Mentalizing Countertransference? A Model for Research on the Elaboration of Countertransference Experience in Psychotherapy

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Abstract

As a construct, the elaboration of countertransference experience (ECE) is intended to depict the implicit and explicit psychological work to which therapists submit their experiences with clients. Through ECE, defined as a mentalizing process of a particular kind, therapists' experiences are presumed to acquire and increase in mental quality and become available for meaning-making and judicious clinical use. In this paper, we claim that such an ongoing process facilitates engagement with common therapeutic factors, such as the therapeutic alliance and countertransference management, enhancing therapist responsiveness in psychotherapy. We synthesize relevant literature on countertransference, mentalization, and, in particular, therapists' mentalization, informed by a systematic literature review. As a result, we propose a model for assessing ECE in psychotherapy, comprising 6 diversely mentalized countertransference positions (factual-concrete, abstract-rational, projective-impulsive, argumentative, contemplative-mindful, mentalizing), 2 underlying primary dimensions (experiencing, reflective elaboration), and 5 complementary dimensions of elaboration. Strengths and limitations of the model are discussed.

Key Practitioner Message

- What therapists experience with clients within and between sessions is an important component of psychotherapy process across therapeutic models
- Elaboration of these experiences may facilitate engagement with common factors of psychotherapy, such as alliance and countertransference management, and enhance therapists' responsiveness to the emerging needs of each singular client
- This psychological work can be studied and understood with help from a model describing predominant mental attitudes towards experience (countertransference positions) and different dimensions of elaboration of that experience

Keywords: countertransference, mentalization, therapist factors, therapeutic relationship, common factors

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From a relational standpoint, therapists' experiences in and between sessions may shape important aspects of process and outcome across psychotherapy schools. However, the prevailing concern in psychotherapy pertains to clients' experiences and how to address them.

In this paper, we focus on the implicit and explicit psychological work to which therapists' experiences are submitted, naming it the *elaboration of countertransference experience* (ECE). We intend to operationalize this process for research purposes. To this end, we start with a brief outline of the concept of countertransference (CT) and propose a synthesis of previous theorizations through a four-component view of CT experience. In order to conceptualize ECE, we frame it in the previous work on CT management (Gelso & Hayes, 2007) and propose a shift in focus from management to elaboration, describing the latter as a particular form of mentalization (Fonagy, Bateman, & Luyten, 2012; Lecours & Bouchard, 1997). Following a review of the mentalization construct and research on therapist's mentalization informed by a systematic literature review, we finally present our operationalization of ECE, a model describing six diversely mentalized CT positions, two underlying primary dimensions, and five complementary dimensions/facets of elaboration.

We claim that successful CT management, considered a promising therapeutic element in evidence-based research (Norcross, 2011), requires and largely operates through ECE, which in turn can facilitate other well established common factors of psychotherapy and enhance therapists' responsiveness to the emerging needs of singular clients. To the extent that most of the studied common factors explicitly involve therapists handling emotional states and relational processes in-session (e.g., alliance development and rupture repairing, empathy, positive regard, congruence), it is our belief that the type of psychological work depicted in ECE is involved. Furthermore, findings highlighting the importance of therapist effects in psychotherapy outcomes are robust, but the understanding of what such effects are made of is still in its first steps (Wampold, 2015). It seems reasonable to presume that relevant differences across therapists and within particular therapists' cases may rely on the successful use of common factors and, thus, on ECE and its vicissitudes.

Countertransference: Converging and Contending Views

Historically, CT was initially seen as a disturbance and later as an instrument of psychoanalytic work, depending on its construal as therapist's reactions stemming from unresolved neurotic conflicts (*classical view*) or his or her global emotional response to a particular patient, correlative of the latter's unconscious experiences (*totalistic view*) (e.g.,

Gelso & Hayes, 2007). Additionally, a more recent trend often called *constructivist* tends to focus on a "third" entity created by each unique dyad and examine transference and CT as a function of this "field" (see M. J. Diamond, 2014; Gabbard, 2001).

Yet, a common ground emerged concerning a number of assumptions about CT, within and beyond psychoanalysis (Gelso & Hayes, 2007; Kiesler, 2001), namely: (a) the inevitability of CT phenomena in all therapeutic processes, even from a narrow conflict-based standpoint (Gelso & Hayes, 2007); (b) the acceptance of these phenomena as *joint creation*, despite variable emphasis on the relative contributions of therapist and client (Gabbard, 2001); (c) the idea that they can hinder the therapeutic process, particularly when insufficiently recognized by therapists (Ligiéro & Gelso, 2002; Racker, 1968); and (d) that CT can be a useful tool, or at least not harmful, particularly to the extent that it is acknowledged, managed, and/or worked through (e.g., Ligiéro & Gelso, 2002).

Important divergences remain, though, and empirical research on the field often addresses different classes of phenomena (Gelso & Hayes, 2007). Thus, a clear position is required from investigators. We now present our own view.

A Model of Countertransference Experience

Our view of CT experience echoes a totalistic position since it requires attending to and working with the total response to the patient. However, it discriminates four experiential components, derived from previous literature, to which different therapists may assign distinct clinical value: subjective CT, objective CT, therapeutic attitude, and emerging experience.

Subjective countertransference (SCt) (Keisler, 2001) refers to experiences deriving from the therapist's conflicts and blind spots, as in the classical view and Gelso and Hayes' (2007) extension of the concept. SCt may exert an unrecognized and involuntary relational pull on the patient and come out as detrimental CT behavior (Friedman & Gelso, 2000).

Objective countertransference (OCt) (Winnicott, 1949; Kiesler, 2001) includes experiences stemming from "realistic/average expectable" complementary reactions to the patient's interpersonal style, his or her relational pull, defensive operations employed, or the internal object relation activated (namely, the self or object representation projected onto the therapist) at a given moment. In our understanding of the concept, it may operate through processes previously described as introjective identification (Tansey & Burke, 1989) or projective counteridentification (Grinberg, 2001).

Therapeutic attitude (TAt) refers to the usual mindset of a given therapist as a function of his or her particular theoretical approach to psychotherapy – which is part of a wider frame commonly designated as the therapeutic setting (Zachrisson, 2009). Examples include the so-

called evenly-suspended/hovering attention (Freud, 1912/1958), for psychoanalysts; congruence, positive regard, and empathy (Rogers, 1957) for humanistic-experiential therapists; or a more rationalist, active, and directive stance among cognitive-behavioral therapists (McGinn & Sanderson, 2001).

