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Countertransference as object of empirical research?

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

Key words: *Countertransference, measure, psychoanalysis, quantitative studies, qualitative studies, psychotherapy 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, we can 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, Dare, and Holder (1973, p.48) 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.

The same holds true for countertransference as a phenomenon that started its history in psychoanalysis as Cinderella, finally turning into a radiant princess (see Chapter 3 in Thomä & Kächele, 1994a).

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 actualize a transference fantasy. These ideas, in conjunction with the contributions of the social constructivists and relational theorists, as well as Sandler's conceptualization 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 that started as a formal scientific activity around the 1950s in the centers of psychoanalytic empirical research. In order to organize the material, we shall use a graphic representation for five phases of research (Figure 1) (Kächele & Strauss, 2000).

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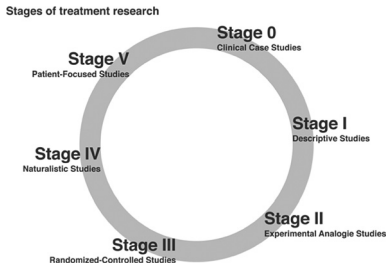

Figure 1.

Clinical case studies

Using the PEP database and searching for the term "countertransference" in the titles of papers, around 730 articles using the term countertransference are returned from 1952 until 2012; since 2000, the information provided (193 papers and books) underlines that countertransference is indeed enjoying a high degree of attention. It would be a Herculean task to categorize the varieties of uses. As an illustration, we quote from a paper by Betan and Westen (2009, p. 179) that conveys a fairly typical clinical experience – any clinician will recognize the countertransference issues involved:

> From the start, the patient criticized his therapist's therapeutic style, choice of words, and efforts to explore his reactions. Most times the therapist ventured to speak, her words triggered the patient's angry outbursts. He demanded the therapist repeat verbatim the words he wanted to hear, and it seemed he could not tolerate anything but perfect and absolute mirroring. Paraphrasing, using synonyms, pointing out the controlling quality of his demands brought an onslaught of criticism of the therapist's personhood with accusations that the therapist was inhumane, disingenuous, and even nonhuman. The patient's efforts to dehumanize and annihilate the therapist intensified during periods of consistent attendance. Normally, however, the patient arrived 30 min late if he arrived at all.
>
> 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.

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 occurrence 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 adding to clinically relevant knowledge.

Descriptive studies

Descriptive studies as a formal research activities fulfill the task of systematically describing the phenomena under scrutiny. Singer and Luborsky (1977, p. 483) 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."

The first systematic attempts to capture 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, by a series of questions, to assess the extent to which countertransference had hindered the therapy. Luborsky et al. (Luborsky,

Fabian, Hall, Ticho, & Ticho, 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) in studying the emotional reactions of three analysts who recorded their feelings on a notepad while in session.

In the early 1970s, the Ulm group, on single-case process research, analyzed the formal judgment of the degree of transference and countertransference by both the analyst and a second participant observer who listened to the first recording of a psychoanalysis in Germany. A factor analysis of the twofold datasets showed clearly that both the 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 (Kächele, 1971).

Sometimes the noninclusion of countertransference as an object of study is also informative. Graff and 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 have used recorded sessions try to catch the disruptive emotional involvement of a therapist. For example, the Psychotherapy Process Q-Set (PQS; Jones, 2000) identifies whether or not a therapist's emotional response (the countertransference reaction) intrudes into the patient–therapist relationship (PQS Item 24). In a comparison of three psychotherapy samples, Seybert et al. (2011) found that emotional conflicts intruded less into the short-term psychodynamic psychotherapy sample than among the longer forms of treatments. Among the longer treatments, the emotional conflicts were seldom observed or were even considered irrelevant by the observers.

Here one may question how accurate an observation of the therapist's emotional response from the outside can be. Not only is it difficult for an observer to determine if a therapist's response derives from the therapist's own emotional or psychological conflicts, but also it may be the case that disruptive responses are easier to capture than emotional responses that do not intrude into the therapy relationship inappropriately. The latter may also be the case in therapeutic practice.

While being aware of the limitations of countertransference observation (the PQS rater is different from a supervisor that knows about the therapist's 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 the 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 toward or lacking acceptance of the patient (Item 18) can be an important indicator of acting out countertransference.

Here we can see that the PQS can greatly contribute to 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. It is necessary here to interpret the context of the relevant process items that describe the interaction within the dyad. A therapist who demonstrates condescending or patronizing (Item 51) or tactless (Item 77) behavior toward the patient in the context of a patient who is controlling within the session (Item 87) and/or who tests the boundaries of the relationship (Item 20) is different than the situation occurring with a patient who is compliant, collaborating, and so on.

