Countertransference in the treatment of adolescents and its manifestation in the therapist-patient relationship

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Abstract

Countertransference is a central construct in the clinical literature (Freud, 1910; Gabbard, 2001), yet it has generated very little research to date. The present study used the CCRT method (Luborsky & Crits-Cristoph, 1998) to measure countertransference themes in a sample of 12 therapists, who described relationship episodes with their parents and with two clients. Results showed high repetitiveness of the parent themes in the narratives about the patients for all three components of the CCRT: Wish, Response of Other and Response of Self. A qualitative analysis of the narratives generated four countertransference dynamics: repeating the parent RO, repairing the parent RO, identification with the patient, and withdrawing. It is suggested that these four dynamics constitute the process which links the origins and triggers with the manifestations and effects in Hayes’s (2004) operational model of countertransference.

Keywords: psychoanalytic/psychodynamic therapy; qualitative research methods; countertransference; CCRT method

Psychotherapy is an ongoing interaction between two people who perceive each other and respond to each other through the lenses of their characteristic interpersonal patterns (Aron, 1996; Safran & Muran, 2000). This relational “dance” is the context in which technique is applied and received, and through which patients learn about themselves. An abundance of research on the therapeutic relationship has yielded consistent results linking it to positive outcomes (Horvath, 2006; Samstag, 2006). However, most studies have focused on the working alliance, and mainly on patient factors (Horvath & Bedi, 2002; Lambert & Barley, 2001; Muran, 2002), whereas little attention has been paid to the therapist’s contribution to the relationship and its effect on the therapy process. One of the recommendations of the APA task force on empirically supported therapy relationships (Norcross, 2002) was to study “both patients’ and therapists’ contributions to the relationship and the ways in which those contributions combine to impact treatment outcome” (Norcross, 2002; p. 443). The present study focuses on therapist countertransference, which is one of the features of the therapeutic relationship listed by the task force.

Countertransference is a central construct in the clinical literature (Freud, 1910; Gabbard, 2001; Hayes & Gelso, 2001; Maroda, 1991), yet the amount of clinical research that it has generated is disproportionate to its clinical and theoretical importance. Fauth (2006) identified two main obstacles in this area: the first is a lack of conceptual clarity in the field, and the second is a lack of appropriate measurements to capture the complexity of countertransference.

Definitions of Countertransference

Hayes (2004) presented three main definitions of countertransference in the psychotherapy literature. In this study we adopted the “integrative” definition of countertransference, which has served as the basis for most research in this area (Fauth, 2006). The integrative definition pertains to therapists’ unresolved conflicts as the basis for countertransference reactions. These reactions can be conscious or unconscious, triggered by patient transference or other phenomena (Gabbard, 2001; Hayes, 2004; Sandler, Dare, & Holder, 1992).

We have found Hayes’s (1995, 2004) operational model of countertransference very useful in terms of...
defining the focus of this study. The model breaks the construct of countertransference into five components: Origins—those areas of unresolved conflict in the therapist from which countertransference reactions stem; Triggers—therapy related events that touch on these conflicts, such as patient transference, certain content areas discussed by the patient, or the phase of therapy (e.g., termination); Manifestations—affective, cognitive, behavioral and visceral reactions that therapists experience (e.g., avoidance behaviors, over-involvement with patients); Effects—consequences of these reactions on the quality of the therapy process and outcome; Management—the ability to deal with and minimize the negative impact of countertransference (e.g., how therapists deal with their anger or anxiety, degree of self-awareness in sessions). Our research objectives in this study were to identify the origins of countertransference, mainly therapists’ interpersonal patterns with parents, and also to examine some examples of the effects of counter-transference on process.

Countertransference in the Treatment of Adolescents

The psychotherapy research literature has paid little attention, to date, to the therapeutic process in the treatment of adolescents (Kazdin, 2004). Adolescents are usually referred to therapy by adults (parents, teachers) and keeping them in treatment presents a challenge for the clinician. Therapists need to develop a flexible therapeutic relationship with adolescents, in order to gain their trust and allow for fluctuations between autonomy and dependence (Anthony, 1974; Sarles, 1998). Adolescents by the very nature of their developmental stages frequently provoke strong countertransference feelings inside the therapist (Sarles, 1998), therefore they are a particularly good sample for studying countertransference.

