = - .14, $p$ = .10, 95% *CI* [-30, .03], $N$ = 1065 participants; $k$ = 11 studies)

here Table 2

c) Managment of countertransference is associated with better treatment outcomes ($r$ = .56, $p$ = .000, 95% CI [.40, .73], $N$ = 478 participants, $k$ = 7 studies).

here Table 3

The handling respective the managment of countertransference depends mainly on personal qualities of therapists (Hayes et al. 2011). If they show certain features

(f.e. self-awareness) or are able to implement certain exercises (e.g. meditation) they are more likely to handle their countertransference. However certain characteristica of patients play also a role. Some patients (e.g. borderline patients) generate countertransference reactions that are more likely to be difficult to handle (Hayes et al. 1998). Therefore the demonstrated negative correlation between countertranference 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 managment ones countertransference reactions in a reflective way supports a positive results of therapeutic efforts. The countertransference-interaction hypothesis (Gelso & Hayes, 2007) has been confirmed 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).

*Habitual Countertransference*

Experimental research on the social psychology of transference (Miranda & Anderson, 2010, p. 489) provides good evidence that also therapists are vulnerable to operate under the spell of their own, idiosyncratic transferential tendencies. This endorses the idea of habitual countertransferences wich was also taken up by Drew Westen´s research group in Atlanta. They point out that in research specific 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. As a result, countertransference was operationalized 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 specific characteristics of therapists´ involvement they have designed the *Countertransference Questionnaire* (Betan et al. 2005). This instrument

assesses 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 research group was 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 such an instrument works, we report some details on the most salient factors that Betan and Westen (2009) 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
She/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 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.

*Patient-Focused Qualitative Studies*

The notion of countertransference has evolved from an isolated hindrance to an

unavoidable part and parcel of the therapeutic interaction so that most analysts nowadays speak of a transference – countertransference link. One step further one encounters the tendency to speak of the here-and-now where everything the patient says is transference and everything the analyst contributes bespeaks his or her countertransference. The traditional effort to distinguish between the real relationship, the therapeutic alliance and the transference is loosening (Gelso 2011). The concept of comprehensive countertransference flattened out the distinctions. The same process also can be observed in empirical research. The microscopic level of observing therapeutic interaction leads to the disappearance of the transference and countertransference notions.

> „Psychoanalysts have elaborated nonverbal aspects of the patient-therapist interaction. Sandler (1976) emphasized nonverbal interaction as a connecting link between transference and countertransference.....The introduction of microanalytic instruments to investigate affective interaction.....provided access to the interaction patterns that appear to be key elements of the psychotherapeutic relationship“ (Beutel & Rasting 2005, p.188).

Ever since psychotherapy was formally conceived as conversation (Labov & Fanshel 1977) the field has been moved beyond the traditional terms; instead the notions of discourse analysis and conversational analysis provide the tools to describe what is going on in sessions. The more microscopic the tools the less one can distinguish transference or countertransference from what is going on in discourse.

The basic insight for qualitative analysis of countertransference stems from a clinician. Harold Searles, clinically experienced in an original approach of borderline therapy (1977), felt the patient's transference to be something like a kind of disturbance of the analyst's ability to calmly observe and only later it appears to him, "that all patients… have the ability to 'read the unconscious' of the therapist" (1978, p. 177). This insight aligns with qualitative basics such as "to give a voice" to those otherwise unheard (McLeod 1996, p. 314) and it aligns with a fundamental view of the therapeutic encounter as being a (micro-)social endeavor. Freud already observed that the unconscious understands the unconscious of the other and made this the base for his description of analytic attitude.

Nevertheless, the word “countertransference” does not show up in the second edition of McLeods outstanding book (2011). This might be due to a bifurcation in research interests. On one side are qualitative researchers who make their way by the analysis of interviews conducted with therapists and/or clients (Cox 2012), try to integrate qualitative research with standard empirical requirements (Ponterotto 2005) or carefully develop research criteria like “trustworthiness” as an equivalent for “validity” in quantitative research (Williams & Morrow 2009). On the other hand researchers claim that the main impact of qualitative research is in “naturalistic data” which means to analyze original talk-in-interaction and view therapy as a co-production of at least two participants. For each approach short examples will be presented here now.

We will conclude with reviewing selected studies on interactional phenomena in psychotherapies that can commonly be based in the concept of the present unconscious (Sandler & Sandler 1994).