It is relevant to identify the interpersonal context in which countertransference reactions occur not only for clinical, but also for research purposes. 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 excel the often rather crude quantitative approaches. However, as we shall detail later in the 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 1950s and 60s, a number of researchers generated truly experimental approaches to studying 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 propensities for countertransference was performed by Beckmann (1974). Applying a psychoanalytically informed but psychometrically sound questionnaire, the Giessen-Test (Beckmann & Richter, 1972), he studied a group of psychoanalytic candidates who observed many patients in an initial psychoanalytic interview through a one-way window. The patients and candidates all had to fill out the same questionnaire about themselves, and the candidates had to describe all patients with the instrument.

Beckmann's (1974) findings were fairly strong: candidates who qualified with higher levels of depressive features overrated the degree of hysterical features in the patients; conversely, 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). Good proof of Freud's idea of personal equation (1951) was thus demonstrated by good experimental work.

Furthermore, it became clear from this study 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 countertransference. In addition to this, concrete clinical instances might lead to more or less actualization 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. And why not, 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 could be performed with real patients. However, it might be feasible to conceive a study in which therapists with low or high habitual countertransference propensity could be randomized.

Naturalistic studies

This type 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 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, and Hummel (2011). They reviewed three meta-analyses. The first focused on the impact of countertransference on the outcome of treatment; the second considered the issue of whether the capacity to manage countertransference reduced the actualization of countertransference feelings; and the third asked whether managing countertransference improved the outcome.

The instrument used by all included studies was the *Countertransference Factors Inventory* (CFI), which exists in three versions: the CFI (Van Wagenor, Gelso, Hayes, & Diemer, 1991) with 50 items and two shorter versions; the CFI-D (Gelso, Latts, Gomez, & Fassinger, 2002) with 21 items; and the CFI-R (Hayes, Riker & Ingram, 1997) with 27 items. The CFI captures features of therapists that describe the handling of countertransference and the functioning of a therapist in the therapeutic situation. The instrument consists of five subscales: self-insight, self-integration, anxiety management, empathy, and conceptualizing ability. The CFI may be used as self-rating instrument or can be applied by a rater, for example the supervisor. What follows is a simplified presentation of the findings of the meta-analyses:

1. Countertransference responses show a negative yet numerically small correlation with treatment outcome ($r = -0.16$, $p = 0.002$, 95% CI -0.26, -0.06, $N = 769$ participants, $k = 10$ studies; Table 1).
2. Factors of countertransference management play only a small role in the mitigation of countertransference reactions ($r = -0.14$, $p = 0.10$, 95% CI -30, 0.03, $N = 1065$ participants, $k = 11$ studies; Table 2).
3. Management of countertransference is associated with better treatment outcomes ($r = 0.56$, $p = 0.000$, 95% CI 0.40, 0.73, $N = 478$ participants, $k = 7$ studies; Table 3).

The handling of the management of countertransference depends mainly on the personal qualities of the therapists (Hayes et al. 2011). If they show certain features (e.g., self-awareness) or are able to implement certain exercises (e.g., meditation), they are more likely to handle their countertransference. However, certain characteristics 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.,

Table 1. Studies on the relationship between countertransference and outcome

Authors	*N* (sample size)	Design	Setting	*r* (correlation coefficient)
Mohr, Gelso, & Hill (2005)	88 P, 27 Th[a]	Correlational	Laboratory	−0.04
Myers, & Hayes (2006)	224	Experimental	Laboratory	−0.04
Cutler (1958)	5 P, 2 Th[a]	Correlational	Naturalistic	−0.24
Rosenberger, & Hayes (2002b)	1 P, 1 Th	Correlational	Naturalistic	−0.06
Ligiero, & Gelso (2002)	50[a]	Correlational	Naturalistic	−0.32**
Hayes, Riker, & Ingram (1997)	20 P, 20 Th[a]	Correlational	Naturalistic	−0.33
Hayes, Yeh, & Eisenberg (2007)	69 P, 69 Th	Correlational	Naturalistic	−0.03
Nutt Williams, & Fauth (2005)	18 P, 18 Th	Correlational	Laboratory	−0.37
Yeh, & Hayes (2010)	116	Experimental	Laboratory	−0.38***
Bandura, Lipsher, & Miller (1960)	12 P, 17 Th	Correlational	Naturalistic	−0.53*

Note: These references are cited and abbreviated from Hayes, Gelso, and Hummel (2011).
P, patients; Th, therapists.
[a]Therapists were students in psychotherapy training.
*$p \leq 0.05$, **$p \leq 0.01$, ***$p \leq 0.001$ (p value one-tailed).

