



## Countertransference Triggered Activity in Treatment. Good, Bad or Useful?

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### Authors' contributions

This work was carried out in collaboration between all authors. Author HLS designed the study, wrote the protocol, and wrote the first draft of the manuscript. Author KP managed the literature searches, author FD the analyses of the study, author US managed the experimental process. All authors read and approved the final manuscript.

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### ABSTRACT

The aim of the "Dismantling Psychotherapy Research Study" was to evaluate whether the psychotherapist is more or less active in connection to his or her countertransference, the therapist-patient-interaction and the patient's level of object relationship quality.

We worked with 234 tape-recorded therapy sessions with depressed patients from the Munich Psychotherapy Study (Huber, 2012), a comparative quasi-experimental study of psychoanalysis (PA), psychodynamic therapy (PD) and Cognitive behavioral therapy (CBT). The study aimed to maximize external validity by examining non-manualized and representative psychotherapies under the conditions of day-to-day practice.

The tape recordings were rated and analyzed using the Psychotherapy Process Q-Set (PQS), the Countertransference Questionnaire/Therapist response questionnaire (CTQ/TRQ), the Shedler-Westen-Assessment Procedure-200 (SWAP) and the Quality of Object Relations Scale (QORS). 90 patients with a definite diagnosis of depressive disorder and 12 clinical psychologists/psychotherapists with at least 5 years of professional experience took part in the study.

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Findings show a clear correlation between the therapist's activity and the ongoing countertransference. Further, the therapist's activity is linked to the patient's emotional and psychological state. This implies a more active therapeutic work as well as a better therapy outcome treating healthier patients. However, therapy outcome is not necessarily related to the patient's object relation quality. Nevertheless, it has become clear that a therapist responding with negative countertransference and acting it out impairs not only the patient-therapist-interaction but also the therapeutic process itself. The findings illustrate that there are specific countertransference feelings related to the patients' respective unconscious transference. We conclude to encourage therapists to use their own countertransference reactions as a diagnostic and therapeutic asset.

*Keywords: Countertransference; therapist's activity; therapist-patient-interaction; object relationship; therapy process.*

## 1. INTRODUCTION

The objective of the "Dismantling Psychotherapy Research Study" was to evaluate whether the psychotherapist is more or less active, depending on his/her countertransference and therapist-patient-interaction or the level of patients' quality of object relationship.

The study is set up as a hypothesis testing data analysis, at the Department of Psychoanalysis and Psychotherapy in Vienna General Hospital - 90 Patients with a definite diagnosis of depressive disorder and 12 clinical psychologists/psychotherapists with at least 5 years of professional experience. The therapist's activity, countertransference dynamics as well as the interaction between therapist and patient were the central issues analyzed in the study. Close attention was paid to the quality of the therapist's activity and the influence of countertransference on the therapy process.

### 1.1 Current State of Research

**Effectiveness Research:** During the previous decades research has focused on a diverse array of aspects in psychotherapy process studies. Initially, studies primarily compared the impact of different therapy methods in order to determine the most suitable therapy techniques for specific patient groups. Accordingly, efficiency of the therapy methods was most relevant. Therapy methods were grouped in two categories, namely the manualized structured therapy methods (RTC - *randomized controlled trial*) and the naturalistic design.

Psychotherapy process research, in contrast to effectiveness research, which stresses therapy outcome, is concerned with details and minute processes, occurring in individual therapy sessions. The most crucial and influential factors

that have been and are being studied are the therapist, the patient, duration and setting as well as transference and countertransference dynamics.

Beutler et al. [1] compared 19 studies in regards to patient characteristics and suitable therapy method. 80% of the studies concluded that patients, who have the capacity for self-reflection and self-observation, profited from insight-oriented treatment models. In contrast to this, patients who seemed rather impulsive, aggressive and uncontrolled were suited for symptom-focused psychotherapy methods. Gaston et al. [2] found that explorative psychotherapy methods show results after only two years of treatment and there is a positive relationship between patient and therapist.