Finally, e*merging experience* (EEx) refers to the experience of a new interpersonal field (D. B. Stern, 2010), unfolding as the "real relationship" develops and takes shape, in which neither therapist's nor client's unresolved conflicts play the leading defining role, despite their inevitable participation. It is a relationship-specific emerging ground of experiences, as opposed to a predictable general pattern, and it includes the therapist's experiences coming from (and constantly reshaping) the shared implicit relationship (D. N. Stern et al., 1998). The special quality of these EEx is not that they are more "real" or "rational". To this respect, we prefer Morgan et al.'s (1998) idea that, although transference and SCt affect the therapeutic exchange, "what is experientially prominent in the here and now [of the real relationship] is the past the patient and therapist share together, rather than the past they share with other people." (p. 326). In this sense, EEx is what accounts for the development of a *new relationship*, potentially providing corrective emotional experiences (Bernier & Dozier, 2002) or the rearrangement of implicit relational knowing (Lyons-Ruth et al., 1998). This is facilitated by the therapist's abilities to unhook from and disconfirm[1] cognitive-interpersonal cycles (Bernier & Dozier, 2002; Kiesler, 2001; Safran & Muran, 2000).

These distinctions, though, *don't actually exist as such at the experiential level*. They can be tentatively inferred, elaborated, or hypothesized through psychological work, but not before they are experienced *as a whole*. Besides, none of these experiential components is *ever* absent or inactive, and, as pointed by Levine (1997), they often share the same underlying psychological processes. Therefore, we prefer the assumption that any of the four components can be dominant at a certain point in time (*acute* CT experiences) or as an enduring relational pattern (*chronic* CT experiences); and that overlooking or disowning *any* of them is a threat to the therapeutic process (e.g., underestimating SCt may facilitate excessive acting-out on the therapist's part and burden the patient; unawareness of the EEx may be a signal of an overly "saturated" [Bion, 1970] mental state within the therapist; etc.).

[1] Resonating with and expanding Strachey's (1934/1969) formulation, we believe that whenever a therapist provides a mutative/reparative relational experience, a distinction emerges between what would be a patient's transference-based expectancies and what comes to be a new "disconfirming" experience.

Conversely, overestimating any of these qualities of experience also proves problematic (excessively technical TAt, defensive or naïve selective focus on EEx, etc.).

We then propose the term *countertransference experience* to refer to the range of phenomena we intend to investigate. In our view, the desirable methodological efforts to distinguish different components or sources of therapists' (inter)subjective experiences with patients shouldn't elude the fact that none of them can subsume the others, and that it is mainly through *elaboration* that each of them can be attended to and made available to inform clinical decision-making. We conceive of this psychological work as a meaning-making process in which the four components described must be held in mind as permanent *generative working hypothesis*. Like many others, we take *meaning* as both discovered and created, and meaning-making as a process in which mostly pre-conceptual felt experience constrains but does not fully determine meaning (Angus & Greenberg, 2011). This felt experience is regarded as being dialectically transformed through symbolization, in turn giving rise to new experience (in this sense, ECE is likely to expand EEx). Thus, ECE is proposed to be a dialectic, transformative, integrative, contextual, and agency-enhancing process of making "clinically relevant" sense of experience.[2]

Elaboration of Countertransference Experience

Managing and Elaborating Countertransference

As stated earlier, with the construct of ECE we intend to conceptualize the therapist's psychological work involved in the successful use of CT experience in psychotherapy across therapeutic models. We believe this is a relevant process mediating accurate clinical decision-making. To our knowledge, though, little research has been done on such a process.

Charles J. Gelso and Jeffrey A. Hayes' pioneering work on CT management (CtM) (e.g., Gelso & Hayes, 2007) represents an exception. According to the authors, CtM is a process by which therapists try to prevent detrimental effects of CT, repair or minimize these effects, and use CT to benefit the work with patients. Five factors are expected to underlie successful CtM: therapist self-insight, self-integration, empathy, anxiety management, and conceptualizing skills (Hayes, Gelso, & Hummel, 2011). Among other results, the authors found support for what has been called a *two-step model for CtM* (Latts & Gelso, 1995) which involves, at first, the therapist becoming aware of his or her feelings, and then being able to interpret them within a theoretical framework. Evidence that conceptual ability in the absence

[2] We assume the coexistence of diversely structured/saturated ingredients of unconscious experience, some of which are dynamically defended against (e.g., Levine, 2012). Still, we choose to include the range of required modalities of psychological work under the broad designation of ECE, an ever-incomplete quest of making sense of the whole experiential field involving more than dealing with resistances.

of awareness of feelings produces high levels of CT behavior was interpreted as revealing that a "defensive use of theory" is ineffective in terms of CtM (Hayes et al., 2011).

We think CtM can be reappraised in some points. First, the two-step hypothesis may support a conceptualization of effective CtM as a *cognitive-affective integrative process in which there is something more than strictly managing or regulating aroused experience – this "something more" being a dialectical process from which new meaning and new experience emerge* (see EEx above). Second, we believe theory is not the exclusive cognitive resource participating in this process (reflection, personal memories, or personal beliefs are concurring instances). Finally, CtM research tends to assess trait-like correlates or factors rather than state-like actual constituents of CtM. Gelso, Fassinger, Gomez, and Latts (1995) refined an existing measure of the five factors mentioned above (Countertransference Factors Inventory; Hayes, Gelso, Van Wagoner, & Diemer, 1991) by only retaining items that directly address therapists' work with clients. This, along with session-specific uses of the instrument in naturalistic studies, allows a more direct apprehension of CtM. Still, in our view, it remains closer to a *person level* than to a *process level* approach. For these reasons, we think it is useful to further conceptualize the actual psychological work performed by therapists towards CT experience.

