Psychoanalytic Process: the Montréal Transference Countertransference Measure

Marc-André Bouchard, Caroline Audet, Patrice St-Amand, John C. Perry, Chantal Picard, & Daniela Wiethaeuper

Towards a Multidimensional Monitoring of the Psychoanalytic Process:

The MTCM (Montréal Transference Countertransference Measure) represents the efforts of our group to achieve the objective of offering a psychoanalytically grounded multidimensional descriptive and operational measure of the psychotherapeutic process. As it's name suggests, it organized and focused around the crucial and time-honored phenomena of transference and countertransference. Transference is construed within an object-relations framework, to which we add a description of three classically distinguished manifest situations (transferential, extra-transferential and past), an indication of displacements and allusions (Gill), and finally of defensive turning of aggression against the self (Gray). Countertransference includes independent ratings of (a) the therapist's interpretative focus (transferential or not, awareness or resolution, etc.); (b) the degree of inference (clarification, direct opinion, confrontation and interpretation); (c) moving beyond some of our previous work, a differentiation between three in-session mental states: objective-rational, reactive and reflective.

Internalized Object Relations in the Transference

The analysis of the transference is of central concern to the psychotherapeutic/psychoanalytic process. From the present object relations viewpoint, analyzing transference means focusing on the reactivations in the here-and-now of past internalized object relations. The notion of internalized object relations is fundamental to the approach proposed by Jacobson, Mahler and Kernberg, and basic to the present operational effort. An internalized object relation (IOR) consists, in its fundamental core, of a fantasy (unconscious, preconscious or conscious), composed of a self representation, an object representation and of their accompanying affects, wishes and desires (drive derivatives).

The MTCM

There has been persistent efforts to study object relations empirically (Smith, 1993). Projective tests (Blatt, Brenneis, Schimek & Glick, 1976; Westen, Lohr, Silk, Gold & Kerber, 1990), elicited early memories (Fowler, Hilsenroth & Handler, 1995; Ryan & Bell, 1984), dreams (Krohn & Mayman, 1974), descriptions of significant others (Diamond, Kaslow, Coonerty & Blatt, 1990), as well as rating scales of the quality of representations of people and relationships (Westen, 1990; Westen, Ludolph, Block, Wixom and Wiss, 1990) and have all been used as measures of object relations. But as discussed elsewhere (Dymetryszyn, Bouchard, Bienvenu, de Carufel & Gaston, 1997), it has been our belief, shared with others (e.g. Kantrowitz, Katz, Paolitto, Sashin and Solomon, 1987; Kernberg, 1984), that the transference is a unique "in vivo" object relationship available for assessment, in particular when observed in comparatively unstructured situations, such as occurs in a psychodynamically oriented psychotherapy or in psychoanalysis.

On the transference side, four dimensions are examined.

1. **Maturity of object relations**. A continuum of maturity of object relations is described, from the

psychotic (levels ONE and TWO) to the borderline (level THREE) projective identification mode of relating to the familiar neurotic (level FOUR) and integrative (level FIVE) positions. The principal aim is to provide a measure of the patient's contribution to the psychotherapeutic process through a detailed examination of continual shifts in presently actualized object relations within the transference. Each category of the rating Manual contains a definition and illustrative examples are documented.

In what we have called "A" and "B" ratings, the patient's levels of maturity of object relations are thus specified. Presently, eleven (11) categories define level three functioning, for the most part made of projective identifications and primitive idealizations, but also including splitting, enactments and somatizations typical of this level. Level Quasi-four (twelve categories) reflects what has been termed the narcissitic resistances to a level three conflict. It contains such ego states as a defensive maintenance in fantasy of an ideal object-ideal self couple, an identification with a grandiose self, etc. Also included are such phenomena as an idealizing transference, obsessional operations in the service of a quasi-four posture (in contrast to a true level four obsessional functioning), etc. Comprised here are categories reflecting the crucial dividing line of self and object constancy (Mahler). Therapeutic alliance, understood as a collaboration between the patient's observing ego and the therapist's observing functions, is also included, at each level.

Level four covers the neurotic level of maturity of object relations, in two sections. In the first part, thirty (30) categories describe the transference moments as organized by the drives and in a form not typical of an identifiable neurotic character structure. Expressed in more classic freudian terminology, these cover oedipal transferences, those involving the ego-ideal (mature narcissism), as well as the phallic-narcissistic, anal regressive and oral regressive transferences. In the second part the definitions (sixty-one categories), represent typical neurotic forms of transferences, of either the hysterical, obsessional-compulsive or depressive-masochistic type. Under each character configuration, some specific manifestations are included, such as the "hysterical theatrical self", or the obsessional "sadistically overpowering self", or the depressive-masochistic "identification with sadistic superego imago", etc.