However, the multi-layered variables determining a positive outcome in psychotherapy have yet to be investigated in further detail in order to allow a complete understanding of the psychotherapy process.

In recent years, more and more studies have explored the patient variable, the therapist variable (qualification, experience, professional competence etc.) as well as the therapeutic relationship and the quality of the relationship (method, duration, etc.). Kim et al. [3], for instance, were able to show that approximately 8% of the variability in therapy result can be attributed to the therapist.

The present study ties in with this focus, highlighting the role of the therapist. In this area of research several areas have been examined. A large meta-analysis of 58 studies [4] has concluded that female therapists favour the therapy outcome and that patients with therapists of the same sex are more likely not to discontinue the treatment. Sue et al. [5] and Snowden et al. [6] highlighted, that the same or a

similar ethnicity between therapist and patient is also beneficial for a positive outcome.

Not only demographic data of the therapist have been studied, but also their professional qualities. Factors such as qualification, specialization and use of techniques of psychiatrists and psychologists have been analyzed in great detail. Smith et al. [7] showed in a systematic survey that due to their specific training and supervision, psychologists achieved slightly better results in their therapies than psychiatrists. Blatt et al. [8] compared therapists who prescribed medication for their patients with depression and those who treated the depression only with psychotherapy. The results indicated that those therapists who focused on the mental aspects of the depression showed more progress. Several studies demonstrated that experience, as well as thorough training have a significant influence on the outcome of the therapy.

In addition, the therapist's verbal activity, for instance introducing certain topics in the conversation, the usage of emotionally charged language, as well as dealing with countertransference dynamics have been proven to be crucial factors in successful treatment.

In recent years, the issue of countertransference has become an increasingly important research area. For the most part, research focuses on highlighting different qualities in the countertransference experience (positive vs. negative countertransference), on the emotional response of the therapist to his or her countertransference feelings and on countertransference in connection to the patient's pathology. In 1958 Cutler [9] investigated the connection between countertransference dynamics and the therapist's recollections of sessions. He highlighted that therapists tend to report a slightly distorted version of the sessions, indicating that defense mechanisms and countertransference were closely intertwined. Differentiating countertransference feelings from the transference of the patient is therefore essential, as Tyson [10] notes. Countertransference, however, is also a reaction of the material brought to the session by the patient and can be influenced by the sensitivity, care and concern felt by the therapist. Therapists who are less worried for the patient feel more emotionally involved with the narrations of the patient. This group also seems to develop less

intense countertransference feelings than the worried group [11].

It is considered proven that with an increase of experience, countertransference feelings become less influential. Prospective therapists, therefore, display more fears and are more likely to be influenced by their countertransference feelings than their more experienced colleagues. [12] Inexperienced therapists report having too frequent and excessive emotional outbursts, whereas experienced therapists can control their emotions better and are not subjected to countertransference dynamics as regularly. On the one hand, depending on the specific personality traits of each therapist, a set of specific respective countertransference feelings are aroused, which are independent of the psychopathology of the patient [13].

On the other hand, there are some correlations between the patient's pathology and countertransference, which get activated the same way in all psychotherapist personalities.

Betan [14] investigated the correlation between eight countertransference factors (1. *overwhelmed/disorganized*, 2. *helpless/inadequate*, 3. *positive*, 4. *special/overinvolved*, 5. *sexualized*, 6. *disengaged*, 7. *parental/protective*, and 8. *criticized/mistreated*) and various Axis II-personality pathologies of the patients. The results showed that the personality structure „eccentric/odd” and the countertransference factor and “criticized/mistreated” correlated, as did the personality structure “histrionic” and the countertransference factor “*overwhelmed/disorganized*”. These results thus show that the therapist can utilize his or her countertransference emotions to some extent as a diagnostic and therapeutic tool. This was also confirmed by a recent study by Rossberg [15]. This study indicates that positive countertransference reactions lead to a significant progress in therapy.