1998). Therefore the demonstrated negative correlation between countertransference 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 beneficial for the treatment outcome. The capacity to management one's countertransference reactions in a reflective way supports positive results of the therapeutic effort. The countertransference-interaction hypothesis (Gelso & Hayes, 2007) has confirmed that specific patient variables interact with certain conflicts of the therapist. Thus, the key for a therapeutic usefulness of countertransference resides in the connection between theory and personal knowledge (Polanyi, 1958).

Habitual countertransference

Experimental research on the social psychology of transference (Miranda & Anderson, 2010) provides good evidence that therapists are also vulnerable to operating under the spell of their own idiosyncratic transferential tendencies. This endorses the idea of habitual countertransferences, which was also taken up by Drew Westen´s research group in Atlanta, USA. 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, this group has designed the *Countertransference Questionnaire* (Betan, Heim,

Table 2. Studies on the relationship between management of countertransference and countertransference reactions

Autors	*N* (Sample size)	Design	Setting	*r* (correlation coefficient)
Gelso, Fassinger, Gomez, & Latts (1995)	68[a]	Experimental	Laboratory	−0.04
Robbings, & Jolkovski (1987)	58[a]	Correlational	Laboratory	−0.04
Forester, (2001)	96	Correlational	Naturalistic	−0.10
Kholocci, (2007)	203	Correlational	Naturalistic	−0.15
Hayes, Riker, & Ingram (1997)	20 P, 20 Th[a]	Correlational	Naturalistic	−0.18
Peabody, & Gelso (1982)	20 P, 20 Th[a]	Correlational	Naturalistic	−0.24
Nutt Williams, Hurley, O'Brian, & Degregorio (2003)	301	Correlational	Naturalistic	0.29*
Nutt Williams, & Fauth (2005)	18 P, 18 Th[a]	Correlational	Laboratory	−0.43***
Latts, & Gelso (1995)	47 Th[a]	Correlational	Laboratory	−0.45***
Hofsess, & Tracey (2010)	35 Th[a],12 S	Correlational	Naturalistic	−0.57***
Friedman, & Gelso (2000)	149 Th	Correlational	Naturalistic	−0.59***

Note: These references are cited and abbreviated from Hayes, Gelso, and Hummel (2011).
P, patients; S, supervisors; Th, therapists.
[a]Therapists were students in psychotherapy training.
*$p \leq 0.05$, **$p \leq 0.01$, ***$p \leq 0.001$ (p value one-tailed).

Table 3. Studies on the relationship between management of countertransference and outcome

Authors	*N* (Sample size)	Design	Setting	*r* (correlation coefficient)
Rosenberger, & Hayes (2002b)	1 P, 1 Th	Correlational	Naturalistic	0.38***
Fauth, & Williams (2005)	17 P, 17 Th[a]	Correlational	Laboratory	0.17***
Nutt Williams, & Fauth (2005)	18 P, 18 Th	Correlational	Laboratory	0.18
Gelso, Latts, Gomez, & Fassinger (2002)	63 P, 32 Th[a], 15 S	Correlational	Naturalistic	0.39**
Peabody, & Gelso (1982)	20 P, 20 Th[a]	Correlational	Laboratory	0.42*
Van Wagoner, Gelso, Hayes, & Diemer (1991)	122 P	Experimental	Laboratory	0.55***
Latts (1996)	77 P, 77 Th[a]	Correlational	Naturalistic	0.89***

Note: These references are cited and abbreviated from Hayes, Gelso, and Hummel (2011).
P, patients; S, supervisors; Th, therapists.
[a]Therapists were students in psychotherapy training.
*$p \leq 0.05$, **$p \leq 0.01$, ***$p \leq 0.001$ (p value one-tailed).