Anastasopoulous and Tsiantis (1996) describe therapists’ countertransference with adolescents as stemming from three factors: the adolescent, the family and parents, and the therapist.

The adolescent: Working with adolescents requires that therapists be open to their emotional swings, their constant unwillingness to speak, and their challenging the therapists’ authority and competence. Therapists have to rely strongly on their own emotional process in order to understand adolescents. Parents and family: Therapists tend to feel that they are entering a competition with the parents, due to their unresolved conflicts with their own parents. They may find themselves identifying with the adolescent “against” the parents. Therapists try to connect to the parts of the adolescents’ self that their own parents ignored. The stronger the ungratified dependency needs and emotional needs of the adolescent, the stronger are the countertransference feelings in the therapist.

Measuring Countertransference

One of the difficulties inherent to studying countertransference is finding a reliable and valid measure for a construct that is multifaceted and partially unconscious. Another important issue in this regard is the use of self reports versus relying on outside raters (colleagues or supervisors) to define therapist countertransference. Several seminal studies in the 1950’s grappled with these issues (see Hayes, 2004, and Fauth, 2006, for a review). In one of the early classic studies, Cutler (1958) investigated the “blind spots” of two therapists as identified by the discrepancies between their self rating and ratings by their close acquaintances on a set of interpersonal attributes. The results of this study showed that when patients talked about material related to their therapists’ blind spots, the therapists manifested avoidance behavior. Subsequently, avoidance behavior was used as an indicator of counter transference in other studies (e.g., Hayes & Gelso, 1991; Peabody & Gelso, 1982; Robbins & Jolkovsky, 1987). Rosenberger and Hayes (2002), using a similar procedure, found that the stronger the therapist’s avoidance behavior, the weaker was the therapeutic alliance, rated by both therapist and patient.

One of the limitations of counter transference studies up to the 1990s was their heavy reliance on analogue studies. In these studies, patient material was taped by actors, and therapists responded to these tapes, not to real live situations. Moving into the field and using qualitative methodology, Hayes et al. (1998) analyzed data from 127 interviews conducted with eight experienced therapists immediately after their sessions. They identified a wide variety of countertransference origins, triggers and manifestations. Examples of origins included issues with family of origin, parenting and role as romantic partner. Countertransference manifestations were grouped into four categories: approach reactions, avoidance reactions, negative feelings and treatment planning/process decisions. Therapists experienced countertransference in 80% of their sessions, lending support to modern conceptualizations of countertransference (Gabbard, 2001; Maroda, 1991) which view it as prevalent in the course of psychotherapy.

There are two measures that are currently used in countertransference research. One is the Inventory of Counter-transference Behavior (ICB, Friedman & Gelso, 2000) and the Counter-transference Factors
Inventory (CFI, Van Wagoner, Gelso, Hayes, & Diemer, 1991). The ICB assesses countertransference behaviors, such as avoidance or enmeshment. The CFI assesses characteristics that can facilitate countertransference management including self-integrity, insight, conceptual skills, anxiety management and empathy. Although both instruments have acceptable reliabilities, they don’t tap into the origins of countertransference nor do they demonstrate how countertransference behaviors stem from these origins.

In their recommendations for further research, both Hayes (2004) and Fauth (2006) argue that measurement remains the greatest challenge in this area. Hayes (2004) emphasized that: “To study counter-transference meaningfully one needs to be confident that therapist’s reactions stem from areas of personal conflict” (p. 32).

In a recent paper Hayes, Gelso, and Hummel (2011) present the results of three meta-analyses which examined the relation of countertransference to therapy outcome. Particular emphasis was placed on the management of countertransference. Results showed a modest but significant inverse relation of countertransference to therapy outcome, and a strong and significant relationship between managing countertransference and better outcome. In their conclusion the authors call for more controlled quantitative field research on countertransference.

