COMMENTARY

Countertransference in Child and Adolescent Psychiatry-A Forgotten Concept?

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Abstract

Objectives: The purpose of this paper is to review the evolution of the concept of countertransference, its clinical utility and unique features in the child and adolescent psychiatry setting. **Methods:** This article employs a selective literature review of papers relevant to countertransference in general and in child and adolescent psychiatry. **Results:** Reviewed papers indicate that countertransference is a ubiquitous phenomenon in child and adolescent psychiatric practice and that it can have important clinical implications. **Conclusions:** Recognition and management of countertransference is a crucial skill in child and adolescent psychiatry. Recommendations are made regarding its incorporation in residency training and psychiatric practice.

Key words: *countertransference, child and adolescent psychiatry*

Résumé

Objectifs: Analyser l'évolution, l'utilité clinique et les spécificités du concept de contre-transfert en pédopsychiatrie. **Méthodologie:** Étude sélective d'articles sur le contre-transfert en psychiatrie et en pédopsychiatrie. **Résultats:** Le contre-transfert est un phénomène omniprésent en pédopsychiatrie qui peut avoir de sérieuses implications cliniques. **Conclusion:** Il est essentiel que le pédopsychiatre soit en mesure de reconnaître et de gérer le contre-transfert. L'auteur recommande d'intégrer ce concept dans le programme de formation des résidents et dans la pratique psychiatrique.

Mots clés: *contre-transfert et psychiatrie de l'enfant et de l'adolescent*

Introduction

Recognizing and managing countertransference reactions is a crucial skill for clinicians at all levels of training in psychiatry (Langsley & Yager, 1988; Mohl, Sadler, & Miller, 1994; Royal College of Physicians and Surgeons of Canada, 2009). Presently, its teaching in psychiatric residency is confined mainly to psychotherapy supervision, particularly psychodynamic psychotherapy. As psychotherapy training becomes less heavily weighted in proportion to psychopharmacologic interventions in residency training, combined with an increasing focus on 'here and now' therapies and the marginalization of concepts related to psychoanalysis by many academics, these important skills may be eroded (Gabbard, 2005b; Rao, Meinzer, & Berman, 1997; Torrey, 2005). Countertransference (CT), however, exists in all therapeutic situations and has important implications for the therapeutic alliance, clinical decision-making and even clinical outcomes (Gabbard, 2005a; Gelso, Latts, Gomez, & Fassinger, 2002). In addition, different clinical settings (inpatient or outpatient treatment, crisis intervention) elicit qualitatively different CT and understanding and exploring the origins should be emphasized across these settings.

Child and adolescent psychiatry is unique in terms of the quality and intensity of CT (Abbate, 1964; Showalter, 1985). In comparison to work with adults, interactions with children, adolescents and their families bring up particularly complex and confusing feelings, which if unrecognized, can significantly influence clinical judgment and clinician behavior in unpredictable and potentially counter-therapeutic ways. Alternatively, the recognition and processing of these

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complex reactions with team members and colleagues provides an excellent opportunity for a more complete clinical understanding and the opportunity to enrich teaching and develop therapeutic skills in psychiatric trainees as well as psychiatric staff at different professional and developmental phases of their career.

This paper will examine the concept of CT, its importance and clinical implications with a particular focus on child and adolescent psychiatry. While other terms could be used to describe similar psychodynamic reactions, I have not encountered another term as comprehensive and clinically pragmatic. I will argue that clinicians should re-familiarize themselves with CT and teach it to learners, recognizing that utilizing the concept itself can enhance clinical effectiveness without the need to accept the totality of classical psychoanalytic theory.

Evolution of the Concept

Since Freud first used the term countertransference, its definition has evolved. Initially described somewhat pejoratively as "defects [in the psychoanalyst] that hold back from consciousness what has been perceived by the unconscious…" (Freud, 1912), CT was viewed as an obstacle to the analyst delivering effective treatment. Over time, the concept has gradually broadened to encompass a psychiatrist's total reaction to a patient in a therapeutic situation (Brandell, 1992; Ens, 1998; Gabbard, 2004; Heimann, 1960). CT arises from the clinician's intrapsychic processing of real patient behaviors, characteristics and appearances, a process that is influenced by the clinician's past experiences. This results in reactions that can range from largely conscious to largely unconscious and are predominantly emotional or cognitive. (Bemporad & Gabel, 1992; Betan, Heim, Zittel Conklin & Westen, 2005). This can unconsciously influence clinician behaviors and lead to enactment. I will refer to this as countertransference reactions (CTRs). In contrast to Freud's impression of countertransference as a hindrance to effective psychoanalysis, this expanded view recognizes CT to be an important clinical tool that provides in vivo insight into a patient's intrapsychic world, their interpersonal patterns, and the feelings and cognitions that the patient may evoke in significant others. This expanded view of CT recognizes that the origin of countertransference may not be immediately apparent, but that the presence of a CTR may be the first clue to what is going on in a patient (Gabbard, 2004; Heimann, 1960; Sandler, 1976). This view emphasizes that therapist reactions are normal and need to be explored, whereas Freud's original view implied that CT is somehow 'wrong' and this could lead to a 'phobic' avoidance response to one's own CT (Kernberg, 1965).