Conklin, & Western, 2005). This instrument assesses the range of cognitive, affective, and behavioral responses that therapists have to their patients. The authors 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 had never been subject to empirical investigation. To show in concrete terms 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 = 0.90)
This 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 0.72
- I wish I had never taken him/her on as a patient 0.71
- When checking phone messages, I feel anxiety or dread that there will be one from him/her 0.69
- She/he frightens me 0.67
- I feel used or manipulated by him/her 0.62
- I return his/her phone calls less promptly than I do with my other patients 0.61
- I call him/her between sessions more than my other patients 0.60
- I think or fantasize about ending the treatment 0.59
- I feel mistreated or abused by him/her 0.55
- I feel pushed to set very firm limits with him/her 0.54
- I feel angry at him/her 0.52
- I feel repulsed by him/her 0.50

Factor 2: Helpless/Inadequate (coefficient alpha = 0.88)
This 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 0.84
- I feel incompetent or inadequate working with him/her 0.80
- I feel hopeless working with him/her 0.78
- I think s/he might do better with another therapist or in a different kind of therapy 0.67
- I feel overwhelmed by his/her needs 0.62
- I feel less successful helping him/her than other patients 0.62
- I feel anxious working with him/her 0.61
- I feel confused in sessions with him/her 0.52

Factor 3: Positive (coefficient alpha = 0.86)
This characterizes the experience of a positive working alliance and close connection with the patient.

- I look forward to sessions with him/her 0.69
- S/he is one of my favorite patients 0.67
- I like him/her very much 0.67
- I find it exciting working with him/her 0.58
- I am very hopeful about the gains s/he is making or will likely make in treatment 0.52
- I have trouble relating to the feelings s/he expresses 0.48
- If s/he were not my patient, I could imagine being friends with him/her 0.44
- I feel like I understand him/her 0.43
- I feel pleased or satisfied after sessions with him/her 0.43

Factor 4: Special/Overinvolved (coefficient alpha = 0.75)
This 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 0.64
- I self-disclose more about my personal life with him/her than with my other patients 0.64
- I do things, or go the extra mile, for him/her in way that I don't do for other patients 0.52
- I feel guilty when s/he is distress or deteriorates, as if I must be somehow responsible 0.39
- I end sessions overtime with him/her more than with my other patients 0.39

The factor structure offers a complex portrait of countertransference processes that highlights 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, the authors identified distinct experiences of negative countertransference – that is, feeling overwhelmed and disorganized, helpless and inadequate, disengaged, or mistreated by 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 reported 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 to understand and anticipate their reactions toward patients, as well as further clarifying how countertransference influences clinical work and can have diagnostic value.

Although the clinical literature is rich in cogent descriptions of therapists' 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, allows pooling of the experience of dozens of clinicians and thereby identifies 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. Taking a step further, one encounters the tendency to speak of the here-and-now in which everything the patient says is transference and everything the analyst contributes speaks of his or her countertransference. The traditional effort to distinguish between the real relationship, the therapeutic alliance, and the transference is loosening (Gelso, 2011), the distinctions having been flattened out by the concept of comprehensive countertransference. The same process also can be observed in empirical research. The microscopic level of observing therapeutic interaction leads to the disappearance of the notions of transference and countertransference:

> 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. (Rasting & Beutel, 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 into the qualitative analysis of countertransference has stemmed 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 Searles "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 aligns with a fundamental view of the therapeutic encounter being a (micro)social endeavor. Freud had 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 McLeod's outstanding book (2011). This might be due to a bifurcation in research interests. On one side are qualitative researchers who make their way by analyzing 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 such as "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 lies in "naturalistic data," which means analyzing original talk-in-interaction and viewing therapy as a co-production of at least two participants. Short examples will now be presented of each approach.

We will conclude by 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, Wiseman, and Orkinsky (2009) focused on an important aspect of countertransference: holding 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, as well as for therapists and clients. Often clients cannot imagine that a therapist thinks about them between 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. (p. 43)

A sample of 1,040 therapists from the USA, Canada, and New Zealand were confronted with questions such as how often in the last week they had thought of their patients, how often they felt a loss of confidence in finding a solution to treatment impasses, and how often they actively tried to view things from a different perspective. The analysis of the answers was twofold: such thoughtful engagements are both "work-related" and "affect-related":

> 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., 2009, p. 50)

These authors conclude that research has paid much attention to the cognitive, affective, and relational schemata of client, and analysis of such schemata on the therapist's side should become equally relevant. Therapists become part of an interactive system that exerts powerful effects on their affective status and cognitive organization. This kind of research leads to doubts over whether 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 less helpful for use as a standard of "correct treatment technique" against which countertransference could be contrasted. Obviously, well-trained therapists open themselves far more to the patients' influence than a standpoint of "technical standard" can imagine, so they are exposed to mighty experiences of countertransference. How far this powerful influence is stretched out is examined in another qualitative interview study by Spangler, Hill, Mettus, Guo, and Heymsfield (2009), which carries an interesting title: "Therapist perspectives on their dreams about clients."