*Examples of Interview-Studies on Countertransference*

Schröder et al. (2009) focused on an important aspect of countertransference: to hold the patient’s mind in (the therapist’s) mind. Indeed, the experience of “being held in the mind of the other” is a critical formula for mothers and infants and for therapists and clients, too. Often clients cannot imagine that a therapist thinks about them during sessions. Is this “thinking between sessions” part of countertransference or not?

> „It might be reasonable to consider whether therapists‘ intersession experiences should be viewed as a form of ‚homework‘ that therapists either engage in spontaneously or assign to themselves as preparatory problem solving in advance of encountering patients.“ (Schröder et al., p. 43)

1040 therapists from US, Canada and New Zealand were confronted with questions like how often in the last week they had thought of their patients, how often they felt to lose confidence to find a solution for treatment impasses and how often they actively tried to view things from a different perspective. The analysis of the answers

was two-fold: Such thoughtful engagements are “work-related” and “affect-related” both.

> „Furthermore, we found that (a) intersession experiences are more frequently reported by therapists who experience more difficulties in practice, (b) intersession experiences in part serve to help therapists cope constructively with those difficulties, and (c) therapists who follow different theoretical approaches tend to use intersession experiences somewhat differently.” (Schröder et al. p. 50)

These authors conclude that research has paid much attention to the cognitive, affective and relational schemata of clients. To analyze such schemata on the therapist’s side should become equally relevant. Therapists become part of an interactive system which exerts powerful effects on their affective status and cognitive organization. This kind of research lead to doubts if a therapist is something like an external change agent operating with “technical interventions”. It seems that this kind of terminology is less helpful in conceptualizing therapy and it is less helpful to be used as a standard of “correct treatment technique” against which countertransference could be contrasted. Obviously, well trained therapists open themselves far more for the patients’ influence than a standpoint of “technical standard” can imagine and so they are exposed to mighty experiences of countertransferences.

How far this powerful influence is stretched out is examined in another qualitative interview-study by Spangler et al. (2009) that carries an interesting title: „Therapist perspectives on their dreams about clients“.

In 1977 the German psychoanalyst Ralf Zwiebel (1977) had published an impressive self-reflective essay of the analyst’s dreams of clients and concluded that this kind of dreams points to feelings of inferiority and insufficiency. Spangler et al. (2009) formulate the following purpose of their study:

> „The purpose of the current study, then, was to extend previous research of therapists dreams about clients by investigating four questions: What themes occur in therapists dreams about clients? What method do therapists use to explore and interpret dreams about their clients? What meanings do therapists make of dreams about their clients? How do therapists use their understanding of dreams about clients?” (p. 82)

Eight therapists are interviewed twice, the interviews are transcribed and analyzed in a group; this follows the CQR-approach (consensual qualitative research) as described by Hill et al. (1997, 2005). Group members write their memos in a research diary. 15 dreams about 13 clients are reported and analyzed. Therapist often have first dreams at the beginning of their career, there are dreams on special clients, dreams often document a feeling of excessive demand, high workload (more than 10 sessions per day). The authors are not only interested in the dream material but also what therapists make of it. They find that dreams are often used as a sign to change something in the therapist's life, while others use their dreams as stimulus for a creative change of views or finding a poetic word. Even spiritual dimensions appear in dreams. The authors conclude,

> „the dreams were not always a symptom or source of anxiety about competence, but rather they sometimes raised questions for consideration, provided resolution, or affirmed decisions" (p. 93)

So the clinical discovery by Zwiebel (1977) has been expanded by this qualitative study. It enriches our view of therapists dreaming about patients as a relevant dimension of countertransference.

*Conversation Analysis of Countertransference*

It is clear that themes like therapists' dreams or between-session engagement can be explored and studied by interviews. Other authors apply conversation analysis (Jefferson 1992, Schegloff 2007) in order to gain data how the therapeutic discourse is organized in the two dimensions of sequentiality ("turn-taking") and "category bound activities". To analyze "sequentiality" of talk makes visible the fundamental "orderliness" of talk-in-interaction, even if it might appear in a first view as chaotic and "disordered". To analyze "category bound activity" makes visible in what ways utterances are understood by the listener which can be concluded from the listener's next utterance. A listener might categorize a first utterance as invitation, as attack, as calming-down, an analytic patient might hear what the therapist thinks to be an interpretation as seduction, as breast-feeding, as humiliation etc. Schwaber (1995) has applied a similar idea –without reference to conversation analysis – in her