A further elaboration of the concept came when CT was divided into objective (or homogeneous) reactions or subjective (or idiosyncratic) reactions (Giovacchini, 1981; Marshall, 1979; Winnicott, 1949). Objective CT is considered to reflect how most therapists in a similar situation would react (Winnicott, 1949) (e.g. feeling helpless after a patient has repeated overdose ingestions despite the best efforts of the therapist) while subjective CT is considered to stem from the therapist's own unresolved intrapsychic conflicts (Marshall, 1979; Ritvo & Ritvo, 2002). Both objective and subjective CT are important sources of information for the clinician but can have different implications for the clinical situation.

Countertransference is Ubiquitous and has Important Clinical Implications

Countertransference does not only live in the psychoanalyst's office. While transference-countertransference has time to crystallize in long-term psychodynamic or psychoanalytic settings, feelings and reactions to patients are ubiquitous and can present in virtually any therapeutic interaction (Ens, 1998). CT can present before the first visit while reading the consultation letter, reviewing the chart, or even on observation of the receptionist's reaction to the patient in the waiting room (Gabbard, 2004). In dynamic therapies, awareness of, and insight into, CT is generally thought to be an important factor for psychotherapeutic change (Gelso et al., 2002). Countertransference is closely related to empathy; however, negative or even overly positive countertransference feelings can contribute to a weak or unrealistic therapeutic alliance (Ens, 1998; Holden, 1990; Maltsberger & Buie, 1974), an important factor in determining a successful outcome in mental health treatment.

There are countless ways that countertransference can manifest. A study surveyed 181 adult psychologists and psychiatrists and found that CT and CTRs clustered in 8 domains: overwhelmed/disorganized, helpless/inadequate, positive, special/overinvolved, sexualized, disengaged, parental/protective, criticized/mistreated. Interestingly, CT correlated well with patients' personality pathology and were independent of the therapist's theoretical orientation, suggesting that CT may have important diagnostic implications (Betan et al., 2005).

Countertransference also exists in a variety of typically 'non-psychotherapeutic' settings, including pharmacological management. An example of such a manifestation might be a psychiatrist who over prescribes because of underlying

feelings of impotence in response to a patient's demands. Conversely, some psychotherapists may not prescribe a necessary medication because doing so might imply their own psychotherapeutic skills are ineffective (Gabbard, 2005a).

There is evidence that intense, unresolved countertransference feelings can contribute to physician burn out (Meier, Back, & Morrison, 2001). Outside of psychiatry, any medical setting where treatment decisions provoke strong feelings in the clinician can trigger intense CTRs. Rentmeester and George (2009) presented two cases in which patients refused life saving treatment and medical doctors subsequently requested psychiatric consultations. In one case, the physician repeatedly consulted psychiatry for competency assessments in response to fears of legal action. In the second case, the physician responded angrily to the psychiatrist's assessment that the patient was competent, implying an unwillingness to accept the patient's refusal. In both cases, they concluded that countertransference feelings significantly influenced decision-making (Rentmeester & George, 2009).

While the term countertransference has been de-emphasized in the mainstream psychiatric literature, investigation into the role of emotions in decision-making is growing. Cognitive neuroscientists have published evidence demonstrating that when faced with uncertainty, emotions aid decision-making. A network of pathways including the amygdala, ventromedial and dorsolateral prefrontal cortices provide a neuroanatomical basis for this process (Naqvi, Shiv, & Bechara, 2006). To my knowledge, similar studies examining clinical decisions and emotions have not been done, but could provide an interesting neuroanatomical correlate of the countertransference phenomenon.