In psychodynamic psychotherapy countertransference is used in order to reveal and treat the patient's conflicts. Hartkamp [16] highlights that interpersonal problem reports during the session correspond to countertransference dynamics.

If, however, during the session some of the therapist's own conflicts or issues are triggered, the therapist might react with avoidant behaviour

leading to a breach in the therapeutic dyad, the therapeutic process and ultimately the outcome.

## 2. METHODS

The study by Huber et al. [17] investigating the effectiveness of long-term psychotherapies and served as a basis for the present survey. Cognitive-behavior therapy was compared with psychoanalytic and psychodynamic therapy in the treatment of patients with a primary diagnosis of unipolar depression. In a prospective, quasi-experimental design 100 patients were compared at pre- and post-treatment and three-year follow-up. Outcome measures were the Beck Depression Inventory and Global Severity Index for measuring symptoms, the Inventory of Interpersonal Problems and the Social Support Questionnaire for measurement of social-interpersonal functioning, and the INTREX Introject Questionnaire for measuring personality structure. Comparative effectiveness of the experimental groups was analyzed using mixed models. Results found significant outcome differences between psychoanalytic therapy and cognitive-behavior therapy in depressive and global psychiatric symptoms, partly social-interpersonal and personality structure at three-year follow-up. Psychodynamic therapy was superior to cognitive-behavior therapy in the reduction of interpersonal problems.

### 2.1 Research Topics and Questions

The present study investigates various aspects of the therapist's level of activity and correlates them with specific PQS factors.

Correlations were researched following the sequent hypotheses:

The therapist is more active if the PQS factors are high.

The therapist is more active if objectives are discussed with paranoid patients.

There is a connection between the therapist's activity and countertransference feelings.

Another emphasis was given to the correlation of therapist activity items and the object relations level and the psychopathology of the patient, following the sequent research questions:

Is the correlation of the 8 positive therapist PQS-items with higher QORS-values an indication for therapy success?

Do higher QORS-values imply a mature object relations level in the patient?

Is the correlation of high therapist activity with low SWAP-values a sign for therapy success?

The third focus is concerned with the influence of countertransference feelings in the patient-therapist interaction. The correlation between the CTQ/TRQ-syntax and 8 interaction related PQS-items (12, 19, 24, 39, 74, 75, 96, 98), describing the relationship between therapist and patient was calculated.

### 2.2 Study Collective

A total of 90 patients diagnosed with depression and 12 psychotherapists participated in the study. The patient collective was comprised of men and women aged between 25 and 50 years, the average age being 34. According to the ICD-10 classification system, moderate to severe depressions as well as recurring depressions F32.1, F32.2, F33.1, F33.2 occurred within the patient pool. Additionally, the patients were required to have results over 16 in the Beck-Depression-Inventory in order to be included in the study. The participants were not allowed to have had psychotherapy in the two years prior to the start of the study and were not allowed to take antidepressants at the beginning of the study. Criteria for exclusion were uncertain diagnoses, risk of suicide and additional mental illnesses, which necessitate inpatient treatment.

All 12 therapists have completed their training at an officially recognized training institution and have many years of experience. The duration of their psychotherapeutic profession comprised an average of 17.5 years. The average age of the therapists was 47 years (min. 38 –max. 56 years). The methods used by the therapists were psychoanalysis, psychodynamic psychotherapy and Cognitive Behavioural Therapy. Professional experience of less than 5 years was a general exclusion criterion.

The study was approved by the by the ethics committee of the Vienna Medical University.

## 3. RESULTS

The first issue investigated, was whether certain characteristics of the therapist point to his activity levels. Therefore, the connection between high values in the 8 defined positive therapist items and the therapist activity was analyzed (Table 1).

The results confirm the hypothesis, that there is a positive correlation between the eight items and the therapist's activity. If therefore, the therapist attempts to aid the patient in his or her narrative, attempts to calm the patient down, helps to strengthen their defense mechanisms or is sensitive to the patient's emotional state, then the therapist can be described as active.