We use the term *elaboration* inspired by McDougall's (1985) broad sense in which two different kinds of mental labor taken out from Freud's writings are included: working out/working over (*psychische Verarbeitung*) and working through (*Durcharbeitung*). According to Laplanche and Pontalis (2009), working out includes the transformation of "physical quantity into psychic quality" (p. 131, our translation) and subsequent associative or linking (*Bindung*) processes. We believe these are the processes that Bram and Gabbard (2001) qualify as mentalization in its broadest sense: "the ability to put words and images to somatic experience and integrate them in the service of creating psychological meaning" (p. 688). Working through is a more restricted process, originally applied to analysands, that in simple terms involves dealing with resistances to insight, thus preventing repetition and leading to enduring psychological change (Freud, 1914/1958). In McDougall's (1985) use of the term, which she applies to the analyst's mental work, it seems to consist of a reflective effort to make sense of thoughts, feelings, and fantasies stirred up in him (made available by previous working out). So, in this sense, *therapist's elaboration can be seen as a process through which raw experience acquires (and increases in) mental quality and becomes available for meaning-making, involving a close interconnection and integration between implicit-spontaneous and explicit-reflective psychological processes*. Again, this seems

coherent with the two-step model mentioned above. But now we are describing ECE as a process of mentalization, which calls for a consideration of this construct.

Construing Mentalization

Mentalization was first explicitly described by French psychoanalysts studying psychosomatic phenomena in the 1960s, heavily drawing on Freud's initial ideas on the mental apparatus (Holmes, 2006; Lecours & Bouchard, 1997). Since then, Francophone authors have further elaborated this line of thought, while absorbing influences from other sources, most importantly Bion's theory of thinking (see Bouchard & Lecours, 2008; Lecours & Bouchard, 1997). In their review, Choi-Kan and Gunderson (2008) synthesize the psychoanalytic view of the concept as "understanding and transforming internal experience into mentally contained forms" (p. 7). Within this perspective, the term involves something *becoming mental* through some sort of transformation, otherwise being bound to discharge outside the mental realm – namely, through somatization and acting-out. In Allen, Fonagy, and Bateman's (2008) words, "to make something mental – or more *elaborately* mental" (p. 7, italics in the original) is still the bedrock sense of mentalizing.

Still, the most popular and vastly explored use of the term, which might be called the Anglophone perspective, has a more recent origin in the work of Peter Fonagy and his collaborators (e.g., Allen et al., 2008; Fonagy, Gergely, Jurist, & Target, 2002). Bridging concepts and findings from psychoanalysis, attachment theory, developmental psychology, psychopathology, philosophy of mind, and neuroscience, they use the terms mentalization, mentalizing, and reflective function (RF) rather interchangeably, although such distinctions became increasingly relevant as theory refined and expanded. In their definition, mentalization is the ability to represent and understand mental states in oneself and others, and to interpret actions in terms of intentional mental states (e.g., needs, desires, feelings, beliefs, goals, purposes, reasons) (Bateman & Fonagy, 2004). It is a developmental achievement based on the consistent experience of having one's mental state accurately mirrored in a marked contingent way (i.e., attuned but modified) by a significant caregiver, thus allowing for the development of representations of mental states, or second order representations (Fonagy et al., 2002). This metacognitive ability is preceded by two other (prementalistic) modes of experiencing psychic reality: *psychic equivalence*, in which mental states are felt as real, with no "as-if" quality (equating reality instead of representing it); and *pretend mode*, when mental states are decoupled from reality as if unrelated to and having no implications on it (Fonagy et al. 2002; Fonagy & Target, 1996).

That these two perspectives, Francophone and Anglophone – or French-Freudian and developmental-intersubjective (Bouchard & Lecours, 2008), or yet psychoanalytic/clinical-psychodynamic and social cognitive/developmental (Bouchard et al., 2008; Choi-Kan & Gunderson, 2008) –, both use the same word seems nearly incidental at first. In fact, what becomes mentalized in one case and the other (affects, drives, raw experience vs. self, other, actions) is not quite the same. Also, a tendency to focus on intrapsychic processing in the first case and in interpersonal interpretation/social cognition in the second appears to exist. Additionally, a higher emphasis on preconscious automatic mental functions seems to characterize the former where a concern with metacognition and reflection conducted by an agentive self takes the main role within the latter. However, authors believe that different facets of a core mentalization process are illuminated by each perspective (Bouchard et al., 2008).

One possible view would be that mentalization in its broadest sense provides the buildings blocks in which the more complex and specific capacity for RF – using representation and symbolization to make sense of mental states – relies (Bram & Gabbard, 2001; Lecours & Bouchard, 1997). Vermote (2005) defies this idea, arguing that some patients show great capacity for interpreting others' behavior while lacking contact with their own affects. Others are highly creative in associative psychic functioning and in great contact with emotions but at the same time lack ability to interpret their own behavior and that of others. Finer conceptual integration may be facilitated by the recent description of mentalization as a multidimensional construct within which at least four polarities can be described and assessed: automatic (implicit)/controlled (explicit), internally focused/externally focused, self-oriented/other-oriented, and cognitive process/affective process (Fonagy et al., 2012). Clearly, different dimensions and polarities are privileged within different approaches to mentalization.

Of particular interest, though, are the suggestions coming from the study of Bouchard et al. (2008) in which the relationships between three measures of mentalization were examined. After rating the same transcripts from Adult Attachment Interview (AAI) protocols with three different scales – Reflective Function Scale (RFS), Mental States Rating System (MSRS), and "Grille de l'Élaboration Verbale de l'Affect" [Verbal Elaboration of Affect Scale] (GEVA) –, exploratory factor analyses revealed three components of mentalization composed of combined aspects of the rating systems: the capacity to use high-level affective regulatory (defensive) procedures over low-level defensive ones; the capacity to elaborate,

transform, and objectify affects into verbally articulate abstract form; and an attitude of focusing on mental processes.

Importantly, these results suggest that high levels of mental elaboration may not imply reflectiveness, and instead tend to associate with a rational objectivistic attitude towards mental processes. In fact, the formal quality of representations does not inform about their present dynamic role (Bouchard et al., 2008) – for instance, *high levels of elaboration can be used defensively and/or in pretend mode*.

Research on Therapist's Mentalization

Very few studies have addressed therapists' mentalizing processes. In a systematic literature review on assessment methods of psychotherapists' mentalization,[3] we ended with 10 records, to which we added seven more considered relevant coming from prior non-systematic search. From this set, we were able to identify only 12 different empirical studies (reported in 16 references), among which 11 involved therapists as participants and only two included patients as well; four of the 17 records concerned the presentation, validation, and/or development of measures. As to the measures themselves, most of the records employed variants of Lina Normandin and Marc-André Bouchard's Countertransference Rating System (CRS); three studies used the RFS applied to different sources; and one paper proposed a new approach to assess therapist's reflective consciousness based on mentalization and experiencing scales. We now present a review of this research.