Peculiarities of Countertransference in Child Psychiatry

The relative neglect of the topic of countertransference in the mainstream child and adolescent psychiatry literature has been noted previously (Brandell, 1992; Showalter, 1985). Previous authors have hypothesized that this may due to several factors including:

1) an increasing emphasis on evidence based psychiatry; at present, CT and CTRs cannot be precisely measured, nor can their precise clinical effect;
2) the natural discomfort resulting from the serious and honest self-examination that is required to identify and understand CT (Showalter, 1985); child psychiatry may create particularly heightened anxiety and avoidance because admitting to having strong feelings (particularly negative ones) conflicts with our cultural values to protect and help children (Marshall, 1979); and,
3) countertransference was originally a psychoanalytic concept, and the psychoanalytic notion of analyzing children separate from their family and social context was abandoned by child psychiatry as a whole, perhaps explaining why the application of the concept of CT in relation to children, adolescents and families was largely forgotten.

However, CT is particularly relevant to child and adolescent psychiatry encounters because of the frequent, intense and conflicting emotions that commonly occur (Abbate, 1964; Showalter, 1985). Several features of child and adolescent patient encounters make the countertransference process unique. First, the child or adolescent's parent(s) are far more frequently involved in the treatment process than adult patients leading to more systemic complexity with an accompanied increase in countertransference reactions and configurations. In adult psychotherapy, countertransference feelings are mainly directed towards the patient, whereas in child psychiatry, both the parents and the child are recipients of different countertransference emotions. Even in the physical absence of a parent, countertransference feelings are commonly directed at the imagined parental figure. Cases in which children are held in custody of social services in particular can trigger hostile feelings towards the absent parents who have "abandoned" their child (Bemporad & Gabel, 1992).

A second unique factor is the developmental perspective offered by the child and adolescent patient encounter. By virtue of the patient's age and the parental presence, the child and adolescent psychiatrist are able to directly observe the influences on the child's development (as it is occurring in the present versus adult psychiatry where most personality development has already occurred and is viewed retrospectively). This vulnerability may result in the therapist viewing the child as a defenseless product of his/her environment, an environment that is recognized as being largely created by the parent (Ekstein, Wallerstein, & Mandelbaum, 1992). A common CT results from this: positive, protective feelings towards the child and negative feelings towards the parents. Unrecognized, this response can put the psychiatrist at odds with the family and lead to a failure to recognize the parents' own underlying feelings of guilt and shame, which may be important resistances to treatment and parental change, often an important vector in the change process for children and adolescents.

Work with adolescents also commonly arouses the psychiatrist's own adolescent conflicts and this regressive impact can lead to qualitative differences in CT in psychiatrists working

with this age group (Feigelson, 1974). In addition, adolescents often make little effort to disguise their own feelings of boredom or to vocalize their dissatisfaction with treatment, which can activate feelings of inadequacy in the psychiatrist. Suicidal adolescents can trigger powerful fears within psychiatrists, leading to a variety of behaviors and feelings including feelings of inadequacy, anger towards the patient for not improving, avoidance of the topic of suicide, and feelings of hopelessness (Brandell, 1992).

Termination of treatment can similarly arouse a variety of feelings in a clinician. While reactions vary based on innumerable factors including the patient's pathology, the length of the treatment and the fit between clinician and patient, countertransference feelings commonly arise towards the end of treatment. On one end of the spectrum, the clinician may prematurely terminate the therapeutic relationship or refer them on to another clinician rather than recognizing and exploring the feelings that have led to such an action, particularly with difficult patients and families. Conversely, a clinician may 'hang onto' a number of patients for whom they have positive feelings. Often, the clinician will have fantasies of being the perfect, better parent. In such instances, unwittingly the clinician may foster dependence with the patient and have mixed feelings when the patient improves and moves on with their life. This may be especially strong in child and adolescent psychiatry, where improvement often means continuing along their developmental trajectory. Clinicians need to be aware of the unconscious desire they themselves may have for patients not to move on, as this can be a resistance to treatment (Parsons, 1990).