The second question revolved around the patient's activity in respect to the patient's personality, investigated through the example of the case: "Discussion of objective factors with paranoid patients (coded by the SWAP-items 14, 22, 116, 135, see Table 2)". The objective factors were described by those PQS items which defined neutral issues. The prevalent affect "fear" and other psychopathological symptoms of paranoia were not described by these items.

The active therapist speaks mainly about objective factors with paranoid patients ( $r = .250$ ,  $p = .000$  see Table 3). From this, it can be concluded that the personality trait „paranoid“ can be changed, when the therapist actively speaks about objective factors. The paranoid-delusional patient will change more in his interaction with the therapist, the more active and engaged the therapist is towards his patient.

The third question investigated whether countertransference feelings have an influence on their therapist's activity and which countertransference feelings influenced the therapist most in his work. The CTQ/TRQ questionnaire highlights many important aspects of the therapist's interaction with the patient. How the psychotherapist perceives and deals with upcoming or transferred emotions from the patients and how he or she interprets them, is dependent on the competence of the therapist. In

the present paper, these processes were analyzed according to the statistical connections between countertransference and therapist activity.

The statistics revealed a clear significant negative correlation between the activity of the therapist and feeling "criticized/mistreated" ( $r = -.429$ ,  $p = .000$ ). Furthermore, there is a significant negative correlation between the countertransference factor "helpless/inadequate" and the therapist's activity.

Being in a countertransference state of "disengagement" however, influences the therapeutic activity and the interaction ( $r = -.334$ ,  $p = .000$ ). If the therapist feels "helpless" this leads to a decrease in activity and attempts to help the patient. The analysis of the correlation also showed a significance of the therapist's activity and the factor "positive" ( $r = .192$ ,  $p = .003$ ) and "overwhelmed/ disorganized" ( $r = -.197$ ,  $p = .003$ ). Only the factors "parental/protective" and "special/overinvolved" did not show significant correlations.

The other cluster of issues analyzed in the studies was concerned with the therapeutic activity in connection the object relations quality and the psychopathology of the patient.

The first question inquires whether there is a correlation between therapist activity items and whether a high object relation quality is a prerequisite for a successful therapy process. The results show that there is no statistically significant correlation. This indicates that therapeutic success does not necessarily depend on the quality of the object relations of the patient.

**Table 1. PQS therapist activity items**

Item-Nr.	Item description	M	SD	Min.-Max.
3	Therapist's remarks are aimed at facilitating patient speech	<b>6.53</b>	1.16	3-9
6	Therapist is sensitive to the patient's feelings, attuned to the patient; empathic	<b>6.57</b>	1.04	3-8
<b>PQS</b> 18	Therapist conveys a sense of non-judgmental acceptance	<b>6.50</b>	1.28	1-9
27	Therapist gives explicit advice and guidance (vs. defers even when pressed to do so)	<b>5.75</b>	2.10	1-9
45	Therapist adopts supportive stance	<b>5.39</b>	1.69	1-9
66	Therapist is directly reassuring.	<b>5.89</b>	1.61	1-9
86	Therapist is confident or self-assure	<b>6.52</b>	1.24	1-9
89	Therapist acts to strengthen defenses	<b>6.08</b>	1.73	1-9

**Table 2. Bonferroni-test therapist activity & objective factors/"Paranoid"**

	SS	df	S <sup>2</sup>	F	p
Objective Factors_PQS	26.4 x 133.42	28	.95	1.45	.076
	2				
Paranoid_SWAP	15.2 x 68.42	28	.54	<b>1.63*</b>	.030
	2				

SS: sum of squares, df: degree of freedoms, F: F-ratio, \*p<.05, \*\* p< .01, \*\*\*p< .001