Without initially making explicit use of the concept of mentalization, Normandin and her colleagues created the CRS (Lecours, Bouchard, & Normandin, 1995; Normandin & Bouchard, 1993), in which they described three types of therapist's mental (or CT) activities: *objective-rational* (Obr), where a detached observer rather than a participant position is adopted, and a concern with generalizability beclouds the uniqueness of the patient's experience; *reactive* (Reac), representing the classical idea of CT as defensive reactivity turning the therapist into an unaware participant; and *reflective* (Ref), when a therapist-

[3] The review was conducted according to PRISMA guidelines. Eleven databases were searched in November 2014. Search terms were: (1) therapist* OR psychotherapist* OR counselor* OR counsellor* OR countertransference OR counter-transference (Subject); AND (2) reflective function* OR mentali* OR mental state* OR affect* elaboration; NOT (3) mentalist; NOT (4) mentalism. We found 665 results, 504 after removing duplicates. Through an intentionally overinclusive screening process, we filtered 101 results, applying exclusion criteria only: editorials, reviews, errata, interviews, non-scientific documents, and records that did not link the two dimensions were kept out. Elegibility was assessed with more strict criteria (references with explicit mention to therapist mentalization and presenting research methods and/or results), resulting in 10 records. No restraints were introduced respective to language and type or year of publication.

participant contains and elaborates to some extent his or her emotional reaction without falling into unrecognized impulsive mental activity. In initial versions of the CRS, only the Ref activity was further divided into phases and sub-phases. Later, subtypes were added to the Obr and the Reac dimensions as well (Normandin & Ensink, 2007); Bouchard developed the MSRS (see above) as a general model of adult mental states that has been applied to CT research (e.g., Goldfeld et al., 2008); and the CRS was converted into the Therapist Mental Activities Scale to make it fully compatible with Fonagy's model (Ensink et al., 2013).

Research using the CRS across different psychotherapeutic models, rating therapist's written reactions to clinical material, has suggested that, contrary to expectation, novices tend to respond with higher proportions of Ref activity, whereas experienced therapists show more Reac activity; however, the latter came up with richer Ref activity (Séguin & Bouchard, 1996; Lecours et al., 1995; Normandin & Bouchard, 1993). A profile for high-level therapist's reflective functioning was suggested, including the *ability to achieve high reflective elaboration, to let oneself react* (adaptive regression), *and to be flexible enough to reexamine this reactivity* (Normandin & Ensink, 2007; Séguin & Bouchard, 1996).

D. Diamond, Stovall-McClough, Clarkin, and Levy (2003) studied therapists' and patients' attachment state of mind and RF regarding the therapeutic relationship and their impact on the process and outcome in Transference-Focused Psychotherapy over the course of one year. Results showed that the same therapist may reveal different levels of RF with different patients, a finding for which the authors offered three explanations believed to be at work: "(1) The therapist's RF rating is picking up a countertransference factor that might curtail or enhance his or her capacity to mentalize; (2) The therapist's RF may be modified by that of the patient so that it comes to mirror that of the patient, or vice versa; or (3) The RF might be coconstructed such that each patient and therapist contributes to the creation of a unique interpersonal climate that may allow RF to flourish or wither for both participants." (p. 242). In his reanalysis of this study, Goodman (2010) further explored the first explanation and found evidence suggesting that "therapists working with traumatized patients, whose mental contents might feel overwhelming, summon a highly sophisticated and complex RF to protect themselves from feeling so overwhelmed" (pp. 86-87). In sum, in different ways, both approaches to this study support our assumption that *therapists' mentalization must be studied as a relationship-specific state-like process* rather than (or additionally to) a general trait-like capacity, and they suggest that it is a *relevant dimension in dealing with CT phenomena*.

This conclusion appears to be supported by a more recent study from Rizq and Target (2010). Findings indicated that higher RF in counseling psychologists could be associated

with the ability to manage feelings evoked by difficult and challenging patients, and lower levels of RF were accompanied by accounts of distancing or becoming overwhelmed by strong feelings and patient's in-session behavior. However, exceptions were found. Specifically, one of the 12 participants' high RF appeared to fuel clinically detrimental anxious and depressive ruminations. Thus, *a useful model of ECE should allow discriminating productive mentalization of CT from ruminative self-consciousness* – which, according to Campbell et al. (1996), is involuntary, emotionally negative, and motivated by anxiety, in contrast to reflection, which is voluntary, emotionally positive, and guided by curiosity.

Measuring therapists' RF through semi-structured interviews about specific patients, a recent study (Reading, 2013) assessed the relationship between the mentalizing capacity of 43 therapists' conducting Brief Relational Therapy and a number of process and outcome variables. Results suggest that therapists' RF can predict relevant process dimensions (namely with regard to addressing and resolving alliance ruptures) and therapeutic results reported at 6-month follow-ups. Hence, therapists' mentalization appears to facilitate relational work, which in turn may be an important mediator of long-term therapeutic gains.

Lamboy, Blanchet, and Lecomte (2004) validated linguistic indicators of therapists' reflective consciousness based on descriptions of reflectivity extracted from CRS, GEVA, and the Experiencing Scale manuals (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986 – see below). The authors intended to reduce inference and increase objectivity and inter-rater fidelity, which they demonstrated to be problematic in the measures reviewed, with the final goal of creating the "Grille d'Analyse de la Conscience Reflexive du Thérapeute" [Therapist Reflective Consciousness Rating System]. To our knowledge, the task was left unfinished so far, but the motivations and preliminary findings of this study are important to the field, showing that linguistic markers can be an alternative and/or add objectivity to rating systems in assessing reflectivity.

Although lacking explicit reference to mentalization, and thus uncaptured in our systematic review (see footnote 3), a few other lines of research may be relevant to our scope. In particular, research addressing therapists' mental activity as *referential process* (Bucci, 2002) and *experiencing* (Klein et. al, 1986) has an arguable connection with mentalization.

Bucci's (2002) Multiple Code Theory draws on the psychoanalytical notion of multiple systems of thought and proposes a new metapsychology based on both cognitive science and psychoanalytic ideas on emotional information processing. Specifically, three systems of processing and representing information are described (nonverbal subsymbolic, nonverbal symbolic, and verbal symbolic), each with its own operating principles. These

systems are connected, partially and to varying degrees, by the *referential process* – a bidirectional process by which emotional and bodily experience, largely subsymbolic, is linked to imagery and then to language, and the words of others are connected to one's own emotional and bodily systems (Bucci, Maskit, & Hoffman, 2012). Based on the debate, held by the authors, comparing the referential process with Lecours and Bouchard's model of mentalization (Bouchard & Lecours, 1998; Bucci, 1999; Lecours & Bouchard, 1999), we believe there are significant points of contact between the two, despite a greater emphasis on *integration* achieved through the former while *transformation* is central in the latter.