Finally, level five is meant to reflect moments when the patient demonstrates an integrative, comparatively more abstract and reflective understanding of any of the previously defined level four or less conflicts.

In addition to the maturity of reactualized internalized object relations (IOR), the MTCM allows for a description of other crucial components of the patient's experience as part of the transference and process: the manifest register of the relationship ("C" rating), allusions and displacements, and defensive turning of aggression against self ("D" ratings).

2. **There manifest relationship situations**. As is well established, examination of the patient's manifest associations may reveal the present intentional focus to be transferential (TR), that is, concerned with the immediate here-and-now situation with the therapist, or extra-transferential either from the present (OEX: "Object is External"), or past-genetic, i.e. extra-transferential from the remote past (OPA: "Object from the past"). These divisions in time reference are both necessary and convenient. But it is also important to underline that in our view, when the patient is manifestly expressing himself as involved with an extra-transferential, past or present object, this always reflects something of the present status of the transference since these associations are made **in the presence of the therapist**. This is following Klein's notion of transference as a total situation.

3. **Allusions and displacements**. Particularly when the patient does not feel secure enough about a given conflict presently being reactivated in the transference, it is hypothesized, following Gill's initial suggestions (see Gill, 1979; 1982; Gill and Hoffman, 1982), that the present conflictual experience within the transference is displaced (rated DIS) and expressed indirectly by means of allusions (rated ALLU) through an extra-transferential register (OEX or OPA), while still being unconsciously meant to refer to the present transaction.

4. **Defensive Turning of Aggression Against Self**. One major additional rating of the transference experience adopts a line of thinking developed by Paul Gray (1992), following Anna Freud, in monitoring the ego's activity motivated by considerations of safety (S. Freud). Following the

expression of some wish or drive-derivative in the presence of the therapist, the patient, presumably encountering some difficulty with a superego function, or perhaps even an internal persecutory object, defensively turns aggression against self (TAS). At a higher, neurotic level of functioning, this may be recognized by explicit self-derogatory statements, especially following expression of some drive-derivative (Gray). It may then imply typical higher-level defenses like repression, undoing, etc. On occasion, superego activity may further become apparent and manifest in the material, and then specified by the following: (S/E).

The Countertransference.

Under the general heading of **countertransference**, the MTCM offers a multidimensional evaluation of the therapist's contribution to the process.

1. **Interpretive Focus**. First, adapted from Gill and Hoffman's (1982) contributions, is the interpretive focus, being either transferential (TR) or non-transferential (NTR; or extra-transferential). Within the transferential field, the therapist may focus on resistances to an awareness of the transference (RAWR), or may be aiming towards resolution (RES: a proposed connection or understanding). Within the resolution mode, the therapist could focus his interpretive work on the here-and-now immediate situation (HNOW), or else relate the immediate transference to some contemporary (CONT) scene, or to an ancient scene by proposing a genetic (GEN) interpretation. Within the non-transferential (NTR) field of activity, the therapist is not addressing the patient's immediate situation, and is either focusing on a contemporary (CONT) or genetic (GEN) extra-transferential register. Finally, the therapist could be concerned with addressing the frame, the contract or the rationale (C/R).

2. **Therapist Level of Inferential Communication**. Second, therapist interpretative activity is situated on a continuum of inferential communications which we have proposed previously (see Bouchard, Lecomte, Charbonneau and Lalonde, 1987; Bouchard, Brueckmann and Lecomte, 1987). This is now integrated with classic distinctions made between kinds of interpretive work. Thus the MTCM proposes, following also work by others (e.g. Koenigsberg, Kernberg, Rockland, Appelbaum, Carr and Kernberg, 1988) to distinguish four levels of inferential communication: clarification (CLA), confrontation (CFR), direct opinion (DOP) and interpretation (INT).

3. **Therapist Mental State**. Also following up on our previous work with the Countertransference Rating System (CRS: Bouchard, Normandin & Séguin, 1995; Lecours, Bouchard & Normandin, 1995; Normandin & Bouchard, 1993; Séguin and Bouchard, 1997), three mental states are differentiated: the objective-rational mode, the reflective (process-oriented mode) and the reactive (classical freudian) mode.