**Table 3. ANOVA (PQS\_Th\_8\_pos as Factor<sup>1</sup>, CTQ/TRQ \_Syntax as depended variable)**

CTQ/TRQ -Factors	SS	df	S <sup>2</sup>	F	p
criticized/mistreated	18.9 x 33.3	28	.68	<b>4.20***</b>	.000
	2				
positive	14.8 x 85.32	28	.53	1.27	.174
	2				
parental/protective	7.5 x 66.22	28	.27	.83	.709
	2				
overwhelmed/ disorganized	3.1 x 20.82	28	.11	1.10	.339
	2				
special/overinvolved	1.01 x 8.82	28	.04	.83	.721
	2				
disengaged	16.9 x 64.92	28	.61	<b>1.91**</b>	.006
	2				
helpless/inadequate	17.7 x 40.62	28	.63	<b>3.19***</b>	.000
	2				

SS: sum of squares, df: degrees of freedoms, F: F-ratio, \*p<.05, \*\* p< .01, \*\*\*p< .001

<sup>1</sup>Factor: gathered items describing the therapist's activity:

Item3: Therapist's remarks are aimed at facilitating patient speech.

Item6: Therapist is sensitive to the patient's feelings, at tuned to the patient; empathic.

Item18: Therapist conveys a sense of nonjudgmental acceptance. (N.B. Placement toward uncharacteristic end indicates disapproval, lack of acceptance.)

Item27: Therapist gives explicit advice and guidance (vs. defers even when pressed to do so)

Item45: Therapist adopts supportive stance.

Item66: Therapist is directly reassuring (N.B. Place in uncharacteristic direction if therapist tends to refrain from providing direct reassurance.)

Item86: Therapist is confident or self- assured (vs. uncertain or defensive).

Item89: Therapist acts to strengthen defenses.

The second question investigates whether the therapist is more active or more involved in the process of the treatment when the patient's pathology is less severe. The analysis showed that if the SWAP-values are under < 3.99 and the therapist-activity-values higher than the mean value 5.0, then there is a significant correlation (r = -.155, p = .02). This shows that the healthier the patient is psychically, the more active the interaction in therapy will proceed and the more successful will the therapy be.

The last aspect explored revolved around the influence of countertransference on the interaction between therapist and patient. Countertransference dynamics are an essential

part of the therapist's "acting out". When the therapist feels positive emotions, an increase in activity occurs. However, negative emotions such as hostility or helplessness cause a reduction of activity. The question addressed was therefore, whether countertransference does also have an influence of the therapeutic process or the patient-therapist interaction.

Table 4 shows a statistically significant correlation between the factor "criticized/mistreated" and the patient-therapist interaction. This entails that when the therapist acts out his or her negative transference feelings, the interaction as well as the process is impaired.

**Table 4. ANOVA (PQS\_Pat\_Th\_interaction as Factor<sup>1</sup>, CTQ//TRQ\_Syntax as depended variable)**

CTQ/TRQ -Factors	QS	Df	S <sup>2</sup>	F	p
criticized/mistreated	14.6 x 37.62 2	27	.54	<b>2.97***</b>	.000
positive	9.4 x 90.72 2	27	.35	.79	.766
parental/protective	8.4 x 65.42 2	27	.31	.98	.495
overwhelmed/ disorganized	2.8 x 21.12 2	27	.10	1.02	.445
special/overinvolved	1.0 x 8.82 2	27	.04	.89	.630
disengaged	6.2 x 75.72 2	27	.23	.63	.926
helpless/inadequate	7.9 x 50.42 2	27	.29	1.20	.238

SS: sum of squares, df: degrees of freedoms, F: F-ratio, \*p<.05, \*\* p< .01, \*\*\*p< .001  
 18 items concerning the therapist- patient interaction; taken from the 29 PQS interaction items:

Item12: Silences occur during the hour.

Item19: There is an erotic quality to the therapy relationship.

Item24: Therapist's own emotional conflicts intrude into the relationship.

Item39: There is a competitive quality to the relationship.

Item74: Humor is used.

Item75: Interruptions or breaks in the treatment or termination of therapy, are discussed.