The inpatient psychiatry ward merits specific discussion as the above CT becomes more complex and more intense on inpatient units as the number and length of clinical contacts is increased. The majority of literature in this area is based on observations during a period of time where long term stays were the norm rather than today's emphasis on brief, focused admissions (Rinsley, 1980). Nonetheless, CT is present on inpatient units where different roles and boundaries may set up multiple CTRs between interdisciplinary team members. One example of an early reaction of the treatment team are thoughts of taking the child in, away from the parents and caring for and 'fixing' the child (Ekstein, Wallerstein, & Mandelbaum, 1992). From this point, subtle dichotomization occurs where the hospital environment is viewed as the 'good' place and home is the 'bad' place. However, over time, if the rescue that the team members envisioned does not occur, and the child does not improve to the degree they hoped despite having been removed from the 'bad' environment, the team's fantasy that it was related to the home and would quickly resolve loses steam. This leaves the team members feeling anxious, even bewildered and new displacement objects are sought out. Often, the main treater (psychiatrist) takes on the role of the parent in the eyes of the treatment team and disappointment is displaced onto him/her (Ekstein, Wallerstein, & Mandelbaum, 1992). Conversely, the main treater's (psychiatrist's) disappointment is usually dispersed amongst the other members of the team. While these reactions may not have time to fully develop given the current philosophies of mental health care systems, cases often arise that do not go as planned and leave treatment teams frustrated and bewildered and patients returning with repeated brief admissions. An understanding of the unconscious feelings at play creates a framework for managing such cases.

Helping the Multidisciplinary Team Recognize and Address Countertransference

Recognizing and managing CT is a crucial clinical skill that must be taught and developed throughout a training program. Following a patient encounter, non-judgmental encouragement of self reflection with a supervisor can help learners start to recognize emotions they may have felt in their interactions with a patient (Alonso & Rutan, 1988; Hughes & Kerr, 2000). The use of judicious self-disclosure on the part of the teacher may help learners become cognizant of emotions that may be occurring in themselves. In working with children and adolescents, beginners may initially ignore particularly strong, unacceptable emotions. This may be due to the idea that having negative emotions towards a child is morally wrong. However, unrecognized reactions may lead to acting out of the countertransference feelings (Lewis & King, 2002). Learners should be alerted to focus on interactions when they recognize that they may not be 'acting like themselves', as this could be a clue to underlying, intrapsychic conflicts. Strong, emotional responses should similarly be recognized and explored. Excessive preoccupation about a patient long after an encounter may be a hint that countertransference is at play.

Once a reaction is identified, facilitated exploration to determine whether a reaction may be unique to them or whether it is more homogeneous is important. Often, child and adolescent psychiatry services work in teams and team-based reflection may shed light as to which feelings and reactions were related to the patient (objective) and which may be related to the learner's unique makeup (subjective). In addition to teasing these reactions apart, having these discussions normalizes the process of having emotions towards patients and encourages working through those difficulties, rather than the potential downfalls of ignoring them altogether - avoidance and

enactment. T-groups (training or process groups) have also been identified as potentially valuable tools in explorations of psychological processes in learners (Rao et al., 1997). In the clinic or on the ward, CTRs need to be discussed within the framework of interdisciplinary team case discussions, or in one to one or group supervision as part of ongoing case formulation and management.

Clinical Case Vignettes

I present two non-psychotherapeutic clinical encounters, one from an inpatient setting and one from an outpatient encounter where CT was at play with a resident (whose identity is thinly veiled) during a child and adolescent clinical encounter.

Case #1

A 16 year old male is admitted to an inpatient unit with severe melancholic depression and suicidal ideation. He has cognitive slowing, is largely unreactive, withdrawn and wants to be in hospital. He is followed by a third year resident who initiates pharmacotherapy. The resident meets with the patient frequently, going through a fairly rigid "checklist" of symptoms each time. The patient does not improve and the resident assumes that this "must be" because of the severity of the patient's depression, so quickly changes the plan to Electroconvulsive therapy (in consultation with the staff person). However following a course of ECT, the patient's symptoms do not improve, nor do features on the mental status examination. The resident sees the patient less and less often, assuming that the "patient is on ECT" and may not be able to "cognitively handle" frequent interviews. While on pass, the patient attempts suicide. The resident is taken aback by the suicide attempt and discusses the case with a fellow resident. He wonders why his style of relating to this patient was different than from most other patients. He recognizes that he felt uncomfortable with the patient, feeling as though the patient "did not like him" as evidenced by the patient's one-word answers and apparent lack of engagement. He began to see that the patient's severe, unresponsive psychopathology combined with the resident's need to "help people", led him to feel impotent and bewildered. He realized that at least part of his avoidance of the patient may have been avoidance of these feelings. The resident then decided to meet with other members of the team and discuss the issue of relating to this patient. It turned out that the other members of the team also noticed they were avoiding the patient because they felt that they were bothering him. This led to the team addressing this issue and then moving forward in the patient's care. They gained important information into the patient's stressors and subsequently were able to initiate successful treatment with pharmacotherapy and psychotherapy.