From an objective-rational attitude (OBR), the therapist demonstrates that he adopts a certain distance from the patient, but in an adaptive, non-defensive manner, so as to occupy the position of a non-participating observer. The therapist is in a **I-It mode** (Buber, 1970); (s)he is mentally oriented towards observation **from the outside** rather than participation as subject and observation **from within** the "intersubjective field" (Atwood et al., 1989). This is a process of objectification aimed at a rational understanding of the analysand based on one's **working model** (Greenson, 1960; Peterfreund, 1983).

The **process-oriented mode** (POR), usuallly devolves from a preconscious and conscious **reflective** type of psychical activity. Here the therapist is both subject and object, involved in self-analysis (Reik, 1949). According to Racker (1957, p. 308), such reflective processing rests "on the continuity and depth of one's conscious contact with oneself." This mental state serves as an instrument, the result of a maintaining of an interpretive attitude linked to the process. This implies some recognition and elaboration of one's inner reactions as a participating subject (e.g. Freud's "evenly suspended attention", 1912b, p. 111).

Finally, the **reactive** (REAC) mental state corresponds to the classic freudian view of countertransference as an **obstacle** and a **defense**, the outcome of an unconscious reaction, a "blind spot", a residual neurosis, or projective counter-identification (Freud, 1910, 1912; Reich, 1951; Grinberg, 1962; 1979). The content of the therapist's understanding or technique is accordingly

distorted, and (s)he appears to be more in touch with his/her own desires, conflicts and defenses or else resolutely enmeshed in those of the patient.

4. **Immediate (microscopic) Impact to the Resolution of the Current Transference Conflict**. Finally, the immediate, microscopic impact is assessed through the patient's resolution (as opposed to repetition) of his presently actualized conflict in the transference. Five possibilities are identified: negative (NEG), positive (POS), neutral (NEU), negative therapeutic reaction (NGR), or unspecified (UNS). This approach is in part related to the notion of confirmation of expectancies, but mostly understood psychoanalytically as cycles of projection and reintrojection.

The DMRS (Defense Mechanisms Rating Scales)

The DMRS (Perry, 1990; 1993) defines 28 defense mechanisms distributed along seven hierarchically organized levels of maturity. The mature defenses (level 7) are adaptive coping strategies including affiliation, altruism, anticipation, humor, self-assertion, self-observation, sublimation and suppression. The obsessional defenses (level 6) are isolation, intellectualization and undoing. The other neurotic defenses (level 5) comprise repression, dissociation, reaction formation and displacement. Omnipotence, idealization and devaluation form the minor image-distorting (level 4) or narcissistic defenses. The disavowal mechanisms (level 3) include denial, projection and rationalization; although scored at this level but not a disavowal defense is autistic fantasy. The major image-distorting (level 2) or borderline defenses consist of splitting of other's images, splitting of self-images and projective identification. Finally, the action defenses (level 1) are acting out, hypochondriasis (or "help-rejecting complaining") and passive aggression.

Method

Subject and Material

Mrs. A. is a 44 year-old divorced woman, a mother of three children in their twenties. The youngest is still living with her. Unemployed during the time of her treatment, she had just completed six years as a management secretary. She has a stable but strained and distant relationship with a man twenty years older than her. Mrs. A. suffered from anxious and depressive symptoms following a burn-out episode. She was seen twice a week by an experienced male psychoanalyst. The sessions, conducted face to face, were all audiotaped. Her psychotherapy proper consisted of 14 sessions at the end of which she unilaterally decided to terminate her treatment. The therapist described her as being articulate but defensively "slippery", in reference to the fact that he felt she had been escaping him throughout most of their meetings.

Rating Procedure

The rating procedure involves two separate steps, each performed by a set of at least two independent judges. Following the collecting of the independent ratings, used for assessing interrater agreements (minimum Kappas so far are around .65), consensual agreements are reached, and used for further analyses.

Preliminary Rating. The preliminary rating entails the identification of significant units (SU). This involves a first pair of independent judges reading the transcription and delimiting successive spontaneous figures (**gestalten**) as they form through the flow of the events of the session. There is no priority in the rules. So far however the number of units per 45-50 minute sessions has typically varied from 7-8 to 25-28.

Main Rating. The first task is preparatory and requires that raters read the segmented material (including eventually the listening of audio or videotaped versions), underline key words, perhaps comment in the margins and write a 3-5 sentence summary of the story line of the presently considered unit. The idea is to observe and to document what is manifest, in order to remain as close as possible to the surface material. Summary formulations should be seen as an attempt at reformulating the material with minimal inference. The rating phase proper means to shift to an interpreting of the "observables", when raters then proceed to sense whatever is felt to be actualized by both participants within the given unit. Inferences are permitted but should enlighten and be

articulated with the observable elements identified in the preparatory work. A possible countertransference response of the rater to the therapist is always a possibility to keep in mind...