Using the CCRT to Measure Origins of Countertransference

One of the measures that seems promising for countertransference research is the Core Conflictual Relationship Theme Method (CCRT, Luborsky & Crits-Christoph, 1998), originally developed as a measure for assessing transference. The premise underlying the CCRT is that patients’ early relational patterns with their parents are carried over into subsequent relationships, and specifically into the relationship with the therapist. Central relationship patterns consist of three basic components: A wish (W), the perceived Responses from Other (RO), and the Response of Self (RS) to the other. The Wish component covers a wish, desire, or intention that the person has towards the other (e.g., to be loved, to be assertive); the RO refers to an actual, anticipated, or fantasized response from the other (e.g., supportive, disapproving); and the RS refers to the person’s anticipated or fantasized response of the self in the form of thought, emotion, behavior, or symptom (e.g., feels accepted, depressed). The three components of the CCRT are derived from relationship episodes (REs), in which patients tell about specific interactions with others.

In addition to their specific content, the RO and RS can be rated as negative or positive, and the relationship between the three components is rated as complementary or conflictual. The person’s central relationship theme is composed of the most frequently recurring W, RO, and RS across a set of REs. Whereas in the past CCRT researchers sought one predominant theme, recent studies have shown that there are several different CCRT patterns within different significant relationships (Connolly, Crits-Christoph, Barber & Luborsky, 2000).

The CCRT has been employed widely as a reliable and valid measure of transference and interpersonal patterns with others (Connolly et al., 1996; Luborsky & Crits-Christoph, 1998). Several studies have shown that the CCRT changes over the course of psychotherapy, consistent with psychoanalytic theory. Specifically, Crits-Christoph & Luborsky (1998) reported a significant decrease over the course of therapy in the pervasiveness of ROs and RSs, with the largest decrease in the negative RO, in a sample of depressed adults. A study tracking changes in patients’ CCRTs in long-term psychodynamic psychotherapy found an increase in positive responses from others and the self, suggesting increased flexibility as a result of therapy (Wilczek, Weinryb, Barber, Gustavson & Asberg, 2004). In a recent study Sommerfeld, Orbach, Zim & Mikulincer (2008) showed that ruptures in the therapeutic alliance were positively related to the emergence of patients’ CCRT themes regarding the therapist. The CCRT has not been used to date to study therapists’ central relationship patterns, and this is the first study to test its usefulness in studying countertransference. In this exploratory study we sought preliminary answers to the following research questions:

1) Do therapists’ central relationship themes with their patients appear in their relationship with their patients?
2) Do interpersonal patterns with therapists’ parents appear in their narratives about one or two patients? description of one or both patients for each therapist?
3) How is countertransference expressed in therapists’ interventions with the patients?

Method

Therapists. Twelve female social workers, who worked in 11 different mental health centers for adolescents. Their ages ranged from 30 to 40, they were all native Israelis, and they had 2–10 years of experience conducting psychotherapy. Ten had an MA degree and two were BA-level social workers.
They all practiced psychodynamic psychotherapy (based on object relations theories). Each therapist told narratives about two adolescent patients, for a total of 24 patients. Sixteen of them were female and eight were male patients. The choice of social workers was due to their willingness to participate in the study.

**Raters.** Three female raters coded the interview material. Two were graduate students (one in clinical psychology and one in social work) and one was an undergraduate student in social work.

**Measures**

**Core Conflictual Relationship Theme (CCRT; Luborsky, 1977).** The Relationship Anecdote Paradigm (RAP) interview (Luborsky & Crits-Christoph, 1998) was employed to assess therapists’ interpersonal patterns. Therapists were asked to relate 12 meaningful interactions with each of the following people: father and mother (three REs each), and two patients of their choice (three REs each). The fully transcribed interviews were then coded on the CCRT rating form (Barber, Foltz, DeRubeis & Landis, 2002) by two independent raters. The Hebrew version of the CCRT rating form (Wiseman & Barber, 2004) yields an adequate reliability coefficient (Wiseman, Metzl, & Barber, 2006).

