

Is it possible to measure countertransference?

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Abstract

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.

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 ratings 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. Four therapists conducting psychoanalytic treatments over a long period of time had to assess weekly the degree of expression of such concepts on the therapy rating 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 was given for the degree of resistance, the number of dreams, the kind of interpretations given, last not least the therapists 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. In the same year this study was published Luborsky and his junior colleague Singer summarized the unsatisfying state of the art of catching the butterfly of countertransference by formal research methods (Singer & Luborsky 1977).

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 interdependence of both clinical concepts was quite substantial. To take this finding as a corroboration of the clinical nexus between both concepts was too easy an escape.

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 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 quite strong findings. 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. 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 actualization of countertransference 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* that exists in three versions: CFI¹ with 50 items, CFI-R² with 27 items or CFI-D³ with 21 items.

The CFI captures features of therapists that describe the handling of countertransference respectively the functioning of a therapist in the therapeutic situation. The instrument consist of five sub-scales: self-insight, self-integration, anxiety management, empathy, conceptuality ability. 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 ($r = -.16$, $p = .002$)

Tab. 1 Studies on the relationship between countertransference and outcome

Authors	Sample	Design	Setting	p
Mohr, Gelso & Hill (2005)	N=88 Pat./ 27 Th. ^a	correlation	Labor	0.37
Myers & Hayes (2006)	N=224	experimental	Labor	0.28
Cutler (1958)	N = 5 Pat, 2 Th. ^a	correlation	naturalistic	0.30
Rosenberger & Hayes (2002b)	N = 1 Pat, 1 Th.	correlation	naturalistic	0.42
Ligier & Gelso (2002)	N = 50 ^a	correlation	naturalistic	0.01**
Hayes, Riker & Ingram (1997)	N = 20 Pat, 20 Th. ^a	correlation	naturalistic	0.08*
Hayes, Yeh, & Eisenberg (2007)	N = 69 Pat, 69 Th.	correlation	naturalistic	0.40
Nutt, Williams & Fauth (2005)	N = 18 Pat, 18 Th.	correlation	Labor	0.07
Yeh & Hayes (2010)	N = 116	experimental	Labor	0.00
Bandura, Lipsher &	N = 12 Pat,	correlation	naturalistic	0.04*

¹ Van Wagenor et al. 1991

² Gelso et al. 2002

³ Hayes et al. 1991

Miller (1960)	17Th.			
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^a Therapists were students in psychotherapy training; $p \leq .05^*$; $p \leq .01^{**}$

- Factors of countertransference management play only a small role in the mitigation of countertransference reactions ($r = -.14$ $p = .10$)

Tab.2 Studies on the relationship between CT-Management and CT

Autoren	Stichprobe	Design	Setting	p-Wert
Gelso, Fassinger, Gomez & Latts (1995)	N= 68 ^a	experimenta l	Labor	0.40
Robbings & Jolkovski (1987)	N= 58 ^a	correlation	Labor	0.38
Forester (2001)	N= 96	correlation	naturalistic	0.17
Kholocci (2007)	N= 206	correlation	naturalistic	0.19
Hayes, Riker & Ingram (1997)	N=20Pat/20 T ^a	correlation	naturalistic	0.22

- Successful management of countertransference correlates significantly with better treatment outcome ($r = .56$, $p = .000$)

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

Authors	Sample	Desi gn	Setting	p
Rosenberge & Hayes (2002b)	N= 1 P, 1 T	correl.	naturalistic	
Fauthe & Williams (2005)	N=17P, 17T	correl.	Labor	
Nutt Williams & Fauth (2995)	N= 18P, 18T	correl.	Labor	
Gelso, LAtts, Gomes & Fassinger (2002)	N= 63P, 32	correl.	naturalistic	
Peabody & Gelso (1982)	N= 20P, 20T	correl.	Labor	
VanWagoner, Gelso, Hayes& Diemer (1991)	N= 122	experim	Labor	
Latts (1996)	N= 77P, 77T	correl.	naturalistic	

The handling respective the management 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 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 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 results of therapeutic efforts. The empirical confirmation of the countertransference-interaction hypothesis as stated by Gelso & Hayes (2007), which states that patient and therapist variables 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 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 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' 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. They 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 such 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 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 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 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 inexperienced, 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 mentioned 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“ (Dahl et al. 1978).

There are indeed myriad possibilities how the unconscious 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 ist he 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 difficult patients.

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