Judges

Preliminary ratings for the MTCM were performed by one male and one female graduate students in psychology. In addition, two female doctoral level students in clinical psychology separately scored the MTCM. They received approximatively 60 hours of training. Consensual agreements were obtained and used for the analyses.

Two other graduate students in clinical psychology, one female and one male, scored the DMRS. They were supervised by J. C. Perry and received approximatively 35 hours of training.

Results

Reliability Estimates

Reliability estimates for the MTCM were based on the scoring of all 14 of the psychotherapy sessions. Based on a conservative method (see Stinson, Milbrath, Reidbord & Bucci, 1994), the percentage of agreement varied from 67% to 79% (M=74%). The scoring proper of the MTCM categories yielded mean kappas of .72 (range .63 to .87). This indicates good agreement beyond chance (Shrout, Spitzer & Fliess, 1987).

This report will be limited to the first nine sessions of the series of fourteen. This should not however affect the value of the overall description, as by the time the patient got to session 9 she had reached (at least unconsciously) a decision to leave. Further, very little change is observed form then on.

Overall Portrait

To briefly summarize, Mrs. A. spoke mainly during the sessions of her intolerance of dependency, both in herself and others, and of the ways she tried to avoid feelings of pain and frustration related to her denied longings. She also alluded to primitive aspects of her relationship with her mother, which she felt as rejecting and smothering, and to her father's and uncle's inappropriate sexualized attitude towards her precocious developing of large breasts. Through her transference she expressed an intense ambivalence towards the therapy, compounded by her frustrated demands for more direct guidance. The therapist's contribution to the process could be characterized by an insistence in providing correct but premature interpretations. The two participants thus seemed to have been caught up in a complementary transference-countertransference relationship as she protected herself from disappointment and intrusion by closing herself from intimate contact with her therapist, by becoming "slippery" and unavailable, yet demanding and frustrated, which the therapist attempted to interpret but in a way that was perceived as confirming some of her expectations that he was trying to force his way through her distancing manoeuvres. Mrs. A. thus showed signs of ambivalence towards the therapy from the very first session, but her ambivalence became more obvious when, in session 3, she reported fighting a part of her that she knew mobilized her strong avoidance-defensive reactions whenever she was confronted with a potentially painful experience. Her mixed feelings towards the therapy seemed to have peaked during sessions 6, 7 and 8, in which she spoke openly about the frustrations, fears and concerns the treatment aroused in her. She also showed manifest signs of resistance when she brought a friend to sessions 7 and 8, a point to which the therapist reacted and also attempted to interpret as part of her transference. During these two meetings, Mrs. A. mentioned the possibility of leaving the therapy. However, she never was able to directly discuss her anger towards her therapist in spite of recurring interpretations to that effect. Eventually she shared her decision to leave. Several years later she still had not contacted the therapist.

The Course of the Manifest Transference

The patient's manifest, immediate transferential focus follows a quite striking course. Two indices are used to describe this part of the process: the percent number of words in the transferential mode ("C" rating described above), and the ratio of this score over the sum of the two other registers. A

ratio smaller than one would indicate that the transference material is comparatively less abundant, and vice-versa for a ratio higher than one. For the first four sessions, the transference is a comparatively secondary point of concentration (M for sessions 1-4= 15.50% and M ratio= .167). Then during sessions 5 and 6 a clear intensification of the manifest transference is seen (M= 42.96% and M ratio=0.90), a more balanced distribution among the three registers being observed. But then the transference conflict seems to peak during the following two sessions (M= 80.7%, M ratio= 4.61), which gives us an indication of the clinical significance of these two sessions, in light of what will follow from session 9 and on, where the manifest transferential focus recedes (32.92% with a ratio of .49).

Maturity of Object Relations

Mean maturity of object relations scores for all nine sessions reveal a clear dominance of the quasi-four rating (M= 65.24%), some marginal level three (M= 9.08%), to which we will return below, and very little level four (neurotic) functioning (M= 11.48%). More precisely, it appears that substantial level four mental states are observed only for the first two sessions (M= 42.18%), to become marginal (8.23%) or to disappear completely in other sessions as the therapy progresses. The dominant quasi-four ratings is typical of a person functioning at a narcissistic level of false autonomy, illustrating basically a level of narcissistic defense and resistance against level three conflicts over pregenitally, particularly orally invested, dependency needs (Kernberg, 1984).

