Countertransference in Work with Children:
Review of a Neglected Concept

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Because the instrument of psychotherapy is the therapist, countertransference has important implications for treatment. The concept has been largely ignored in the literature. Yet, because psychotherapy has come under intense scrutiny by researchers, third-party payers, and patients, an awareness of concepts such as countertransference as an aid in a positive therapeutic outcome is important.


The concept of countertransference and even the term have largely dropped out of the vocabulary and awareness of child psychiatrists. It is certainly no longer much mentioned in the literature. While this is also true for many other aspects of psychodynamics, the neglect of countertransference is particularly unfortunate. This paper will review the possible reasons for the neglect, a sampling of the literature on the concept, the ways countertransference frequently presents in our psychotherapeutic work with children and their families, and the ways countertransference can be detected and discussed as part of our child psychiatry training programs.

As defined for this discussion, countertransference is the unconscious influence that a therapist's past needs and conflicts have on his or her understanding, actions or reactions within the treatment situation. This is a relatively narrow definition. Although countertransference is a concept that arose out of psychoanalysis, as with many such concepts it has been found to pertain to psychotherapy as well. Countertransference illuminates the paradox that the therapist's unconscious can be either a help in or a hindrance to understanding a patient.

Reasons for Neglect

In my experience as a supervisor and in talking with other supervisors, countertransference phenomena are no less common now than in decades past. Why then has the concept fallen into disuse in many places? The first possibility that must be explored is that it was found to be of no help clinically and was dropped deliberately. This does not seem true, since supervisors and practitioners who do use it find it helpful, and the concept continues to be debated and commented upon in the literature on psychoanalysis.

More important seems the current emphasis on descriptive and biological psychiatry. While countertransference reactions can be described, it is frequently difficult to know for sure the reactions' etiology. No matter how important, countertransference is a phenomenon that cannot be measured precisely; such phenomena are now out of favor. Also, although it is common to pay lip service to the dual importance of brain and mind, in practice many believe there is a need to embrace either biologic or psychodynamic perspectives.

A final and perhaps the most important motive for eschewing the concept of countertransference is not new and has always been a powerful resistance. This arises from the difficulty and discomfort that are involved inherently in any serious act of self-examination.

A Short History of the Concept

Freud first commented on countertransference in 1910. He described it as arising "in the physician as a result of the patient's influence on his (the physician's) unconscious feelings" (p. 144). It was because of this discovery that Freud required that fledgling analysts undergo analysis during the time that they began analyzing others. As with his discovery of transference, countertransference was first seen only as a hindrance to therapy, but later was recognized as well to be a possible source of information and guidance for the therapist. Both the definition and the clinical impact of countertransference have been much debated. The widespread disagreement about definition was discussed by Mabel Cohen (1952). Marshall (1979) defined the concept most broadly. He described four subtypes, depending upon whether the reaction is conscious or unconscious and whether it is therapist-derived or patient-derived. Although first believed always to be detrimental (Freud, 1910; Reich, 1951), the
view that countertransference can also be a useful way to understand oneself and one's patients (Colm, 1955; Racker, 1968) has been gaining acceptance. Two good general overviews are provided by Orr (1954) and by Epstein and Feiner (1979).

A common conundrum when dealing with psychodynamic concepts is the all-or-none dilemma, where some deny the concept altogether, and others view it as ubiquitous and the cause of everything. This problem has undoubtedly made more difficult the acceptance of the concept of countertransference. When some say it is everywhere, and others say it is nowhere, it is easy to decide not to be bothered to learn about or struggle with it. There has also been debate as to whether countertransference can only pertain when it is a counter-reaction to the patient's transference reaction. The more accepted view is that countertransference need not be “counter” to anything, but is essentially a transferential reaction on the part of the therapist to something within the therapeutic situation.

The reason that countertransference is so important is that the instrument of psychotherapy is the therapist. The clinician's accuracy in seeing things as they are is what patients pay for and rely on. If the work is to be done well, the therapist must be able to react with precision to the patient. Certainly, bad psychotherapy is done because of inexperience, lack of knowledge, and other deficiencies, but countertransference reactions probably represent the most important and least scrutinized source of problems during training and in practice. In a general discussion, few clinicians would deny the obvious fact that they bring personal needs and expectations to their work, but therapists often “forget” this when they should most keep it in mind, while they are doing their work.