In 1977, the German psychoanalyst Ralf Zwiebel (1977) published an impressive self-reflective essay on the analyst's dreams of clients and concluded that this kind of dream points to feelings of inferiority and insufficiency. Spangler et al. (2009) formulated the following purpose for 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 were interviewed twice, before the interviews were transcribed and analyzed in a group; this follows the consensual qualitative research approach as described by Hill et al. (Hill, Thompson, & Williams, 1997; Hill et al., 2005). Group members wrote their memos in a research diary, and 15 dreams about 13 clients were reported and analyzed. Therapists often have their first dreams at the beginning of their career: there are dreams on special clients, and dreams often document a feeling of excessive demand and high workload (more than 10 sessions per day). The researchers were interested in not only the dream material, but also what therapists made of it. They found that dreams were often used as a sign to change something in the therapist's life, while others used their dreams as stimulus for a creative change of views or for finding a poetic word. Even spiritual dimensions appeared in dreams. The researchers concluded:

> 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. (Spangler et al. 2009, p. 93)

So Zwiebel's (1977) clinical discovery 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 such as 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 on 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 at first view to be chaotic and "disordered." To analyze "category-bound activity" makes visible the ways in which 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, and so on. 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" that cannot be dispensed in interaction.

Categorization is a kind of organizing events. We have not only hierarchical or radial categories, but also metaphorical categorizations (Lakoff, 1987): Buchholz (1996/2003) 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 have understood the other's utterance. Traditionally, conversation and cognition were thought to be strange continents inhabited by different tribes of researchers with different paradigms. Molder and Potter (2005) see a scientific development that brings these continents closer to each other. (Molder & Potter, 2005) and that 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, 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" (p. 237) and structures a somewhat chaotic dream experience with 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 in clients coping with medical diagnoses. Like Hanke (2001), they find that telling a story is not only a reproduction but also 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 there are in every story dominant aspects – the main story line – and side effects. Side effects such as adding a detail or digression from a topic indicate a change in coping process. And what is more, storytelling is an activity that has to control the listener's attentiveness. So storytellers sometimes make pauses and cast a glance toward 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 up the conversational activity by presenting *their* questions but stay attentive and silent. In this way, a conversational space is opened up to which the patient can bring 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 that 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 countertransference. Peräkylä analyzed 58 transcribed sessions from two analysts and three patients and focused on how patients

responded to the analyst's interpretation. Analysts responded with a modification of the patient's response, most often by emotional intensification, or picked up a side aspect of what the patient had answered. This was done in a non-marked way and helped to tailor 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, in press) that 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) have termed "non-interpretative mechanisms." So it seems that modern audio and video techniques, used by conversation analysts since the 1960s in a similar way, really open up 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) "antimentalism" 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 what the future role of countertransference will be.

Observing therapeutic interaction

Studies on observing therapeutic interaction seem to have the potential to contribute to what the "clinical facts" are. We have already mentioned the work of Rasting & Beutel (2005). These authors found, in a small sample of 15 clients treated by two therapists, that observing the facial affective behavior of both participants could predict the successful (or otherwise) outcome of treatment.

Benecke and Krause (2005) came to a similar result. They considered affective facial behavior as a tool unconsciously used by 20 patients with panic 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, was expressed in a constant facial smiling behavior. However, this hypothesis could not be completely confirmed. The authors found it necessary to differentiate between two subgroups of patients with panic as half of them showed disgust or contempt as their leading affective facial behavior. It seems to be important how therapists react to this influential microbehavior and how they contribute to it unconsciously.

Merten (2005) describes how 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" (p. 330). Microanalyses 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, found that there was a fine granulated synchronization of such affective facial behavior between therapists and patients – and when this synchronization was constantly observed, it acted as a predictor of a negative outcome of therapy. "Joining" the patient's smiling behavior might then lead to diagnosing the patient as more severely disturbed than thought before – this is a clear countertransference reaction that appears not in the domain of the 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, p. 254) terms the "guru type," willingly following unconscious relational offers from the patient, entering a critical sphere of abuse of the therapeutic relationship. The third group of therapists contributes to the failure of therapy by being aware of the patient's smiling but not being able to refuse to react in a complementary way. This group are aware of their feelings, forced to respond and unable 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 and Sandler (1994). The present unconscious dimension

seems to be as important as the past dimension of the unconscious.