This level three functioning is indeed seen to appear, but in a clinically significant way only during sessions 4 and 5, at a moment of high vulnerability, in the form of the RTHRAPI score, which indicates an intense projective identification, an identification with the victimized persecuted self, with a simultaneous projection of the dangerous persecutory object representation (therapist). This level three mode of object relating is to reappear briefly during the crucial session 7, one where the transference is at it's height, never to be reactualized again until the end, and, most significant, this time in it's reversed form (THRAPI). This is when the patient is identified with the aggressor, with a simultaneous projection of the victimized self representation onto the therapist, the scenario now being played-out even at a manifest level, in the transference (85.88%). Unfortunately at this point, the therapist is being then at his most reactive (55.43%). Further, examination of the more detailed ratings show that the specific form of quasi-four functioning is frequently obsessional for this patient, which is independently confirmed through the DMRS ratings, showing that the neurotic, particularly obsessional defenses, are the most frequent (M=16.91%).

The Story Line We wish now to examine the process, proceeding from the session 1 to 9. As the story unfolds, we will point to specific quantified observations.

Sessions 1 and 2. The series starts with sessions 1 and 2, characterized by the fact that they are the only ones where any significant neurotic functioning is observed (level four: 35.31% and 49.06% respectively). Even then, specific ratings show that this functioning is, for the most part, in the form of FOALL, the alliance rating, which raters probably could not differentiate from a quasi-four alliance, at the time. No level three nor somatic-anxious preoccupation is observed. The manifest register of the relationship is for the most part external or focused on the past, with very little room for the immediate relationship with the therapist. For his part the attitude is mostly process-oriented or objective-rational, with minimal reactive moments.

Session 3. Session 3 shows the appearance of the anxious-somatic preoccupations (15.92% FOSOME rating), in the form of the return of some nightmares and a long-disappeared rash. This is immediately fought by the patient's ego, as shown by a sharp increase in the level of quasi-four functioning (81.69%, in contrast to the mean of 57.14% for sessions 1 and 2). For the patient, this experience however is for the most part, due to external circumstances (OEX= 61.88%) and she cannot at this point accept to relate it to her therapy (TR=23.80%), which however the therapist insists in interpreting to her as indeed being transferential. His attitude is strikingly reactive here, given we are at such an early phase. This session indeed gets the second highest rating for this mental state (REAC=50.8%).

Sessions 4 and 5. These sessions are unique in their showing the appearance of a significant portion of level three functioning, which is then at it's highest (M= 36.23%). Ninety-five percent of this is

aggressively determined, either in the form of a menacing persecutory experience (RTHRAPI) or a splitting towards an aggressively invested object relations (THRASP). The anxiety seems to have led to this increased regressive defensive posture. The neurotic and obsessional defenses as rated by the DMRS are at their highest during these two sessions (25.95% of all words). The therapist's global response is to be either silent or process-oriented (session 4) or process-oriented (73.30%, session 5). His silence during session 4 could be interpreted as a further maintenance of his reactive contribution in session 3, or as an appropriate withdrawal to feel through and understand the patient's transference as well as his own countertransference. Examination of immediate post-session written free associations confirms that this time his withdrawal was in the service of an appropriate reflective work, an understanding of a complementary attitude to her transference.

Sessions 6, 7 and 8. These three sessions seem to contain the intensification and culmination of this complex transference-countertransference encounter and impasse, which will be resolved by the patient's decision to end the therapy, first an unconscious decision which we can observe indirectly in session 9, but only later to be fully acknowledged, during session 14. As stated previously, these three sessions are characterized by a very clear intensification of the manifest transference.

Session 6 reveals a complex state of affairs. It indicates the disappearance of the level three persecutory experience or defensive splitting (RTHRAPI or THRASP), replaced first by a subtle form of quasi-four resistance, disguised as an alliance (QF-FOALL=30.13% an alliance felt ultimately to be part of the quasi-four resistance), and by other forms of obsessional and narcissistic quasi-four resistances (62.56%). If included under the overall quasi-four ratings, such "false alliance" moments observed in other sessions as well (i.e. 3,4,5,7,8 and 9), would increase the global quasi-four score to 75.37%. These observations make use once more of the time-honored distinction introduced by Freud between the manifest and latent contents of the material: manifestly, there is an on-going, one could even say at first view, a robust alliance between the patient's observing functions and the therapist's interpretive function. But beneath this surface, it can be seen that the overall context of some of these sessions, particularly perhaps sessions 3, 7, 8 and 9, has a definite quasi-four resistance mark. The therapist during session 6 is most withdrawn (silence= 52.42%) and process-oriented, an attitude similar to the one observed during session 4. It was at first difficult to ascertain whether this silence had a reactive-defensive function or not. You may note that the session ends with a reactive moment. After the patient left the reactive mental state is still apparent through the post-session response: he is angry. And this is carried on through the next session.