James Anthony (Abbate, 1964) was the first person to stress the view that countertransference reactions are more likely to arise in work with children than with adults. Although he was referring to psychoanalytic work, some of his points are also worthy of consideration in regard to psychotherapy. With adult psychotherapy patients there is usually talk but little or no action; with children this mix is routinely reversed. It is typically much easier to achieve accurate self-observation when one is not also involved motorically. Libidinal and aggressive expressions as direct actions are more likely to provoke direct, personal reactions than are the same impulses when expressed as wishes, fantasies or verbal musings. Indeed, inherent in much of play therapy is the expectation of cooperation and mutuality. Berta Bornstein (1948) has emphasized the frequency of the regressive pull on the therapist when faced with a child’s continual sexual and aggressive provocation. She believed this stress caused many therapists as they got older to work less with children and more with adults. Countertransference difficulties are especially likely when the patient is the same age as one’s children or has problems similar to one’s own children or to oneself. It is only prudent that the therapist always keep these cautions in mind. There are, of course, some therapists who enter the field in order to rework their own wishes to be cared for or, as Burlingham (1935) has noted, to prove oneself a superparent or to prove that parents are always wrong. For such individuals, countertransference reactions are likely to dominate their work.

Examples of Countertransference

Since the range of potential countertransference reactions is confined only by the limits of therapists' personal conflicts, the range is limitless. There is an old joke among analysts that the most common problem in self-analysis is the negative countertransference.

A number of the examples given below come from supervision. How deeply in supervision to explore therapists' personal feelings and motives expressed during therapy is and always has been a controversial issue. My style is at the beginning of supervision to discuss what both of us hope to get out of the experience. I have written on supervision and the importance of countertransference (Schowalter and Pruett, 1975). I tell supervisees I believe this is an area important to explore, that I do not and cannot demand them to say anything they would rather hold back, and that such discussions of countertransference, being case-linked, are not the same as or a substitute for personal therapy. Some supervisees, because they are in therapy or for other reasons, would rather not go more than superficially into areas of possible countertransference. Since second-year residents may choose their supervisors, and I generally supervise people in this group, there is also an obvious factor of self-selection. On a number of occasions, these discussions have made the resident interested in entering psychotherapy. There is then a referral to someone other than me. In no case has the resident reacted with an obvious negative psychological reaction or asked to change supervisors. All of the examples below have been disguised sufficiently to keep the residents' identity confidential.

Diagnosis

In supervision with a child psychiatry trainee, I was struck with his resistance to making a diagnosis of oppositional disorder for a 10-year-old boy who obviously met the DSM-III criteria. The more I pressed to get the decision made the more reluctant he was to
make it. I then changed tactics and questioned whether there were personal reasons why he might hesitate to make the diagnosis. What first came out were the possibility of a wish to be oppositional to me and a stubbornness against feeling evaluated in supervision. Earlier memories then emerged of when as a child he felt unfairly labelled as a trouble-maker. He then realized how much he identified with the patient and did not want to label him.

There are also other conflicts that seem common in countertransference reactions in regard to diagnosis. In the late 1960s and early 1970s especially, some therapists felt uneasy with diagnoses because they suggested an inequality between doctor and patient. For some, to make a diagnosis was viewed as an aggressive or hostile act. It was important for these therapists to eschew the unequal act of diagnosis and proceed to, what they believed, was the more egalitarian process of psychotherapy.

A caveat is in order. As with all of the vignettes offered, it is impossible to distinguish from only the overt behavior which are examples of true countertransference and which are not. That answer can only come from self-reflection. Social and professional trends come and go. As individuals, our past experiences, as well as our present needs, influence which approaches we attach ourselves to, which ones we fight, and which ones we ignore. I do not believe unconscious conflict or unresolved feelings about persons in our past are necessarily decisive in all our choices. For example, therapists may for many different reasons fear hurting their patients by diagnosing them. Only those who do so primarily because the patient or situation taps into a personal conflict from their past are acting out a countertransference reaction.

There is, of course, the other side of the diagnostic coin. Labels can sometimes express a negative feeling a therapist has for a patient or family. Some diagnoses accrete pejorative innuendoes. "Hysteric" and "sociopath" are such examples from the past, and "borderline" probably qualifies in current terminology. Again, one can never on the surface be sure whether such a diagnosis is accurate, inaccurate because of poor diagnostic skills, or inaccurate because of countertransference. What is important is to realize that diagnoses can and do acquire positive and negative connotations. Why a particular diagnosis takes on an emotional charge and then how and why we use that label are areas of self-exploration that are likely to be useful in revealing the influence of countertransference reactions on our work.