concept of “listening to listening”; it is important for the analyst how his own utterance is categorized by the patient. Thus, what conversation analysts view as “categorization” can easily be linked to the idea of “naïve interpretations” which cannot be dispensed in interaction. Categorization is a kind of organizing events. We do not only have hierarchical or radial categories. We also have metaphorical categorizations (Lakoff 1987). Buchholz (2003) analyzed the “interaction of metaphorical imagination” in therapeutic dialogue in a single case study of a 30-session therapy. In every utterance people show each other how they understood the other’s utterance. Conversation and “cognition” have a connection which is close to another (Molder & Potter 2005) and which includes unconscious motives. Hanke (2001) presented a study about telling dreams in which he achieved similar conclusions. Telling dreams is an everyday activity in love relationships or families, it is practiced while expecting some help in problem solving in dealing with one’s own dream. Creating a narration while presenting it to a listener equals a kind of “theory building” (Hanke, p. 237) and structures a somewhat chaotic dream experience in a more logical coherence. This study combines narrative and conversational analysis in an original way.

Gülich, Knerich and Lindemann (2009) studied how change in clients’ narratives comes about in clinical interactions in medical settings and what kind of countertransference-attitude is helpful for this change process. Their interest is about clients coping with medical diagnosis. Like Hanke (2001) they find that telling a story is not only a reproduction but a reinterpreting activity. They demonstrate by conversational data that telling a frightening story has in itself a healing effect because of the ever renewed reinterpretation of the events – sometimes the story of an accident changes from horror to comedy after several versions of narration. But what has a therapeutic listener and his countertransference to do with that? The authors give an interesting answer. They find that in every story there are dominant aspects – the main story line – and side effects. Side effects like adding a detail or digress from a topic indicate a change in coping process. And more, storytelling is an activity that has to control the listener’s attentiveness. So storytellers sometimes make pauses and cast a glance to the listener if he wants to make an utterance. A moderate increase of side effects in storytelling and in control of the listener’s

attention indicates an improvement in coming to terms with the traumatic dimension of such a diagnosis.

These points of turn-taking are relevant for countertransference. It could be shown that medical doctors that are described as trustworthy by their patients practice a style of listening that does *not* take the conversational turn when the patient pauses. These doctors do not take conversational activity by presenting *their* questions but stay attentive and silent. Thus opens a conversational space in which the patient can bring in all she or he wants to say and share. One might speculate that this cautious and gentle style of medical listeners sets in motion a cognitive process of self observation in patients which comes close to what we have learned to view as mentalization.

Anssi Peräkylä (2011a), a social scientist trained in conversation analysis and psychoanalysis, applies conversation analysis to psychoanalytic dialogues. His contribution on the "third position" fruitfully enriches the debate on counter-transference. He analyzed 58 transcribed sessions from two analysts and three patients and focuses on how patients respond to the analyst's interpretation. Analysts respond with a modification of the patient's response, most often by emotional intensification or they pick up a side aspect of what the patient had answered. This is done in a non-marked way and helps to taylor precisely the interpretation first given.

> "In the third-position utterances with the implicit modification of the tenor of the description, the analysts' proposal for the patient to take 'something more' onboard from the interpretation is done implicitly, without the modification being marked or highlighted. This proposal does not constitute any kind of rejection of the understanding of the interpretation that the patient has indicated in his or her elaboration, nor does it demand the patient to see things as the analyst does. The proposal is also tailored – both topically and syntactically – to the understandings that the patient showed in his or her initial response" (Peräkylä 2011b, p. 304)

Countertransference aspects are addressed here in an important, but very indirect way. The "third-position"-utterance seems to come from a "resonating alignment" (Buchholz 2013) which produces a feeling in the analyst that something is still missing and that a further utterance should follow. "Something more" refers to what

Stern et al. (1998) had termed “non-interpretative mechanisms”. So it seems that modern audio- and video technique, used by conversation analysts since the 1960s in a similar way, really opens new horizons for the detailed analysis of what is really said and done in a psychoanalytic session. In a personal comment Peräyklä (2011a) debates how the (alleged) “anti-mentalism” of conversation analysis and the more introspective approach of psychoanalysis can be brought together on the basis of detailed observation. It seems that we might expect for the future a clarification of what the “clinical facts” (Tuckett 1994) of psychoanalysis are and how the future role of countertransference will be.