Recent studies assessed components of the referential process in session transcripts and therapists' case notes through computerized linguistic measures of referential activity (RA) and reflection (REF) (Bucci & Maskit, 2007; Bucci et al., 2012; Hoffman, Algus, Braun, Bucci, & Maskit, 2013). RA, considered pivotal in the referential process (narrative/symbolizing phase, following the arousal phase), can be considered a measure of engagement in experience, the degree to which language processes emotional experience. In the opposite direction, representing the reorganizing/working through phase of the referential process, REF means regulation or distancing from emotional experience. In the first of these studies, assessing session transcripts of a psychoanalytic treatment, high levels of RA in the analyst's speech were significantly correlated with session effectiveness as rated by independent judges (Bucci & Maskit, 2007). In the second one, involving case notes from successful and unsuccessful psychoanalytical processes, high positive correlations were found between measures of therapists' RA and therapeutic effectiveness assessed by independent judges based on initial and final treatment notes (Bucci et al., 2012). REF yielded a nonsignificant mild negative correlation with the same measure of change. The fact that REF and RA clearly vary in opposite directions suggests that the term "reflection" within this model is employed somehow differently from the common use in mentalization research (see last paragraph from the previous section). REF's emphasis on logic functions and distancing from experience may lie closer to MSRS's objective-rational and high-level defensive mental activity. Its use by therapists may also be part of the type of regulatory mechanism activated with more challenging patients that Goodman (2010) highlighted (see above).

The dimension of experiencing was mostly conceptualized in the work of Eugene Gendlin and Carl Rogers as "the process of attending to that unverbalized yet ongoing visceral flow and using it as a referent against which one can check tentative symbolizations, thereby discovering the meanings and significance of what one is feeling" (Pascual-Leone & Greenberg, 2006, p. 33). EXP (Klein et al., 1986), its operationalization for research, rates the

quality of an individual's experiencing of himself through seven levels as revealed in verbal communications, ranging from impersonal, superficial, or abstract-intellectual content at low levels, to more advanced stages where feelings are purposefully explored and emergent levels of experiencing serve as referents for problem resolution and understanding (Klein et al., 1986). It has been suggested that the experiencing construct may fill a gap in mentalization literature regarding implicit self-oriented mentalization of affect (Liljenfors & Lundh, 2015). Although research on therapists' experiencing is very scarce, one of the two studies we found (Kazariants, 2011) supports the relevance of the matter, suggesting that it benefits the resolution of alliance ruptures. The other one demonstrated that "experientially grounded reflection", measured with EXP, can be positively impacted by training (Safran et al., 2014).

In conclusion, several previous models pertain to the field of ECE. However, by proposing a new model we intend to, simultaneously: extend the scope of CT management research, namely through a preferential focus on *elaboration*; narrow the scope of previous mentalization models by limiting the object of study to self-oriented psychotherapist mentalizing processes (i.e., by sticking to the field of CT phenomena); and widen the range of psychological processes contemplated under the notion of elaboration, by absorbing influences from other models describing the mental processing of experience.

Mentalizing countertransference experience: A model for research

Based on the reported literature, thus, we are interested in designing a model for ECE that accounts for increasing levels of elaboration without losing sight of the quality of experiential engagement. We believe two primary dimensions are needed to this end, separating non-defensive immersion in and awareness of experience from reflection. Others found value in similar distinctions, from supporters of the aforementioned two-step model to authors defining self-reflexivity as a "dialectical process of experiencing oneself as a subject as well as of reflecting on oneself as an object" (Aron, 2000, p. 668), integrating objective and subjective self-awareness; or even those suggesting a "kind of bidimensionality" in EXP, where stages 1 to 3 represent progressive ownership of affective reactions; stage 4 is the turning point, characterized by an account of fully owned experiences from an inward attention focus; and stages 5 to 7 involve increasing self-exploration, questioning, and awareness of emergent feelings and internal processes (Greenberg & Safran, 1987; Klein et al., 1986). Descriptions of CT internal processing in terms of phases also identify a turning point from evenly-hovering attention to active search for meaning, from containment to observation and questioning (Tansey & Burke, 1989). In mentalization terms, these dimensions may be regarded as implicit versus explicit poles.

In addition, and in line with the importance of linguistic features mentioned above (Lamboy et al., 2004), we believe narrative research may also provide us with useful clues as to how psychological work can be traced in therapists' discourse, considering that narrative organization may reveal implicit information-processing, defensive, and affect-regulatory mechanisms employed in the topic being addressed (e.g., Daniel, 2009). For instance, Habermas (2006; Habermas & Diel, 2010) distinguished between elaborated, dramatic, and impersonal narrative types. Differences among these types may signal varying levels of defense mechanisms, and are indicated by linguistic features such as the number of perspectives included/excluded, focus on present-narrator/past-protagonist perspectives, or subjectivity markers (e.g., mental expressions, presence of grammatical subject).

We propose, then, a bidimensional model to study ECE as a mentalization process varying in **Experiencing** and **Reflective Elaboration**. Contrary to some of the examples just cited, our dimensions are not cumulative, but virtually *independent* instead. Complementing these primary dimensions, our model assesses five other facets of ECE, inspired by the literature reviewed above and narrative and language research. These additional dimensions can be separately investigated and rated, and are described in detail in Table 1.[4] Besides clarifying ECE in greater depth, our seven dimensions may be articulated in a continuous score, which is useful for research purposes. In practice, ECE is to be assessed in therapists' comments on particular sessions and/or patients.