Prognosis

In supervision of a white child psychiatry trainee, the resident had just finished evaluating a 7-year-old black boy who exhibited a mild to moderate phobia of germs. The patient came from a poor, single-parent family, and it seemed to me that the boy had formed a good relationship with the trainee and was well motivated for treatment. After presenting the evaluation material concisely and completely, the trainee said he was concerned that the boy would not come to the sessions if treatment was offered. He seemed reluctant to continue with the case, and this reluctance was far out of proportion to the data he had presented to me. We discussed his feelings about phobias, about black people, and about poverty. It was from the latter subject that pertinent information arose. He had been brought up in quite severe poverty and remembered using the emergency room as a family pediatrician and missing a number of clinic appointments for which he and his mother were scolded by the clinic staff. This background had made him interested in the issue of social class and compliance. He knew from his reading that social class was usually only slightly, if at all, linked with psychotherapy outcome (McDermott et al., 1970) and that high on many lists of factors contributing to success in psychotherapy (Buckley et al., 1984) is "support by the therapist."

Why then was he withdrawing his support? Once I realized that it was not a lack of knowledge that led him to his exaggerated and unrealistic concerns about the prognosis, we discussed the issue more deeply, and it became clear that it was in large part his past shame that prompted him in a tendency to identify with the aggressor clinic staff of his childhood. It was discovered that he had previously avoided other low socioeconomic children and that this had been a pattern he had not fully realized consciously. He did take the child into treatment, and the treatment went smoothly and successfully.

It has long been debated whether or not one can treat competently a patient for whom one feels a strong emotion, such as hate, fear, anger, or love. Understanding the concept of countertransference cannot give a definitive answer to this debate, but it can sometimes help the therapist understand and thereby diminish the intensity of the emotion.

Parents

There are many reasons for child psychiatry trainees to be overly involved or to be overly reluctant to see parents. Although the opposite may occur, in my experience residents more often either arrange for another therapist to treat the parents or avoid the parents more than is indicated. This may be due to legitimate concerns about confidentiality, but the possibility of a common countertransference etiology is intriguing. Beiser (1971) found that analysts who work with children, when compared to those who work with
adults, tend to identify with the mother role. Burlingham's (1935) observation, already noted, was that some child therapists enter the field with the fantasy of \textit{“being a better mother.”} It would probably be more accurate to say that some people become child therapists to prove that they are better mothers or fathers than were their own. The practical reality that parents usually must be kept favorably disposed to a child's treatment if it is to continue and progress, can raise a troublesome conflict for a therapist who either competes with parents or who overidentifies with the part of the patient that feels poorly parented. Of course, countertransference can also sometimes influence therapists to be overcautious out of an excessive concern about hurting the parents' feelings.

\textit{Collaboration}

A child psychiatry trainee was excellent in every way except that she had a reputation for always fighting, or at least disagreeing, with her female social worker colleagues. As an administrator, I heard of these continual problems and called the resident into my office to discuss the weakness in her otherwise exemplary performance. Her first explanation was that the social workers were not up to her standard and her second explanation was that she worked best alone. The facts were, however, that it was a stable social work staff with whom other, equally demanding, residents were well satisfied and that she did work in harmonious collegiality with male collaborators. Her relationship with the one other female resident was decent, but distant. She was the oldest of three sisters and a brother. She was aware that she resented having to care for her siblings and at the time tended to vent her feelings by being bossy. She was not aware that she did it still. She identified with her patient, usually the child, and tended to feel toward the collaborator the way her patient felt toward the collaborator's patient.

Gendel and Resier (1981) have written about \textit{“institutional countertransference”} to describe the phenomenon when a long-term clinic or hospital patient is no longer seen as an individual, but only as a persona developed by the present therapist through associations to the staff that provided the patient's previous treatment.

\textit{Research}

The emphasis in this paper is on the impact of countertransference in clinical work. This, of course, can be germane also in clinical research. The most obvious example is the researcher who is so influenced by infantile or childhood based needs for recognition, success, or particular outcomes that he or she sees success or failure where it does not exist or produces it in the patient in a manner not provided for in the research protocol. This does not include conscious fraud or those unconscious determinants which do not transform the patient or subject into an object to be used to repeat or try to work through past needs or conflicts. Countertransference is a major reason why psychotherapy research is so difficult to do well. It also, however, affects pharmacologic and other protocols. It is because unconscious influences are so common that research methodology for prospective clinical trials routinely require the clinician to be blind to who the subjects and who the controls are. Although such precautions do not deter conscious manipulation of data, they do eliminate the researcher's unconscious manipulations.