Furthermore, we would like to conclude that there are two general levels of interactional events. One is an *affective* level while talk-in-interaction happens; the other is a *symbolic* level of interaction order with the subdimensions of organizing sequentiality and of category-bound activities as studied by conversation analysts. The example of downgrading a diagnosis (symbolic) influenced by an affective conflict held unconsciously shows how these two levels influence each other. Conversation analysts have a subtle ear for these dimensions and have shown the importance of the role that is played by pauses, interruptions, turn-takings, tags, and so on. These can be considered to be affective elements at a 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 their awareness and management of the myriad reactions they have toward patients. What uses will such research instrumentation have for training 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 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 can – in the light of these (and other) studies – be seen as an integral part of psychoanalytic interaction, but its definition covers a wide range of views. 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 for analyzing "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 with more than 300 patients that significant changes can hardly be understood by measuring patient variables alone; client change was most often preceded by a significant change in the therapist's countertransference, especially when dealing with projective and externalizing mechanisms (Löffler-Stastka, Bleuml, & Boes, 2010). Here quantitative and qualitative research results converge convincingly with clinical experience.

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

References

Bandura, A. (1956). Psychotherapists' anxiety level, self-insight and psychotherapeutic competence. *Journal of Abnormal and Social Psychology*, *52*, 333–7.

Beckmann, D. (1974). *Der Analytiker und sein Patient. Untersuchungen zur Übertragung und Gegenübertragung* [The analyst and his patient. Studies on transference and countertransference]. Bern: Huber.

Beckmann, D. (1988). Aktionsforschungen zur Gegenübertragung. Rückblick auf ein Forschungsprogramm [Action research on countertransference. Review of a research program]. In P. Kutter & D. Beckmann (Eds.) *Die psychoanalytische Haltung* (The psychoanalytic attitude) (pp. 231–244). München: Verlag Internationale Psychoanalyse.

Beckmann, D., & Richter, H.-E. (1972). *Gießen-Test. Ein Test für Individual- und Gruppendiagnostik* [Giessen-Test. A test for individual and group diagnostics]. Bern: Huber.

Benecke, C., & Krause, R. (2005). Facial affective relationship offers of patients with panic disorder. *Psychotherapy Research*, *15*, 178–87.

Bergman, P. (1966). An experiment in filmed psychotherapy. In L.A. Gottschalk & A.H. Auerbach (Eds.) *Methods of research in psychotherapy* (pp. 35–49). New York: Appleton-Century-Crofts.

Betan, E.J., & Westen, D. (2009). Countertransference and personality pathology: Development and clinical application

of the Countertransference Questionnaire. In R.A. Levy & J.S. Ablon (Eds.) *Handbook of evidence-based psychodynamic psychotherapy. Bridging the gap between science and practice* (pp. 179–198). New York: Humana Press.

Betan, E., Heim, A.K., Conklin, C.Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry*, *162*, 890–8.

Buchholz, M.B. (1996/2003). *Metaphern der "Kur". Qualitative Studien zum therapeutischen Prozeß* [Metaphors of the cure. Qualitative studies on the therapeutic process] (2nd ed). Giessen: Psychosozial-Verlag.

Buchholz, M.B. (in press). Growth – what reconciliation of conflicts could mean. A lesson from the history of psychoanalysis. *International Forum of Psychoanalysis*.

Cox, R.D. (2012). Teaching qualitative research to practitioner-researchers. *Theory into Practice*, *51*, 129–36.

Fiedler, F.E. (1951). A method of objective quantification of certain countertransference attitudes. *Journal of Clinical Psychology*, *7*, 101–7.

Gabbard, G.O. (1995). Countertransference: The emerging common ground. *International Journal of Psychoanalysis*, *76*, 475–85.

Gelso, C.J. (2011). *The real relationship in psychotherapy. The hidden foundation of change*. Washington, DC: American Psychological Association.

Gelso, C.J., & Hayes, J.A. (2007). *Countertransference and the inner world of the psychotherapist: Perils and possibilities*. Mahwah, NJ: Lawrence Erlbaum.

Gelso, C.J., Latts, M., Gomze, M., & Fassinger, R.E. (2002). Countertransference management and therapy outcome. *Journal of Clinical Psychology*, *58*, 861–7.

Graff, H., & Luborsky, L. (1977). Long-term trends in transference and resistance: A quantitative analytic method applied to four psychoanalyses. *Journal of the American Psychoanalytic Association*, *25*, 471–90.