*Observing Therapeutic Interaction*

Studies on observing therapeutic interaction seem to have the potential to contribute to what “clinical facts” are. We have mentioned the work of Beutel & Rasting (2005). These authors found in a small sample of 15 clients treated by two therapists that to observe the facial affective behavior of both participants could predict the successful (or not) outcome of treatment.

Benecke & Krause (2005) came to a similar result. They considered affective facial behavior as a tool unconsciously used by 20 panic patients to regulate the relationship with the therapist. Their core conflict to urgently need a relationship with a positive confirming object and their inability to include negative feelings or maintain autonomy and self-determination is expressed in a constant facial smiling behavior. However, this hypotheses could not be completely confirmed. The authors found it necessary to differentiate between two subgroups of panic patients. Half of them showed disgust or contempt as the leading affective facial behavior. It seems to be important how therapists react to this influential micro-behavior and how they contribute to it unconsciously.

Merten (2005) describes that the awareness of the “leading affect” (p. 326), specific for types of mental disorders, has a powerful influence on the therapist’s reactions – independent of the kind of therapy! The synchronization of both participants’ affects in the first interview can be used as a predictor of outcome. “It becomes obvious that the contribution of the therapist to the quality of the therapeutic relationship is much higher than it is assumed in studies based on ratings” (Merten 2005, p. 330). Micro-

analyses are the methods of the future when we want to understand what clinical facts are, what countertransference means and how therapists contribute to the process.

Krause (2005) in an overview of studies conducted by his research group finds that there is a fine granulated synchronization of such affective facial behavior between therapists and patients – and when this synchronization can constantly be observed this is a predictor of negative therapy outcome. “Joining” the patient’s smiling behavior might than lead to diagnose the patient as more severely disturbed than thought before – this is a clear countertransference reaction which appears not in the domain of therapist’s feelings or fantasies, but in the field of his technical decisions. Krause proposes a taxonomy of therapeutic reactions. The first group features therapists who have no sense for the affective dimension; they are considered to be “affectively blind”. The next group Krause (2005, S. 254) terms as the “guru type”, willingly following unconscious relational offers of the patient entering a critical sphere of abuse of the therapeutic relationship. The third group of therapists contributes to the failing of therapy by being aware of the patient’s smiling, but cannot refuse to react in a complementary way. They are aware of their feeling forced to respond and cannot manage to escape; they register their countertransference but cannot handle it. Only the fourth group feels free to respond with an affective reaction different from that they feel forced to.

These considerations and results can be summoned in the concept of “present unconscious” as proposed by Sandler & Sandler (1994). The present unconscious dimension seems to be as important as the past dimension of the unconscious. Furthermore, we want to conclude that there are two general levels of interactional events. One is an *affective* level while talk-in-interaction happens and the other is an *symbolic* level of interaction order with the subdimensions of organizing sequentiality and of category bound activities as studied by conversation analysts. The example of down-grading a diagnosis (symbolic) influenced by an affective conflict held unconsciously shows how these two levels influence each other mutually. Conversation analysts have a subtle ear for these dimensions and have shown what an important role is played by pauses, interruptions, turn takings, tags and the like. These can be considered to be affective elements in the more symbolic level.

In empirically studying countertransference the interplay between these two levels of affective and symbolic order has become an important field of interest.

*Clinical Use*

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, Betan and Westen 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).

*Conclusion*

Countertransference – in the light of these (and other) studies – can be seen as an integral part of psychoanalytic interaction, but its definition covers a wide range. On the one hand countertransference is a term encompassing too much – everything in the analytic discourse, on the other hand it seems to be an instrument how to analyze "what is going on". This overview on quantitative and qualitative studies can

clarify the field. Countertransference expands to dreams and between-session activities and shapes the microstructure of the psychoanalytic conversation. To observe the details of conversation means in psychoanalytic terms to catch sight of extensively ignored countertransferential aspects. The empirical work of a Viennese study group has demonstrated on more than 300 patients that significant changes can hardly be understood by measuring patient variables alone (p. 26); client change most often was preceded by a significant change in the therapist's counter-transference especially when dealing with projective and externalizing mechanisms (Löffler-Stastka et al. 2010). Here quantitative and qualitative research results converge convincingly with clinical experience.

The lesson to be learned might be that it is helpful not only to look "behind" what is said and done in a session, but more to look *onto the surface:* what happens in the details of conversation and narration. We encounter the unconscious freshly on the surface of conversational exchange, not only in the "depth" of early and preverbal experience. One of the psychoanalytic paradoxes might be that depth appears on the surface.