Session 7 is indeed striking on several accounts. First the manifest transference is at it's most intense, but precisely at a moment when the therapist's in-session mental state is the most reactive (55.43%). Not surprisingly perhaps, the patient's quasi-four activity is very high (72.79%). Further, the DMRS reveals for this session and next one a very high percentage of action defenses (36.20% and 36.56%), combining hypochondria (defined as a "help-rejecting-complaining" attitude) and passive-aggressive manifestations. It is also one of the three sessions (with 5 and 6) where no displacement (QFADIS category) is observed. Reading the session material, one can easily indeed observe a combination of a clear sense of drama, risk and misunderstanding. Even after the session the therapist can still be seen to be reactive, but in a more defensive way.

Session 8 demonstrates a further increase in the patient's defensive-narcissistic attitude (89.63%), which is then at it's strongest, and no doubt in part in response to her conflict which was just reenacted and thus consciously and unconsciously reconfirmed during the preceding session. The attitude is still manifestly in the transference, again in the form of the action defenses described above, but there is a return to some displacement (QFADIS). This time also, the therapist's mental state during the session would seem "cooler" as he has shifted to an objective-rational mode (OBR=54.05%), with nevertheless still some reactive moments (REAC=23.47%). This is reflected after the session in his interesting reflective involvement with his own experience in the transference.

Session 9. Session 9 could be described as a "closing-in and return to status quo". First this session still in part occurs within a transferential focus, it also initiates a clear reduction in the intensity of the immediate transference, which will never return to the level observed in the previous three sessions (TR= 32.92%). The overall quasi-four mental state is down from 89.63% to 58.27%, which is still a sizable portion, replaced in part by an important alliance activity (FOALL= 41.65%). This we interpret as discussed above, as a manifest collaborative attitude, but clearly embedded in the

underlying narcissistic resistance. Everything discussed now feels "safe", out of reach of the dangers represented by the therapy (and therapist). This view is supported by the return on the "front of defenses", to a situation which prevailed before sessions 7 and 8, of a dominance of the obsessional defenses (19.41%) and a simultaneous significant reduction in the action defenses (8.59%), as measured by the independent DMRS ratings. Paradoxically, but systematically in line with these important changes within the patient, the therapist here shows his most process-oriented session (88.81%) and absolutely no reactive moments.

Discussion

One main objective of this study was to test out the possibility of using the transference manifestations as an indication of the maturity of object relations as measured by the MTCM. Overall ratings of the clinical sessions here discussed indicate a clear predominance of a specific form of object relations, the quasi-four level of maturity, which would situate Mrs. A. in the range of the narcissistic character structures, reflecting her life-long struggle over her dependency needs. However, the MTCM ratings proved sensitive to the momentary shifts within the transference, as when some level three projective identification appeared, where particularly during sessions 4 and 5, she would project her harsh, malevolent object onto the therapist, while being in touch with her vulnerable self representation; as well her somatic-anxious preoccupations could be reflected in the ratings. Moments of therapeutic alliance were also at times predominant (see Table 4, sessions 1, 6 and 9), but the status of these alliance ratings (FOALL) was found to vary in more complex ways than was expected.

Interestingly, ratings for defenses were complementary to those provided for the affect-laden and defensively actualized object relations in the MTCM. Further, some complex combinations would also seem to occur. Certainly the most striking contribution of the DMRS came with the observation of the sharp increase of the "action defenses" during sessions 7 and 8, which, when combined with the MTCM "C" rating of the manifest register, gave a very useful portrait of the conflict being played out within the transference. This converged with other observations of the therapist's intensely reactive mental state.

A second major objective of this study was to investigate the use of the MTCM as an index of the contribution of the therapist to the process. In particular, the careful examination of three mental states were hypothesized as reflecting the countertransference. In our opinion this trial is satisfactory and very encouraging. Raters can differentiate between basically the same three mental states which we had previously defined. This then moves beyond the work we have reported elsewhere (Normandin & Bouchard, 1993; Lecours et. al**.**, 1995; Séguin & Bouchard, 1997), which was limited to reactions to vignettes presented to the therapist, in contrast to the present observation of in-session attitudes and activity. The MTCM therapist ratings seem to allow for finely tuned monitoring of the shifts in the therapists' attitude, as required by a process measure. Obviously further work is in order to validate this measure of therapist mental state, which will also benefit from a close examination of the therapist transferential focus and degree of inference.