Gülich, E., Knerich, H., & Lindemann, K. (2009). Rekonstruktion und (Re-) Interpretation in Krankheitserzählungen [Reconstruction and re-interpretation in illness narratives]. *Psychoanalyse - Texte zur Sozialforschung*, *13*, 110–24.

Hanke, M. (2001). *Kommunikation und Erzählung* [Communication and narrative]. Würzburg: Königshausen & Neumann.

Hayes, J.A., Riker, J.B., & Ingram, K.M. (1997). Countertransference behavior and management in brief counseling: A field study. *Psychotherapy Research*, *7*, 145–54.

Hayes, J.A., McCracken, J.E., McClanahan, M.K., Hill, C.E., Harp, J.S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative date in search of a theory. *Journal of Counseling Psychology*, *45*, 468–82.

Hayes, J.A., Gelso, J.C., & Hummel, A.M. (2011). Managing countertransference. *Psychotherapy*, *48*, 88–97.

Heimann, P. (1950). On counter-transference. *International Journal of Psychoanalysis*, *31*, 81–4.

Hill, C.E., Thompson, B.J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *Counseling Psychology*, *25*, 517–72.

Hill, C.E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*, 196–2005.

Høglend, P., Amlo, S., Marble, A., Bögwald, K-P., Sörbye, Ö., Sjaastad, M.C., & Heyerdahl, O. (2006). Analysis of the patient-therapist relationship in dynamic psychotherapy: An experimental study of transference interpretation. *American Journal of Psychiatry*, *163*, 1739–46.

Jefferson, G. (1992). *Harvey Sacks - Lectures on conversation*. Oxford/Cambridge: Blackwell.

Jones, E.E. (2000). *Therapeutic action: A guide to psychoanalytic therapy*. Northvale, NJ: Jason Aronson.

Kächele, H. (1971). *Zur Dimensionalität klinisch-psychoanalytischer Stundenbeurteilungen* [On the dimensionality of clinical session ratings]. Unpublished report. Ulm: Abteilung Psychotherapie, Universität Ulm.

Kächele, H., & Strauss, B. (2000). Phases of research in psychotherapy research. In M. Siwiak-Kobayashi, S. Leder, C. Czabala, & T. Sakuta (Eds.) *Psychotherapy at the turn of the century from past to future. Proceedings of the 17th World Congress of Psychotherapy* (pp. 85–95). Warsaw: Polish Psychiatric Association.

Kohut, H. (1959). Introspection, empathy, and psychoanalysis. An examination of the relationship between mode of observation and theory. *Journal of the American Psychoanalytic Association*, *7*, 459–83.

Kohut, H. (1968). The evaluation of applicants for psychoanalytic training. *International Journal of Psychoanalysis*, *49*, 548–54.

Krause, R. (2005). *Das Gegenwartsunbewusste als kleinster gemeinsamer Nenner aller Techniken* [The present unconscious as the shared consensus of all techniques]. In G. Poscheschnik (Ed.), *Empirische Forschung in der Psychoanalyse. Grundlagen - Anwendungen – Ergebnisse* (Empirical research in psychoanalysis. Foundation - application - findings) (pp. 25–40). Giessen: Psychosozial-Verlag.

Labov, W., & Fanshel, D. (1977). *Therapeutic discourse. Psychotherapy as conversation*. New York: Academic Press.

Lakoff, G. (1987). *Women, fire, and dangerous things. What categories reveal about the mind*. Chicago: University of Chicago Press.

Löffler-Stastka, H., Blueml, V., & Boes, C. (2010). Exploration of personality factors and their predictive impact on therapy utilization: The externalizing mode of functioning. *Psychotherapy Research*, *20*, 295–308.

Luborsky, L., Fabian, M., Hall, B.H., Ticho, E., & Ticho, G.R. (1958). Treatment variables. *Bulletin of the Menninger Clinic*, *22*, 126–47.

McLeod, J. (1996). Qualitative approaches to research in counselling and psychotherapy: Issues and challenges. *British Journal of Guidance & Counselling*, *24*, 309–16.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London: Sage.

Merten, J. (2005). Facial microbehavior and the emotional quality of the therapeutic relationship. *Psychotherapy Research*, *15*, 325–33.

Meyer, A.E. (1988). What makes psychoanalysts tick? In H. Dahl, H. Kächele, & H. Thomä (Eds.) *Psychoanalytic process research strategies* (pp. 273–290). Berlin: Springer.