**Procedure**

The interviews were conducted by the second author, a graduate student in Social Work, who was trained in the CCRT method. The interviews lasted 60–90 minutes. The therapists were blind to the research questions, and they were told that this was a study about therapeutic relationships. They were first asked to describe interactions with their parents, and then to describe meaningful interactions with two patients of their choice who were in ongoing treatment. In each interaction therapists were asked to describe what happened, how the other person reacted, how the relational episode ended, and how they felt about it. Following the relational narratives, therapists were asked about their reasons for choosing the two patients, and how they viewed the relationship with those patients.

**Coding.** Raters were trained using a procedure described by Luborsky and Crits-Christoph (1998). They practiced coding similar materials until they reached an inter-rater agreement level of Kappa = 0.85.

The coding procedure was as follows: The three raters formed three rating “pairs,” and each “pair” received a third of the interview material. The REs of the parents and patients were divided up randomly between the rating pairs, so that they did not always rate the parents and patients of the same therapist. Within each “pair” raters worked independently, and they were blind to the research hypotheses. When coding the interviews, each relationship episode was defined as a separate scoring unit. Raters used the list of categories provided by Barber et al. (2002) to rate the wishes (W), responses of other (RO), and responses of self (RS) in each episode. Each W, RO and RS was rated on a 7-point Likert scale, indicating the extent to which the particular item was present in the relationship episode. The two Ws, ROs and RSs that received the highest ratings constituted the therapist’s CCRT in a specific relationship. Thus, for each therapist we defined a CCRT with mother, father and each of the two patients.

**Results**

**Interrater Reliability**

Each interview was coded by two raters, with a total of three raters for all 12 interviews. Interrater reliability was calculated using Spearman’s rank order correlation coefficient. Results showed high interrater reliability for each of the three CCRT components (\( W = .896, \ RO = .874, \ RS = .877, P < .01 \)).

The following results section presents both quantitative and qualitative analyses of the interviews. First, we present a quantitative analysis of repetition of the CCRT themes based on the CCRT coding method. This analysis was used for the first two research questions. For research question no. 3 we used a qualitative approach.

**Do Therapists’ Central Relationship Themes with their Parents Appear in their Relationship with their Patients?**

The data analysis was based on the cluster categories (Edition 3) proposed by Barber, Crits-Christoph and Luborsky (1998).

Table I presents the most frequent CCRT categories in the relationship patterns of therapists with their patients and with their parents, summed across the entire sample. In the relationship with parents, the wishes “to be close” and “to be loved” were the most frequent. In the relationship with patients, the most frequent wish was “to help,” followed by “to be close” and “to be loved.” The main Responses from Other in both relationships were: rejecting and hurting. The Responses of Self were also similar: Hurt.
Table I. CCRTs of therapists’ relationship with parents and patients.

<table>
<thead>
<tr>
<th>CCRT</th>
<th>Parents</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wishes</td>
<td>To be close (13), to be loved and understood (13)</td>
<td>To help (15), to be close (9), to be loved and understood (7)</td>
</tr>
<tr>
<td>Responses</td>
<td>Rejecting (17), loving (12)</td>
<td>Rejecting (15), open (7), accepting, respectful (11)</td>
</tr>
</tbody>
</table>

Numbers in parentheses represent frequencies from two parent interviews and two patient interviews, for a total number of episodes of \( n = 24 \) (12 therapists × 2 parents each).

Do Parental Interpersonal Patterns Appear in the Description of One or Two Patients?

Table IV presents the number (and percentages) of therapists whose CCRTs with their parents appeared in their narratives about one patient only, or in the narratives on two patients. Results show that parent ROs appeared mostly with two patients (91%), and the RS to a somewhat lesser extent (70%). This finding is important in light of the fact that the patients were not perceived as identical by their therapists, and that different parent ROs appeared with different patients treated by the same therapist.

How is Countertransference Expressed in Therapists’ Interventions with Patients?