The preceding examples and categories are at the same time both misleadingly simple and misleadingly selective. The examples, picked for simplicity, are misleading because their clarity contrasts with the ambiguity which is typical in everyday practice and supervision. The categories, kept selective by space constraints, are misleading because they do not convey adequately the ubiquity with which countertransference can intrude into our daily work.

\textit{Discussion}

It is important, but often difficult, to differentiate between countertransference reactions and counter-reactions. Counter-reactions constitute the broad, overall category. They are any reaction stimulated by the clinical situation. A counter-reaction is one that is triggered mostly, if not exclusively, from the patient. Most people would react to the patient in the same way, regardless of their personal psychodynamics. Countertransference reactions, as used in this paper, are \textit{transference} reactions that occur in response to the clinical situation. Although countertransference always "comes" from the therapist, a countertransference response is triggered by the psychopathology of the patient or some other element of the situation. Therefore, countertransference usually is the result of a "fit" between patient and therapist needs. If, for example, the therapist feels inordinately bored with a patient and discovers that this exaggerated feeling comes from an unwanted, neglected child who is provoking from the therapist what he is accustomed to receiving from everyone in his environment, and this reaction is not based on any earlier psychological needs of the therapist, the boredom is best described as a counter-reaction. If the therapist's response is not based solely on the patient's influence, but is at least partially defensive and based on his or her own unconscious needs or feelings of early deprivation, the reaction crosses over into the realm of countertransference. As is obvious, most reactions have some coun-
tertransference component, and how much, rather than whether, is usually the more crucial question.

A couple of common clinical observations offer another demonstration of the relative importance of patient and therapist induced reactions. One observation is that some patients seem able to induce identical reactions in almost everyone who works with them. These are examples of counter-reaction. The other observation is that many therapists become aware through experience that their repetitive, unhelpful responses prevent them from doing well with particular types of patients. This is countertransference.

If countertransference is unconscious, how is it possible to uncover it? Discovery often comes to the fore in supervision or in the therapist's own therapy, but hints are usually also discernible from the clinical work. The following are not pathognomonic signs, but are hints and clues that should trigger self-scrutiny. Countertransference reactions most likely to be noticed are those involving anger, hate, or fear, because they are most likely to cause anxiety in the therapist or disruption in the therapeutic process. Positive feelings, such as affection, admiration or identification, are generally less disruptive and are therefore less likely to come to attention. Competitive feelings, especially with parents or adolescents, also oftentimes go unnoticed. Marshall (1979) lists the following clues to possible countertransference: physical contact, impulsive talk or action, and/or strong, inexplicable feelings toward patient or parents. Other hints I have noted either from my own or supervisees' work are when a case goes poorly "for no reason," or when during the same period of time a group of one's patients begins doing poorly, acting in a certain way, bringing in the same theme(s), or liking or disliking you more than usual. In regard to one's own reactions, danger signs include the notice of stereotypic behavior or the realization that one is doing something but, more than usual, does not know why. All of the above may, of course, also be due to reasons other than countertransference.

A major hindrance to looking for or discussing countertransference is that therapists are expected to be healthy, and, more even than with adult patients, it is taboo to have unwarranted feelings toward children. The truth is that no one is so normal or well analyzed as analysts of adults. The therapist's contribution to treatment.

In conclusion, the concept of countertransference with children was reviewed for a number of reasons. First, because it has been neglected in the recent child psychiatry literature, the youngest generation of clinicians may be unaware of its influence. Second, this is a reminder to supervisors to explore countertransference. Supervisors too often forget or are reluctant to do so (Schowalter and Pruett, 1975), but supervision is undoubtedly the best medium through which to discover and understand countertransference. Saurek and Berlin (1966) once offered therapy as part of supervision. Most residents today want supervision to be supervision. This does not, however, mean that the supervisor must be oblivious to the impact of the supervisee's personal attributes on his or her therapy. Most good supervisors provide what Solnit (1970) described as "more than education and less than therapy" and which fulfills Frijling-Schreuder's (1970) goal to help the supervisee to evaluate himself.

Finally, the understanding of countertransference must not be lost because it is a crucial element in providing good psychotherapy. At a time when psychotherapy is being scrutinized more than ever by researchers, third-party payers, and patients, we who do therapy must never fail to strive for that essential ability to monitor and improve our work and ourselves.

References


COUNTERTRANSFERENCE

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