It is clear already though, that the phenomenon of therapist mental state corresponds to just that: a mental state which varies considerably, and that it should not be considered a trait. Thus we do not think it would be pertinent to develop a typology of therapists based on the three categories used here. On the contrary, it still needs to be shown whether or not a given therapist systematically demonstrates, in recurring fashion, some stable, characterologically determined, mental state, across patients. More typical is our observation of important variations from session to session, and, in one limited observation (one therapist), from one patient to another.

References

Bienvenu, J.P., De Careful, F., Debbané, E., Lamoureux, P. Gaston, L & Szkrumelak, N. (1991). *The McGill Object Relations Scale***.** Montréal, Canada. Unpublished Documents.

Blatt, S.J., Brenneis, C., Schimek, J., & Glick, M. (1976). Normal and psychopathological impairment of the concept of the object on the Rorschach. *Journal of Abnormal Psychology, 85*, 364-373.

Bouchard, M.A., Lecomte, C., Charbonneau, H. & Lalonde, F. (1987). Inferential communications of expert psychoanalytically oriented, gestalt and behavior therapists. *Canadian Journal of Behavioral Sciences, 14*, 275-286.

Bouchard, M.A. Brueckmann, G., & Lecomte, C. (1987). Développement d'une grille d'analyse des inférences communiquées en psychothérapie. *Revue de Psychologie Appliquée, 37*, 215-233.

Bouchard, M.A., Normandin, L.,& Séguin, M.H. (1995b). Countertransference as obstacle and instrument: a comprehensive and descriptive framework. *Psychoanalytic Quarterly, LXIV*, 617-645.

Diamond, D., Kaslow,N., Coonerty, S. & Blatt, S.J. (1990). Changes in separation-individuation and intersubjectivity in long-term treatment. *Psychoanalytic Psychology, 7*, 363-397.

Dymetryszyn, H. (1996). *The Object Relations Clinical Scale (ORCS)*. Unpublished document, part of a Doctoral Dissertation, Université de Montréal.

Dymetryszyn, H., Bouchard, M.A., Bienvenu, J.P., De Carufel, & Gaston, L. (1997). Overall Maturity of Object Relations as Assessed by the McGill Object Relations Scale. *Bulletin of the Menninger Clinic, 61*, 44-72.

Fliess, R. (1942). The metapsychology of the analyst. *Psychoanal. Q., 11*, 211-227.

Fowler, C., Hilsenroth, M.J. & Handler, L. (1995). Early memories: An exploration of theoretically derived queries and their clinical utility. *Bulletin of the Menninger Clinic, 59*, 79-98.

Freud, A. (1936\1982). *The Ego and the Mechanisms of Defense*. New York: Int. Univ. Press.

Freud, S. (1905). Three essays on the theory of sexuality. *S.E.*, 7, 125-245. London: Hogarth Press, 1953.

Freud, S. (1910). The future prospects of psychoanalytic therapy. *S.E.,11*, 141-151.

Freud, S. (1912b). Recommendations to physicians practicing psychoanalysis. *S.E., 12*, 111-120.

Freud, S. (1915). Observations on transference-love (further recommendations on the technique of psycho-analysis III). *S.E., 12*, 157-171.

Freud, S. (1923). The ego and the id. *S.E., 19*, 12-66. London: Hogarth Press, 1953.

Gill, M. M. (1979). The analysis of the transference. *J. Amer. Psychoanal. Assn., 27*, (Suppl.): 263-288.

Gill, M. M. (1982). *The Analysis of Transference*. New York: Int. Univ. Press. Vol. I. Theory and Technique.

Gill, M. M. & Hoffmann, I. Z. (1982). A method for studying the analysis of aspects of the patient's experience of the relationship in psychoanalysis and psychotherapy. *J. Amer. Psychoanal. Assn., 30*, 137-167.

Giorgi, A. (1970). *Psychology as a Human Science. A Phenomenologically Based Approach*. New York: Harper & Row.

Gitelson, M. (1952). The emotional position of the analyst in the psycho-analytic situation. *Int. J. of Psychoanal., 33*, 1-10.

Gray, P. (1994). *The Ego and Analysis of Defense*. Northvale, NJ: Aronson.

Grinberg, L. (1962). On a specific aspect of countertransference due to the patient's projective identification. *Int. J. Psychoanal., 43*, 436-440.

Grinberg, L. (1979). Countertransference and projective counter-identification. *Cont. Psychoanal., 15*, 226-247.

Jacobson, E. (1964). *The Self and the Object World*. New York: Int. Univ. Press.

Jacobson, E. (1971). *Depression*. New York: Int. Univ. Press.