Insert Table 1 about here

Concerning our primary dimensions, *Experiencing* expresses increasing ownership and containment of immediate experience. Its levels (Table 1) resonate with important aspects of stages 1 to 4 from the EXP, the first four levels of the affect tolerance dimension from GEVA (see Lecours & Bouchard, 1997), and several features from CRS and MSRS (see above). In level 0, parts of what is being experienced are warded off, avoided, or dissociated, the result being that an observer has no experiential access to it. On the contrary, in level 2 reactions emerge that can be spotted by an observer although they are insufficiently integrated

[4] Aside from the existing literature, our five complementary dimensions of ECE reflect our effort to refine the capacity of the model to differentiate levels of elaboration when applied to material of varying elaborative quality. Also, we reckoned that adding these dimensions would be useful to further characterize countertransference positions (Figure 1) and thus help future raters, while providing several ordinal scores to be tested separately or in articulation. Future research should examine whether the latent structure of these seven dimensions confirms our hypothesized organization of ECE in two primary dimensions.

by the therapist him/herself. Although "reactivity" is overt at this level, we believe both levels 0 and 2 can substantiate CT reactions, to the extent that they deviate from a therapist's normal/baseline CT experience. Only in level 4 a full acceptance of experience takes place. Although transformation in the mental quality of experience occurs through preconscious spontaneous psychic work at these levels, they entail progressive CT elaboration. Thus, we view experiencing as a dimension of *automatic/implicit mentalization* (Fonagy et al., 2012) of CT experience (although, at level 4, controlled/explicit processes begin to operate).

Reflective Elaboration represents an actual effort to explain, organize, or make sense of things, pertaining to *controlled/explicit elaboration*, and can be simplified in two main levels (Table 1): Level 0, a rather passive account of information, be it a fact, an idea, or a subjective experience, in which the conscious/explicit goal of the speaker is to convey a communicative content already present in his or her mind; and level 2, an active attempt to generate questions, explanations, signification, or understanding – more than a recipient or a vehicle, the subject takes the position of an author.

As stated before, our primary dimensions are independent, meaning that, for example, high levels of reflective elaboration can operate with varying degrees of experiential basis. The result is a model in which six CT positions can be described, as presented in Figure 1.

Insert Figure 1 about here

The concept of CT position employed is borrowed from Racker's (1968) distinction between CT thoughts and positions, where the former can be seen as mental *contents* and the latter imply greater ego involvement, in what may be considered mental *attitudes*. Clearly, our model describes what therapists do with CT experience regardless of its contents, thus making it a model of CT positions. We now describe each position in greater detail.

Factual-concrete position *(detached description)*. When asked to comment on a session, the therapist provides impersonal objectivistic descriptions of events, actions, or concrete personal characteristics. There is a sense of absent subject, as if it would be indifferent who the speaker is, and little can be known about his or her experience of the session. The therapist is more concerned with reporting than explaining or understanding – the emphasis is on *description*. An example might be: *She was about 30. She was silent for a while, and I told her we had 50 minutes to talk about anything she wanted.*

Abstract-rational position *(detached meaning-making).* Here, we also find an impersonal objectivistic comment, but this time the observations are made in terms of general

categories, with the main emphasis on *explanation and classification*. This may include theoretical jargon, description of personal or relational patterns, diagnostic hypothesizing, but always in a rather rational and affectively distant fashion. References to the therapist experience are eventually made, but as if observed from the outside, lacking specificity, and presented as part of a conceptual frame rather than a personal one. The defensive use of theory mentioned above can be present, in which case intellectualization is the specific defense employed. Example: *He is a narcissistic man. Narcissists tend to be leaders, because of their need to be the center of others' attention. Still, they often become annoying for other people, including therapists.*

Projective-impulsive position *(disruptive expression).* These are the cases when the therapist expresses poorly modulated emotions – the emotion having the person rather than the person having the emotion (Angus & Greenberg, 2011). The main emphasis is on *discharge or catharsis*, since the purpose appears to be to expel or get rid of an untolerated experience rather than exploring it. A blind engagement or unrecognized reactivity is present: The internal determinants of what is being experienced are unattended, and instead its object/target is implicitly or explicitly recognized as direct and sufficient cause. Examples: *He's just so boring! No wonder her wife left him…*; or *How could I be so stupid?*

Argumentative position *(disruptive meaning-making).* Also here, the therapist is blindly engaged in some kind of unrecognized reaction, but now there is an emphasis on *justification and self-legitimization*, mechanisms through which he seems to be struggling with some aspect of experience – e.g., guilt. Once more, defensive uses of theory may fall on this CT position, but this time rationalization will be the central defense. Self-legitimization can be either achieved through justification or judgmental appreciations (including self-blaming). Ruminative self-consciousness (see above), driven by whatever type of anxiety, can also be included here. In fact, the main feature in this position is the presence of an undesired experience with which the therapist is trying to deal while failing to accept it in himself. An example for this position might be: *Just because he's new in town and felt lonely for a couple of weekends, doesn't mean he needs a therapist. You shouldn´t go to therapy looking for a friend.*

Contemplative-mindful position *(contained description/expression).* When speaking from this position, therapists will provide an account of emerging thoughts, perceptions, sensations, or emotions from an experiential standpoint. Contents expressed are owned as subjective production, implying that the emphasis is on *disclosure* and the therapist reveals acceptance of, and attention to, different nuances within the experiential field. This kind of

CT position can be easily associated with mindfulness, with its qualities of nonjudgmental and nonreactive awareness of moment-to-moment experience (Kabat-Zinn, 2003). It also intersects with descriptions of congruence (Rogers, 1957), therapeutic presence (Geller et al., 2010), or the type of evenly-hovering attention and openness to internal experience recommended by psychoanalytic authors (Bion, 1970; Freud, 1912/1958; Ogden, 2005). We believe this CT position may have a very relevant clinical impact in itself, as it entails an ability to experience, tolerate, and "survive" feelings evoked in the therapist by the patient's intense emotions – Bion's (1962) containing function –, establishing a form of affective communication through which the latter learns to tolerate and regulate his or her affective experience (Safran & Muran, 2000). Also because this aware, nonreactive taking-in of the patients' emotional life will be decisive for the unhooking from cognitive-interpersonal cycles mentioned earlier in this paper – in our view, Safran and Muran's (2000) *metacommunication*, described by the authors as "a type of *mindfulness in action*" (p. 108) and key strategy to repair alliance ruptures and resolve therapeutic impasses, relies on this CT postition. An example: *At a point I realized I wasn't paying attention. I could sense her feeling of a huge burden, but my mind just wandered away, while a kind of boredom started to grow inside me.*