Item96: There is discussion of scheduling of hours, or fees.

Item98: The therapy relationship is a focus of discussion.

## 4. DISCUSSION

### 4.1 Therapeutic Activity

By means of the PQS we were able to determine whether or not a therapist can be characterized as more or less active through the intensity or manifestation of certain personality traits. Eight items out of 100 were selected, focusing on the description of the therapist's activity.

Orlinsky & Howard [18] found five basic elements of psychotherapy. Alongside with the working and therapeutic relationship, self-involvement and session influences, they state that therapeutic activity („therapeutic operations“) also defines the therapy outcome. However, therapeutic activity has not been sufficiently researched. One main reason for this neglect can be found in the high expenditure of researching the therapist variable. Process research requires empirical survey on a representative therapist/patient population, trained staff as well as valid and reliable measurement instruments. While there are studies on special pathologies, patient and therapist variables, as well as setting, we still

lack a number of consequent screenings throughout the entire treatment. When can a therapist working with a depressed patient be regarded as active or engaged? Although we were not able to fully answer the question, we managed to contribute to further research on this topic. The analysis yielded high values items deriving from positive characteristics. (Calming the patient, being supportive and empathic, and others). The items describe an active therapist's typical skills of empathy, acceptance, supportive attitude and esteem. In this way, „unspecific effect factors“ [19] could again be verified. This survey encompassed therapists from three different schools, including psychoanalysis, psychodynamic psychotherapy and behavioral therapy. It has been shown, that the unspecific effect factors should be employed in all therapeutic methods, as they represent the values, expected from the therapist regardless of his or her therapeutic school or the pathologies he or she works with.

As an example we considered the question of whether a depressed patient with the coexisting personality trait “paranoia” is more open with an active therapist or not.

Interestingly, we found a positive connection between the therapist's activity and the discussion of factual aspects with paranoid patients. It has been noticed that paranoid personality traits are variable if the therapist talks about factual aspects and at the same time shows the abovementioned unspecific effect factors. The more factual topics are discussed, the more traits vary. Presumably, the supportive attitude and esteem, alongside with the active listening and the defense strengthening enable the patient to no longer experience rejection but acceptance. Discussing facts encourages the patient to open up and actively contribute to the therapeutic process.

#### **4.2 Therapist Activity and Countertransference**

Although several studies and surveys revolving around countertransference can be found, the topic has not been researched exhaustively. Countertransference is a useful diagnostic tool [14] and therapeutic instrument. Paula Heimann pointed out in 1950 [20] that countertransference is an important instrument when it comes to exploring the patient's unconscious. But which impact does countertransference have to the therapist's activity?

We found a significant negative correlation between the therapist's activity and the patient feeling mistreated. This underlines the once more the Betan [14] findings about the connection between the personality trait "eccentric/odd" and the countertransference factor "criticized/mistreated". A depressed patient projects his or her unconscious feelings, such as hostility onto the therapist as a sign of projective identification.

For instance, the negative transference of criticism and mistreatment could be causal for depression. Negative feelings emerged from trauma, loss and life catastrophes and the consequent formation of a negative self-image. These feelings combined with the right interpretation of the transferred feelings can hint to the etiology of the pathology. On the other hand results display that negative countertransference decreases the therapist's activity.

This adds up to the report of Rossberg [16] regarding the coherence between the worsening of symptoms and a negative countertransference. Analyzing the

countertransference in therapist-patient interaction we found a correlation between negative countertransference and "hostile/mistreated" in the interaction. Since we therefore consulted only few of the PQS items it is necessary to further investigate which interaction items provoke the contemplated countertransference. We found a negative correlation between therapist activity and animosity, helplessness and boredom. These results show, that if the therapist finds himself or herself helpless or uninvolved in the therapeutic situation, a decrease in the therapist's activity is very likely, as is the ambition to help the patient.