The finding that parent CCRTs appeared in the narratives about patients provided a framework for further explorations of how these themes were expressed in therapists’ intervention with their patients. Two independent judges read all 12 interviews, which had previously been coded for W, RO and RS. This second reading made it possible to track the repetition and evolution of themes in the narratives of each therapist, and to examine how and when they appeared with their patients. The judges were asked to label each instance of repetition as a type of countertransference expression (e.g., repeating the parent RO towards the patient, or expressing...
might represent the "origins" of the parent themes in the narratives about patients. The appearance of two cluster categories (content categories) for W, RO and RS in six therapist interviews two content clusters appeared in both narratives. The appearance of the parent themes in the narratives about patients might represent the "origins" of countertransference (Hayes, 1995). Thus, in response to the Gelso and Hayes (2007) call to find "sophisticated ways of capturing the often unconscious roots of countertransference reactions" the CCRT seems to be a useful measure which provides rich material.

Regarding our first research question, all three components of the therapists’ CCRTs with their parents appeared in their relationships with their patients. The wishes "to be close" and "to be loved" were the most prevalent in the relationship with the parents and were repeated in about one half of the narratives with the patients. These findings show that therapists are not "neutral" in the therapeutic encounter, and they bring their own "agendas" to the relationship. The wish "to help" was the most frequent wish regarding patients and it did not appear in the narratives about the parents. Thus the CCRT method does not automatically produce identical responses for different relationships. The wish "to help" is, of course, characteristic of the helping professions and may represent learned values. However, it might also represent a need to form a "corrective experience" with patients which differs from their own experience of hurt and rejection with their parents. The Response of Other "rejects me" was the most common response in both parent and patient narratives, appearing in 71% of the parent narratives and in 63% patient narratives. When therapists perceived their parents as both loving and rejecting, the RO "loving" did not appear in the relationship with the patients. Thus patients were apparently perceived through the lens of the rejecting parent, which fits the classical definition of countertransference. However, if we consider the fact that the therapists in this sample worked with difficult adolescents, it is possible that the patients which they selected in the RAP interview were actually quite "rejecting." In that case, the RO "rejecting" could be a blend of the real aspects of the interactions, with the subjective experience of therapists, which fits the relational definition of countertransference (Aron, 1992; Gabbard, 2001).

The Response of Self. "Helping" was the most prevalent response in the narratives about patients, which fits with the therapists’ wish "to help." However, the RSs "disappointed" and "hurt," which appeared in the relationship with the parents, also appeared in the relationship with the patients. Here too, there was a blend of familiar Responses of Self with a new response.

Our findings point to a dominance of “negative” countertransference feelings, i.e., it is primarily the negative themes from the parent narratives that appear in the narratives about patients. This raises the issue of the relative impact of positive vs. negative feelings on countertransference. A study by Hayes, Ricker, and Ingram (1997) found a relationship between countertransference feelings and negative outcomes, whereas no such relationship was found with positive outcomes. It is possible that when therapists experience strong negative feelings, and are unable to manage their countertransference (e.g.,

<table>
<thead>
<tr>
<th>CCRT component</th>
<th>Repetitiveness: one patient</th>
<th>Repetitiveness: two patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wish</td>
<td>5 (46%)</td>
<td>6 (55%)</td>
</tr>
<tr>
<td>Response of</td>
<td>1 (9%)</td>
<td>10 (91%)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (30%)</td>
<td>7 (70%)</td>
</tr>
<tr>
<td>Response of Self</td>
<td>4 (6%)</td>
<td>5 (71%)</td>
</tr>
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<td></td>
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</table>

Discussion

In this study we used the CCRT method to collect narratives about therapists’ relationships with their parents and with their patients as a means of identifying countertransference. Our results show that in 11 out of 12 therapist interviews the CCRTs of parents and patients were similar in either one or two cluster categories (content categories) for W, RO and RS. In six therapist interviews two content clusters appeared in both narratives. The appearance of the parent themes in the narratives about patients might represent the "origins" of countertransference. In that case, the RO "rejecting" could be a blend of the real aspects of the interactions, with the subjective experience of therapists, which fits the relational definition of countertransference (Aron, 1992; Gabbard, 2001).
with the help of supervision) this may create a cycle of negativity: the patient is “difficult” and the therapist, due to countertransference, cannot contain the patient’s negative emotions and therefore reacts according to old personal patterns.