Case #2

An 8-year-old boy is brought to emergency by his mother after he seriously hurt another child at school. He has a several year history of disruptive behavior and anger for which he is followed by a clinician for psychotropic medications. He is referred to psychiatry by the emergency room crisis worker because the mother is known to the crisis service and the worker feels that the mother is very frustrated and simply "needs reassurance". In the interview, the child is settled and reading a book. The mother appears frustrated with the child's behavior and with the lack of improvement despite his ongoing engagement with mental health services. She demands that the child be admitted for 'psychopathic behaviour'. She voices the opinion that the child is 'beyond help'. She frequently rehashes the child's very early development including the fact that he was adopted at age 6 months. During and following the interview, the resident notes that he felt a great amount of sympathy for the child who he interprets as having been 'rejected' by his first parents and now perceives this as occurring again by his adopted ones. He finds himself thinking about how he would do things 'differently' himself, if he was parent of the child. He sees the calm boy as someone of tremendous potential and wonders 'only if the parents would see that'. The resident feels anger towards the mother, who he sees as rejecting the child. Later, he could recognize that this response led to an impasse in their interactions. Indeed, rather than validating and exploring the mother's feelings of hopelessness and guilt, the resident took the position of 'defending' the child from the 'rejecting' mother. The final disposition was to send the child home and the resident was responsible for telling this to the mother. The resident felt angry with the crisis worker who' unfairly put him in that position'. He did not bother debriefing with the worker about the anxieties that they both may have faced in this awkward situation. Everyone left the emergency room dissatisfied.

Conclusion

While understanding and exploring one's emotions to patients is still considered an important clinical skill in psychiatry, its emphasis has declined, especially in child psychiatry. As a result, countertransference has become an orphan concept without a theoretical home. The marginalization of this (originally) psychoanalytic concept may be related to a larger movement of purging anything related to psychoanalytic concepts from contemporary psychiatry (Torrey, 2005). But the de-emphasis of the concept of CT has not taken away the reality of the often intense and challenging feelings aroused in

clinicians by their encounters with children, adolescents and families. The inherent systemic complexity of the child and adolescent psychiatry setting provides a unique opportunity for residents to hone the skill of recognizing and managing CT and provides an opportunity for professional interdisciplinary staff case discussions. While evidence based approaches have certainly propelled the discipline of psychiatry forwards, the associated risk is to leave behind understudied (and/or difficult to study) yet important clinical tools. Incorporating all levels of data in working with patients, including the clinician's own emotional responses, can increase diagnostic accuracy, enhance the therapeutic alliance and inform treatment. A heuristic psychiatry would harness this important human dimension in our interactions with patients. This may become even more crucial as we move towards a greater knowledge base in genetics, neuroscience and psychopharmacology.

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Response to Commentary

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Relationships stir emotions. Dr. Rasic succinctly outlines for us the dangers inherent in psychiatry marginalizing or ignoring its most human dimension and the need to reacquaint ourselves with CT responses and re-emphasize their clinical importance.

Dr. Rasic's viewpoint is aligned with recent findings in affective neuroscience. Dr. Allan Schore states the use of an attachment relationship to leverage the empathic therapist's capacity to regulate the patient's arousal state within the affectively charged non-conscious transference - countertransference relationship is critical to clinical effectiveness and emphasizes the effects of secure attachment relationships on right brain development, affect regulation, and infant mental health. CT thoughts and feelings, and the dangerous enactments they might evoke, if unprocessed threaten that security, weaken the therapeutic alliance and thus undermine treatment attempts. Child psychiatry, with its inherent systemic complexity, is ripe for such occurrences. Unconscious phantasies, and their accompanying tendency to romanticize, infantilize or villainize others, can grossly contaminate treatment if left unexamined. In both training and practice, it is important to normalize, dissect and explore the origins of CTR's. Emotions contain vital information and remain our most important tool. The ability to tune into ourselves, and attune with others, is the essence of therapeutic relationship. Be they objective or subjective, the duty remains to examine CTR's in a non-judgmental manner. Ignoring this responsibility leads to grave clinical outcomes, negative iatrogenic effects, and has a profoundly detrimental effect on the physicians and patients, and the systems within we serve.

Strangely enough, by helping us to recognize and understand the importance of relational interactions, countertransference itself may prove to provide the vital point of convergence necessary to begin to allow the seamless integration sought among genetics, neuroscience and molecular biology.

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