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Figure 1

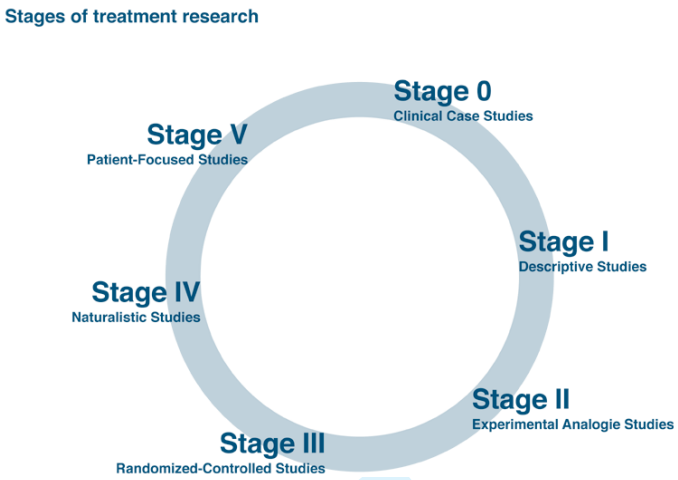

*Table 1. Studies on the relationship between CT and outcome*

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

Pat. = patients, Th. = therapists; [a] Therapists were students in psychotherapy training;
$p \leq .05$*, $p \leq .01$**, $p \leq .001$*** ($p$ value 1-tailed)

*Table 2. Studies on the relationship between CT management and CT reactions*

| Autors | *N* (Sample size) | Design | Setting | *r* (correlation coefficient) |
|---|---|---|---|---|
| Gelso, Fassinger, Gomez, & Latts (1995) | 68 [a] | experimental | Lab | - 0.04 |
| Robbings & Jolkovski (1987) | 58 [a] | correlational | Lab | - 0.04 |
| Forester (2001) | 96 | correlational | naturalistic | - 0.10 |
| Kholocci (2007) | 203 | correlational | naturalistic | - 0.15 |
| Hayes, Riker, & Ingram (1997) | 20 Pat., 20Th.[a] | correlational | naturalistic | - 0.18 |
| Peabody & Gelso (1982) | 20 Pat., 20Th.[a] | correlational | naturalistic | - 0.24 |
| Nutt Williams, Hurley, & O'Brian | 301 | correlational | naturalistic | 0.29* |
| Nutt Williams & Fauth (2005) | 18 Pat., 18Th.[a] | correlational | Lab | - 0.43*** |
| Latts & Gelso (1995) | 47 Th.[a] | correlational | Lab | - 0.45*** |
| Hofsess & Tracey (2010) | 35 Th.[a]; 12 Sup. | correlational | naturalistic | - 0.57*** |
| Friedman & Gelso (2000) | 149 Th. | correlational | naturalistic | - 0.59*** |

Pat. = patients, Th. = therapists, Sup. = supervisors; [a] Therapists were students in psychotherapy training; $p \leq .05$*, $p \leq .01$**, $p \leq .001$*** (*p* value 1-tailed)

*Table 3. Studies on the relationship between zwischen CT management and outcome*

| Authors | *N* (Sample size) | Design | Setting | *r* (correlation coefficient) |
|---|---|---|---|---|
| Rosenberger & Hayes (2002b) | 1 Pat., 1Th. | correlational | naturalistic | **0.38*** ** |
| Fauth & Williams (2005) | 17 Pat.,,17 Th.[a] | correlational | Lab | **0.17*** ** |
| Nutt Williams & Fauth (2005) | 18 Pat., 18 Th. | correlational | Lab | **0.18** |
| Gelso, Latts, Gomez, & Fassinger (2002) | 63 Pat.,, 32 Th.[a], 15 Sup. | correlational | naturalistic | **0.39**** |
| Peabody & Gelso (1982) | 20 Pat., 20 Th.[a] | correlational | Lab | **0.42*** |
| Van Wagoner, Gelso, Hayes, & Diemer (1991) | 122 Pat. | experimental | Lab | **0.55*** ** |
| Latts (1996) | 77 Pat., 77 Th.[a] | correlational | naturalistic | **0.89*** ** |

Pat. = patients, Th. = therapists, Sup. = supervisors; [a] Therapists were students in psychotherapy training; $p \leq .05$*, $p \leq .01$**, $p \leq .001$*** ($p$ value 1-tailed)