Mentalizing position *(contained meaning-making).* From this CT position, the therapist tries to reflect and make sense of his or her experience while engaged in and fully recognizing it as his or her own. The emphasis, now, is in *understanding*, and an investigatory attitude prevails. The dialectic movement between experiencing, reflecting, and transforming shares important features with processes of mentalized affectivity (Jurist, 2005) and advanced experiencing and emotional processing (Klein et al., 1986; Pascual-Leone & Greenberg, 2007). The main difference between this position and the previous is in part pointed by Choi-Kain and Gunderson (2008) when comparing mindfulness with mentalization: The contemplative-mindful position concerns acceptance of internal experience, whereas mentalizing emphasizes the construction of representation and meaning related to these experiences. So, now we find a therapist tentatively exploring his or her CT experience, tolerant to frustration and uncertainty (i.e., cognizant of the opaqueness of mental states), and hopefully achieving new understanding and new experiences regarding what is going on in therapy. The kind of insight coming from this process, no matter how experience-near (Pascual-Leone & Greenberg, 2006), is certainly experience-grounded and has a quality of *emerging knowledge*, which is compatible with using theory as a resource in the process of signification. The fact that clinical understanding is informed by sufficiently mentalized CT experience makes it necessarily rooted in and contingent of the intersubjective field created by

the particular dyad, and this is, to our understanding, the key ingredient of unsaturated (Bion, 1963), lively, clinically relevant knowledge and understanding. Example: *I don't usually get this feeling in the end of our sessions. It feels like I've done most of the talking, like when you're with a stranger in an elevator. I'm wondering why she would feel like a stranger to me, why now.*

Concluding remarks

We presented our operationalization of ECE as a model of CT positions and dimensions reflecting the quality of therapists' mentalization. Mostly, we are interested in investigating whether variations in ECE can be associated with other process and outcome dimensions of psychotherapy from any approach. In fact, we think ECE may play an important role in facilitating a number of studied common factors of psychotherapy such as alliance, empathy, positive regard, congruence, repairing alliance ruptures, and CT management (cf. Norcross, 2011). We also believe it is pivotal in rendering experiential and relational dimensions of therapy as less incidental and more available for patient-customized judicious clinical use as possible.

Conceptualizing ECE as therapist mentalization facilitates a balance among historical tensions regarding CT: within the classical position, CT is decoupled from the patient's reality and treated as if unrelated to it, echoing the pretend mode; but reservations sometimes expressed towards Heimann's totalistic position (cf. Gabbard, 2001) may be synthesized as warnings against the risk of managing CT in psychic equivalence, where disowned personal reactivity is either unrecognized (projected) or felt as a direct expression of external reality (the patient's difficulties). We subscribe to the view that mentalizing CT experience means recognizing it as related to the clinical reality and yet being able to "play" with it (Fonagy et al. 2002; Fonagy & Target, 1996).

It should be clear, though, that our model does not concern but a few dimensions within the broad field of mentalization. In particular, regarding the four polarities aforementioned (Fonagy et al., 2012), we believe ECE is a model of mentalization equally involving automatic and controlled processes (e.g., experiencing and reflecting), with an internal focus (feelings, thoughts, imagery, somatic experiences…) somewhat prevailing over the external focus (e.g., therapist's reactions and actual behaviors), mostly about self (vs. others), and balancing cognitive and affective processes. Also, ECE is quite specific in pertaining to CT experience, rendering dispensable for our model a range of mentalization deficits unlikely to be found in psychotherapists' work (e.g., autistic states, paranoid delusions, severe loss of impulse control), and leaving other-oriented mentalization on a

secondary level of importance. We wish to make a brief point about the implications of this selective focus.

Clearly, we wouldn't suggest that mentalizing about patients and the therapeutic exchange in itself is any less important than ECE, or even that such processes are clearly separable since the latter is grounded in relational experience. We think ECE is an important ingredient of effective psychotherapy, impacting both relational and technical dimensions of the therapeutic process, but we assume it is one among others. More importantly, though, our model *prioritizes the assessment* of self-oriented aspects of mentalization over patient-oriented mentalization. In our view, the distinction between self- and other-focus is clear at the explicit level of mentalization, and an explicit focus on self is rated higher in our model compared to an explicit focus on patient's experiences (e.g., *internal focus* dimension – see Table 1). At the implicit level, though, the distinction between self- and other-focus seems less straightforward, which may be the cause for the gap in mentalization literature mentioned previously (Liljenfors & Lundh, 2015). Still, we believe that the predominance of subjective experiential embeddedness (i.e., the extent to which inner felt referents are used) may account for the self-orientation at the implicit affective level. In turn, self-focused implicit mentalization of cognition may be indicated by signs of post-formal reasoning (e.g., treating one's own thoughts as relative, dialectical, contextual, and subjective; see Marchand, 2002). In the words of Allen (2006), implicit self-mentalizing entails "a sense of self as an emotionally engaged agent – 'what it feels like to be me' in the process of thinking, feeling, and acting" (p. 11). Our model privileges self-oriented mentalization in the sense that its dimensions tend to value markers of implicit and explicit self-oriented mentalizing over mentalization of patients' actions and experiences.

And yet, we believe that ECE (in particular, therapist's implicit self-oriented mentalization) is actually a *necessary* part of clinically useful other (patient)-oriented mentalizing. For instance, highly accurate observations about patients' experiences can be irrelevant or even detrimental if stated from a poorly mentalized CT position – e.g., failing to convey the therapist's containment of his or her own emotions or a full awareness of the subjective and relative nature of his or her own impressions. In other words, we believe important mentalizing principles in psychotherapy, such as the inquisitive stance, not-knowing, or the respect for the opaqueness of mental states (Fonagy et al., 2012), rely primarily on the therapist's attitude towards his or her own mental processes and subjective states, i.e., on CT positions. In this regard, a recent study found a strong positive association between therapists' "professional self-doubt" and patients' improvement in interpersonal

problems, and a negative effect of therapists' self-assessed "advanced relational skills" on patients' global functioning and interpersonal problems (Nissen-Lie, Monsen, Ulleber, & Rønnestad, 2013). In the light of our model, these results might mean diversely mentalized CT positions.

As may have become evident, our major assumptions about the therapist's work are indebted to the work of others, namely Bion's model of container-contained, alpha-function, *reverie*, and theory of thinking (Bion, 1962, 1963; Ogden, 2005), Winnicott's concepts of potential space and transitional phenomena (Winnicott, 1971; Bram & Gabbard, 2001), Kernberg's (1997) defense of a "third position" created by the analyst's reflective stance aside from the engagement in the transference-CT dynamics, Fonagy and colleagues' descriptions of the mentalizing stance (Bateman & Fonagy, 2004), Rogers' delineation of the conditions for change (Rogers, 1957), and Safran and Muran's views on the "beginner's mind" and the use of metacommunication (Safran & Muran, 2000). Regardless of its roots, though, we believe our model addresses ubiquitous phenomena in psychotherapy.