Our findings show that the predominant parent ROs appeared in the narratives about two patients, in almost all the interviews. However, the content categories were not necessarily the same for each patient. Thus, individual patients apparently trigger different aspects of therapists’ CCRT, which supports the notion of countertransference as a mutual creation (Gabbard & Wilkinson, 1994). For example, one therapist perceived her mother as close, loving and warm. Similarly, she described one of her patients as: “close, cuddling… she likes me and wants me to be her mother.” This therapist perceived her father as distant, and described her efforts at fostering closeness between them as unsuccessful. In the RAP interview she described a second patient as distant and flat: “I felt that there was something very monotonous in the session, I wasn’t expecting it to be boring—it wasn’t supposed to be boring… I felt like grabbing her and shaking her. In the end I said that as I saw it, our relationship and our work were very meaningful, even if she didn’t feel that way at the time.” The therapist was clearly concerned with issues of closeness and distance in relationships, and with both of her patients she focused on these issues. However, the relational theme was expressed differently with each patient, parallel to her relationship with each of her parents: with one she felt close and helpless. The same theme re-appeared in her narrative about the patient she described the following interaction: “The patient told me about her fears that her father might die- fears that were out of proportion. I tried to get her to see things in the right proportion. She was very upset. Usually she doesn’t cry. She told me that her aunt died, and she was out of proportion. My aim was to get her into proportion. I told her that she was 13 years old, and it hadn’t happened to her father or mother, and I just wanted to help her to move on with her life.” In this example, the therapist repeated her father’s response to her, although she had experienced this response as very non-empathetic. Thus, under the influence of countertransference, she automatically responded to her patient in a manner that was far from optimal.

**Repeating the response of the parent.** A therapist told a story about her father’s response to her breaking up with her boyfriend of three years: “My father always says: ‘everything will be o.k.’. This is how he copes with problems. I was sad and he said to me that it is just a boyfriend—it’s not the end of the world and that I must put things in the right proportion. I was angry with him. It was very difficult for me.” In the narrative about the patient she described the following interaction: “The patient told me about her fears that her father might die- fears that were out of proportion. I tried to get her to see things in the right proportion. She was very upset. Usually she doesn’t cry. She told me that her aunt died, and she was out of proportion. My aim was to get her into proportion. I told her that she was 13 years old, and it hadn’t happened to her father or mother, and I just wanted to help her to move on with her life.” In this example, the therapist repeated her father’s response to her, although she had experienced this response as very non-empathetic. Thus, under the influence of countertransference, she automatically responded to her patient in a manner that was far from optimal.

**Repair—responding in a manner that is the opposite of the parent RO.** A therapist whose father died when she was a child described her relationship with her mother as being with a friend more than being with a parent. The two of them often got into fights, and her mother wouldn’t speak to her for days, nor assume any responsibility for ending the fights. This left her feeling very frustrated and helpless. The same theme re-appeared in her therapeutic stance vis-à-vis a male adolescent patient, who tried to “fight” with her in the session: “I had to be the adult who was not intimidated by him, who could help. I felt that I was the responsible adult, and that he could fight or reject me, and I was the one who had to contain it.” This therapist, unlike her mother, understood the importance of assuming an adult role in response to an agitated, stormy adolescent. She was also able to recognize the patient’s distress and dependency which lay behind his display of aggression. In this case, countertransference facilitated a therapeutic response based on a “repair” of her painful experience with her own mother.

**Distancing or withdrawal.** Choosing an intervention that expressed minimal involvement with the patient, when the content is “too close to home”: In

Types of Interactions with Patients which Express Countertransference

In the following section we present the four types of therapist-patient interactions that were analyzed in the Results section. Each type of interaction will be illustrated by a characteristic example.