Kantrowitz, J.L., Katz, A.L., Paolitto, F., Sashin, J. & Solomon, L. (1987). Changes in the level and quality of object relations in psychoanalysis: Follow-up of a longitudinal prospective study. *Journal of the American Psychoanalytic Association, 35*, 23-46.

Kernberg, O. (1965). Notes on countertransference. *J. Amer. Psychoanal. Assn., 13*, 38-56.

Kernberg, O. (1987). Projective Identification, Countertransference and Hospital Treatment. *Psychiatric Clinics of North America, 10*, 257-272.

Kernberg, O.F. (1975). *Borderline Conditions and Pathological Narcissism*. New York: Aronson.

Kernberg, O.F. (1976). *Object-Relations Theory and Clinical Psychoanalysis*, Northvale: Aronson. In particular chaps. 1 and 2.

Kernberg, O.F. (1984). *Severe Personality Disorders*. New Haven: Yale Univ. Press.

Kernberg, O.F. (1991). Transference Regression and Psychoanalytic Technique with Infantile Personalities. I*nt. J. of Psycho-Anal., 72*, 189-200.

Kernberg, O.F. (1992). *Aggression in Personality Disorders and Perversions*. New Haven: Yale Univ. Press.

Kernberg, O., Selzer, M.A., Koenigsberg, H.W., Carr, A.H., Appelbaum. (1989). *Psychodynamic Psychotherapy of Borderline Patients*. New York: Basic Books.

Klein, M. (1946). Notes on some schizoid mechanisms. In. Klein, M. Heimann, P., Isaacs, S. and Riviere, J. *Developments in Psycho-Analysis*. London: Hogarth Press. 1952. Pp. 292-320.

Klein, M. (1952). The origins of transference. In *Envy and Gratitude*. London: Virago, 1988, pp. 48-56.

Koenigsberg, H.W., Kernberg, O.F., Rockland, L., Appelbaum, A., Carr, A. & Kernberg, P. (1988). Developing an instrument for characterizing psychotherapy techniques in studies of the psychotherapy of borderline patients. *In* Dahl, H., Kächele, H. & Thomä, H. (Eds.). *Psychoanalytic Process Research Strategies*. Berlin: Springer-Verlag, 1988, Pp. 147-162.

Krohn, A. & Mayman, M. (1974). Object representations in dreams and projective tests. *Bulletin of the Menninger Clinic, 38*, 445-466.

Langs, R. (1982). *Psychotherapy: a Basic Text*. New York:Aronson.

Lecours, S., Bouchard, M.A., & Normandin, L. (1995). Countertransference as the therapist's mental activity: experience and gender differences among psychoanalytically oriented psychologists. *Psychoanalytic Psychology, 12* 259-279.

Normandin, L. & Bouchard, M.A. (1993b). The Effects of Theoretical Orientation and Experience on Rational, Reactive and Reflective Countertransference. *Psychotherapy Research,3*, 77-94.

Perls, F.S., Hefferline, R. & Goodman, P. (1951\1977). *Gestalt Therapy*. New York: Bantam.

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanal. Q., 26*, 303-357.

Racker, H. (1968). *Transference and Counter-transference*. London: Hogarth.

Rank, O. (1936/1978) *Will Therapy*. New York: Norton.

Reik, T. (1949). *The Inner Experience of a Psychoanalyst*. London: Allen & Unwin.

Ryan, E.R. & Bell, M.D. (1984). Changes in object relations from psychosis to recovery. *Journal of Abnormal Psychology, 93,* 209-215.

Segal, H. (1964/1982). *Introduction to the Work of Melanie Klein*. London: Hogarth Press.

Séguin, M.H. & Bouchard, M.A. (1997). Adaptive Regression and Countertransference Mental Activity. *Psychoanalytic Psychology, 13,* 457-474.

Smith, T.E. (1993). Measurement of object relations. *Journal of Psychotherapy Practice and Research, 2,* 19-37.

Westen, D. (1990). Toward a revised theory of borderline object relations: Contributions of empirical research. I*nternational Review of Psychoanalysis, 71*, 661-693.

Westen, D., Lohr, N., Silk, K., Gold, L. & Kerber, K. (1990). Object relations and social cognition in borderlines, major depressives, and normals: A Thematic Apperception Test analysis. *Psychological Assessment, 2*, 355-364.

Westen, D., Ludolph, P., Block, J., Wixom, J., & Wiss, F.C. (1990). Developmental history and object relations in psychiatrically disturbed adolescent girls. *American Journal of Psychiatry, 147*, 1061-1068.