The reactions in the countertransference can alongside with a verbal and mimic communication also be used a channel for communication. The depressed patient communicates through helplessness and detachment. The interpretation of this communication should happen through the therapist's use of his or her countertransference.

Another significant correlation was found between positive therapist activity and the countertransference factors "positive/satisfied". Colli et al [21] managed to prove, that these positive countertransference reactions correlate with the avoidant personality disorder. Merely the factors "parental/protecting" and "special/overinvolved" did not show any significant correlation with the therapist's activity.

#### **4.3 Therapist Activity and Quality of Object Relation**

The patient's object relation quality sheds light on the question if and to what extent an individual is able to build up and maintain a relationship. Hoglend et al. [22] described, that the quality of the object relations increased for patients with mood disorders with the help of transference interpretations during their psychotherapy. Thus only when a therapist actively gives a transference interpretation and amelioration in the patient's object relation can be observed. In contrast to Hoglend's report, the current analysis did not show a significant coherence between the quality of object relations with the therapist's activity. Hence the treatment's success is not bound to the patient's object relations quality.

It is necessary to emphasize, that to date solely the Hoglend and the current study related object relation quality to the therapist's activity respectively the countertransference. This



study's conclusion not only serves as a quality assurance, but is also meant to be an animation for further research on object relations and therapist variables.

Since the quality of object relations informs about fundamental characteristics of the patient's mind and personality it should be used as a moderate variable in future research.

#### **4.4 Therapist's Activity and Personality Traits**

In order to compute the coherence between therapist items and SWAP-values below 3.99, 13-SWAP-Discontinuation-Items defined by Löffler-Stastka [23] were used. This correlation demonstrates statistical significance. Löffler-Stastka pointed out in her work on Q-sort-methods in diagnostics and therapy process observation, that these 13 SWAP Items indicate to the patient's externalization, and therefore to the therapy discontinuation tendencies. In fact SWAP-values below 3.99 indicate a less distinct personality disorder, respectively a successful change in structure.

The recent study by Colli et al. [21] also tested the relation between the therapist's emotional reaction and the patient's personality disorder via SWAP. This analysis revealed that the level of the patient's psychologic functioning depends on the therapist. The more positive a therapist is, the better patients function psychologically.

The probe yielded an additional negative relation between a negative therapeutic interaction and a high level of the patient's psychological functioning. Consequently, it is assumed that a high level of therapist activity contributes to the therapy's success, which answers this survey's the major research question.

#### **5. CONCLUSION**

The aim of the study was to investigate several aspects of the psychotherapist's work in the context of psychotherapy process research. The therapist's activity, countertransference dynamics as well as the interaction between therapist and patient were the central issues analyzed in the study. Close attention was drawn to the quality of the therapist's activity and the influence of countertransference on the therapy process.

The PQS-items used to analyze the therapist's activity are a versatile instrument that enables researchers to find a common language for the

description of a therapy process. Thereby, not only the dynamics in therapy but also various aspects of the patient's pathology, the therapist's skills as well as the quality of the interaction of single sessions can be investigated and can be made accessible to research. (see also [24])

Significant results could be found in all investigated issues, showing that there are specific countertransference feelings related to the patients' respective unconscious transference. We therefore conclude to encourage therapists to use their own countertransference reactions as a diagnostic and therapeutic asset.

#### **6. LIMITATIONS**

Within the scope of this work it was only possible to examine some issues. We see a demand for further research of patient factors. Is there a correlation between the patient PQS items and countertransference? How is the patient-therapist-interaction constituted in regard to the affect perception/ regulation or die quality of the object relation?

Moreover we did not exploit therapy sessions at the beginning or end of a treatment, nor a whole therapy process. For future research we suggest an expansion of the survey size, differentiation of age, gender and education, along with a continuous process research.

#### **CONSENT**

All authors declare that written informed consent was obtained from the patients (or other approved parties) for publication, the study was approved by the local ethics committee.

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#### **COMPETING INTERESTS**

Authors have declared that no competing interests exist.

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