**Identification with patients.** A therapist told the following narrative about her father: “I started crying and he was totally with me, even though he is not a man of words. He was very present, he was there, and I didn’t know what I needed. In retrospect I know that there are moments in which I don’t know what I need, but I want someone else to know for me. I need someone else to be accurately attuned to me, and he really was.” This therapist chose to talk about a patient who had a similar wish, and she told him: “I recognize this feeling that I want the other to do something for me, even though I don’t really know what I need.” In this interaction the therapist understood the patient’s needs not just from listening to him, but also from a deeper, personal place that resonated with the patient’s communication.
these instances the patient’s material may have aroused very strong feelings in the therapists, and one way of dealing with these emotions is withdrawal. For example, one of the therapists grew up with a highly intrusive father who exhibited inappropriate sexual behaviors. She described how her father used to walk around the house in his underwear, showing her that they were too tight for him. In another episode she described how they took a bath together when she was a child, and she was disgusted by his hairy legs. One of her adolescent patients also grew up in a highly charged sexual environment and the therapist described an RE in which the patient discussed possible sexual innuendos by her boss. The therapist described her reaction as follows: “I could see through her—but I couldn’t really touch her. I felt helpless...I could only look at her but I couldn’t say anything.” In this example the patient’s material was similar to the therapist’s CCRT, which may have aroused a great deal of anxiety in the therapist. As a result she avoided addressing the implicit sexual content in the patient’s communication. When she said that she couldn’t touch the patient, it is not clear whether it was the patient that could not be touched, or the therapist who was activated by her countertransference. This example fits with previous studies which identify avoidance as one of the manifestations of countertransference (Hayes & Gelso, 1991; Hayes et al., 1998).

By extending Hayes’ operational model of countertransference (Hayes, 1995, 2004), we suggest that these patient-therapist interactions constitute the process which links the origins and triggers with the manifestations and effects. The therapist’s CCRT (based on the therapist’s relationship with her parents) represents the origins of countertransference. The REs about the patients provide information about the particular triggers and the specific manifestations that occurred in each therapist-patient dyad. The four types of interactions illustrate different processes that therapists go through when old relational patterns are activated by the patient. These internal processes reflected in the REs in our study led therapists to different responses (i.e., manifestations of countertransference) and in-session effects.

There are several shortcomings to this type of study: First of all, collecting and coding CCRT interview data is a lengthy and costly process, which results in using small samples (e.g., Sommerfeld et al., 2008; Tishby, Raitchick, & Shefler, 2007). Our study was based on 12 therapists, which limits the generalizability of the results. However, we felt it was important to test the usefulness of the CCRT method on a small sample before committing to a larger study. Another limitation is that all therapists were female, and all the patients were difficult adolescents. Future studies should use a larger sample, with both male and female therapists, and a wider variety of patients. Such a study is currently in process, in a large outpatient unit in Israel (Wiseman and Tishby). Another methodological issue concerns the sequence of narratives in the RAP interview: Asking therapists to choose two patients following their spontaneous narratives about their parents. Interviewing in this sequence may have influenced the therapists to unconsciously select patients and narratives that “fit” with their narratives about the parents. However, this “fit” also appears to have been governed by countertransference in the course of the interview in the sense that relating narratives about their parents triggered specific issues in the therapists which then generated the REs about the patients. In order to test this issue, future studies should conduct CCRT interviews in a variety of formats; for example, asking therapists to select patient REs before they tell narratives about the parents, or conducting two separate interviews, at two different time points.

Overall, the present study represents an effort to further the exploration of the clinical phenomenon of countertransference. The CCRT was found to be a very useful method for capturing themes from the therapist’s past which re-appear in the relationship with the patient. The therapists’ narratives also shed some light on therapists’ internal process that can lead to patient-therapist interactions in which countertransference is involved. Additional studies in this field are needed in order to deepen our understanding of how countertransference operates, and how therapists can manage countertransference and use it effectively in the treatment process.

References