Miranda, R., & Andersen, S.M. (2010). The social psychology of transference. In J.E. Maddux & J.P. Tangney (Eds.) *Social psychological foundations of clinical psychology* (pp. 476–497). New York: Guilford Press.

Molder, H., & Potter, J. (Eds.) (2005). *Conversation and cognition*. Cambridge/New York: Cambridge University Press.

Peräkylä, A. (2011a). A psychoanalyst's reflection on conversation analysis's contribution to his own therapeutic talk. In C. Antaki (Ed.) *Applied conversational analysis. Intervention and change in institutional talk* (pp. 222–24). New York: Palgrave Macmillan.

Peräkylä, A. (2011b). After interpretation. Third position utterances in psychoanalysis. *Research on Language and Social Interaction*, *44*, 288–316.

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

Ponterotto, J. G. (2005). Integrating qualitative research requirements into professional psychology training programs in

North America: rationale and curriculum model. *Qualitative Research in Psychology*, *2*, 97–116.
Rasting, M., & Beutel, M. (2005). Dyadic affective interaction patterns in the intake interview as a predictor of outcome. *Psychotherapy Research*, *15*, 188–98.
Sandler, J. (1976). Countertransference and role-responsiveness. *International Review of Psychoanalysis*, *3*, 43–7.
Sandler, J., & Sandler, A.-M. (1994). The past unconscious and the present unconscious: A contribution to a technical frame of reference. *Psychoanalytic Study of the Child*, *49*, 278–92.
Sandler, J., Dare, C., & Holder, A. (1973). *The patient and the analyst: The basis of the psychoanalytic process*. London: Allen & Unwin.
Schegloff, E.A. (2007). *Sequence organization in interaction. A primer in conversation analysis*. Cambridge: Cambridge University Press.
Schröder, T., Wiseman, H., & Orlinsky, D.E. (2009). You were always on my mind": Therapists' intersession experiences in relation to their therapeutic practice, professional characteristics, and quality of life. *Psychotherapy Research*, *19*, 42–53.
Schwaber, E.A. (1995). A particular perspective on impasses in the clinical situation: further reflections on psychoanalytic listening. *International Journal of Psycho-analysis*, *76*, 711–22.
Searles, H.F. (1977). The analyst's participant observation as influenced by the patient's transference. *Contemporary Psychoanalysis*, *13*, 367–70.
Searles, H.F. (1978). Concerning transference and countertransference. *International Journal of Psychoanalytic Psychotherapy*, *7*, 16–188.
Seybert, C., Desmet, M., Erhardt, I., Hörtz, S., Mertens, W., Ablon, S., & Kächele, H. (2011). Therapists techniques in psychoanalysis and short-term and long-term psychoanalytic therapy: Are they different? *Journal of the American Psychoanalytic Association*, *59*, 592–602.
Singer, B.A., & Luborsky, L. (1977). Countertransference: The status of clinical versus quantitative research. In A.S. Gurman & A.M. Razin (Eds.) *Effective psychotherapy* (pp. 433–451). Oxford: Pergamon Press.
Spangler, P., Hill, C. E., Mettus, C., Guo, A.H., & Heymsfield, L. (2009). Therapist perspectives on their dreams about clients: A qualitative investigation. *Psychotherapy Research*, *19*, 81–95.
Stern, D.N., Sander, L.W., Nahum, J.P., Harrison, A.M., Lyons-Ruth, K., Morgan, A.C., & Bruschweiler-Stern, N. (1998). Non-interpretative mechanisms in psychoanalytic therapy. *International Journal of Psychoanalysis*, *79*, 903–1006.
Strupp, H.H. (1960). *Psychotherapists in action: Explorations of the therapist's contribution to the treatment process*. New York: Grune & Stratton.
Thomä, H., & Kächele, H. (1994a). *Psychoanalytic practice* Vol. 1. Principles. New York: Jason Aronson.
Tuckett, D. (1994). The conceptualisation and communication of clinical facts in psychoanalysis. *International Journal of Psychoanalysis*, *75*, 865–70.
Williams, E.N., & Morrow, S.L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, *19*, 576–82.
Van Wagenor, S.L., Gelso, C.J., Hayes, J.A., & Diemer, R. (1991). Countertransference and the reputedly excellent psychotherapy. *Psychotherapy*, *28*, 411–21.
Zwiebel, R. (1977). *Der Analytiker träumt von seinem Patienten – Gibt es typische Gegenübertragungsträume* [The analyst dreams of his patient – are there typical countertransference dreams? *Psyche – Zeitschrift für Psychoanalyse*, *31*, 43–59.

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