The main limitations of our approach concern, first and foremost, the impossibility of a direct apprehension of CT phenomena – we will be *inferring* from *derivatives* of our object of study. Second, speech as the source of information about CT has its shortcomings. As much as we put all our efforts in refining a rating system, important unconscious and phenomenological dimensions will remain inaccessible – counteridentifications, imagery, visceral responses, to name a few examples. Third, the focus on CT positions doesn't guarantee a sufficient account of other constituents of the CT construct (Hayes, 2004) – e.g., origins, triggers, effects –, neither does it address larger experiential patterns, or transference-countertransference configurations, unfolding as the process evolves over time.

Still, we hope our model adds to the effort of investigating and drawing attention to the importance of psychotherapists' purposeful use of subjectivity and consideration of the experiences emerging within each unique dyad. In times of treatment manualization, such delicate work may require no less protection than an endangered species.

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Table 1

Dimensions of ECE

DIMENSION	DESCRIPTION	LEVEL				
		0	1	2	3	4
EXPERIENCING	*Increasing subjectivation, ownership, appropriation, or containment of immediate experience*	*Detached:* absent or remote contact with present experience; disengaged, impersonal, and objectivistic accounts of events or ideas		*Disruptive:* reactions insufficiently integrated; feelings not fully owned; subjectivity mostly described as legitimate or inevitable consequence of external determinants		*Containing:* experience fully recognized, accepted, and explored in its subjective quality
				Active meaning-making		
REFLECTIVE ELABORATION	*Effort to explain, organize, or make sense*	*Description/expression:* mere account of information, be it a fact or a subjective experience		*Simple explanation:* conclusive interpretation of causes, meanings, or sources (no awareness of opaqueness of mental states evidenced)		*Investigation/exploration:* open-ended search for questions and meaning as the subject speaks
EPISTEMIC POSITION	*Experienced relation between therapist's psychic reality and external reality (therapeutic process, client)*	*Equation:* feelings, observations, and ideas felt as copy or direct apprehension of clinical reality		*Separation/isolation:* concern with distinguishing subjective from objective aspects of therapist perspective; assumption that subjective is private and only objective is informative		*Dialectic:* feelings and ideas treated as products of dialectic relation to reality, thus clinically meaningful
EXPERIENTIAL GROUNDEDNESS	*Extent to which therapists' observations process/integrate and are anchored in concrete aspects of experience*	*Absent:* nothing in therapist speech particularizes a lived experience		*Diffuse:* therapist tries to report something that forces into phenomenological field, although it cannot be precised		*Vivid:* speech includes imagetic (memories, fantasies...), sensorial and/or bodily (somatic, motor) elements signaling concrete felt experience
EMOTIONAL DIFFERENTIATION	*Complexity and discriminative capacity with which emotional themes (from therapist and/or client) are treated*	*Diffuse/absent:* emotional focus hardly identifiable; if present, emotions mentioned in vague and abstract manner, without reference to concrete situations		*Simple:* emotion recognized; reference to more than one affect, if existent, refers to distinct experiences (e.g., different subjects, different moments) or presumes mutual exclusion (e.g., discerning whether client felt one emotion *or* another)		*Complex:* internal or relational emotional dynamism recognized and expressed in detailed, nuanced, and subtle accounts; or identification of interaction between emotions - simultaneous (mixed, conflicting…) or in causal sequence - or between emotions and other psychological processes
TEMPORAL FOCUS	*Articulation of past and immediate perspectives; differentiation and integration between past protagonist and present narrator perspectives*	*Past:* omits narrator current perspective, focusing exclusively on prior events or experiences; includes use of "historical present"		*Present:* reveals point of view held in the moment the speech is produced; even if reporting to past event, focus on current experience and apprehension		*Present-past:* focus oscillates between present and past perspectives in an effort to compare and integrate them
INTERNAL FOCUS[a]	*Extent to which internal experience is attended to and explored*	*Absent:* external focus; first person scarcely employed		*Implicit:* predominant external focus, but the speech is experiential; evident traces of a personal look (e.g., frequent use of first person, poetic or evaluative language)		*Explicit:* takes experience as the center; external elements used in the service of experience contextualization and depth exploration

Note. The primary dimensions, imported from the bidimensional model (Figure 1), are in boldface. Scores 1 and 3 may be used to rate intermediate processes lying between level descriptions.

[a] We do not imply that therapists should privilege an internal focus in session, but that they should be able to engage in self-exploration when looking back at experiences in session

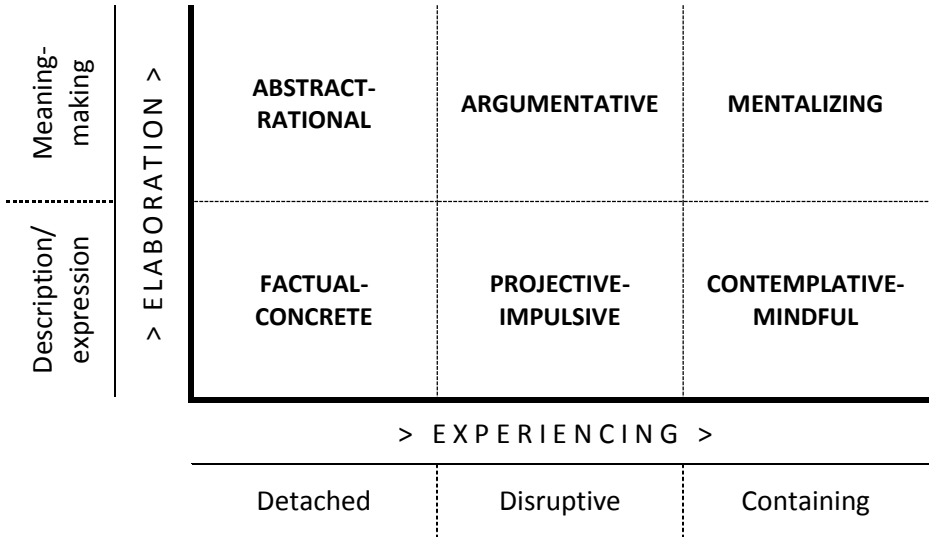

Figure 1. Bidimensional model of the elaboration of countertransference experience.