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**A study of countertransference during therapists' transition
from graduate school to internship**

Kahn, Asher Samuel, Ph.D.
City University of New York, 1990

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A STUDY OF COUNTERTRANSFERENCE DURING THERAPISTS'
TRANSITION FROM GRADUATE SCHOOL TO INTERNSHIP

by

ASHER KAHN

A Dissertation submitted to the Graduate Faculty in
Psychology in partial fulfillment of the requirements
for the degree of Doctor of Philosophy, The City
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1990

This manuscript has been read and accepted for the Graduate Faculty in Psychology in Satisfaction of the Dissertation requirement for the degree in Doctoral of Philosophy.

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CHAPTER I

INTRODUCTION

Each year at the City University Ph.D. program in clinical psychology a group of students completes its' training in-residence and moves on to internship training. While at the university these students are staff psychologists at the City College Psychological Center. In this capacity they treat adults, children, and families. During their final year at the clinic these student-therapists are applying for and then leaving for internship. This professional milestone is also a crisis in that these students leave the familiar setting of the university, teachers, supervisors, and friends and often terminate or transfer the patients with whom they have been working for several years.

The idea that therapists' thoughts and feelings towards their patients are important has been clear since Freud(1910) first conceptualized countertransference. The meanings and uses of countertransference have long been debated in the psychoanalytic literature, but all agree that it needs to be understood in all its' manifestations. The present study is a contribution to this understanding.

During particular life crises of therapists countertransference problems may emerge. The crisis that I studied is that of therapists in a transitional period caused by the demands of their training. In this dissertation, using measures of therapists' anticipation of a session and their ability to recall the session, I have attempted to look at this important clinical phenomenon in an empirical way.

COUNTERTRANSFERENCE

Countertransference is a phenomenon that is integral to most forms of dynamic psychotherapy. Early in the development of psychoanalysis Freud recognized that, just as transference is central in the working out of the relationship between patient and therapist, so is countertransference. He first introduced the concept of countertransference in 1910 with these words: "We have become aware of the 'countertransference', which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall

recognize this countertransference in himself and overcome it" (p.144). The idea that countertransference exists and the instruction to "overcome it" pose a continual series of problems to all clinicians. One problem is to identify countertransference; then to locate it in its various manifestations; after that, to understand the underlying meanings; and finally, to "overcome it".

Freud(1915) continued to assert the importance of the unconscious of the therapist as an instrument of understanding the patient, "It is a very remarkable thing that the Ucs. of one human being can react upon that of another"(p.194). On the other hand the unconscious of the therapist can be troublesome, as he stated in 1910 " we have noticed that no psychoanalyst goes further than his own complexes and internal resistances permit; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients"(pp144-5).

A great deal has been written about countertransference, addressing both theoretical conceptualizations and clinical applications. Yet this literature reveals no unanimity in defining the term,

and there are significant differences of opinion regarding the clinical usefulness of countertransference. Definitions range from the analyst's unconscious response to the patient's transference to all of the therapist's responses to the patient or the treatment. Clinically there are those who think that countertransference always interferes with treatment and those who feel that it may be useful in treatment.

There exists within the various dictionaries of psychology and psychoanalysis a variety of accepted definitions of the term 'countertransference'. J. Laplanche and J.-B. Pontalis(1973) defined it as follows: "Countertransference- The whole of the analyst's unconscious reactions to the individual analysand - especially to the analysand's own transference". From the Longman Dictionary of Psychology and Psychiatry, edited by Robert M. Goldenson, Ph.D. comes the following definition: "Countertransference- in psychoanalysis, the arousal of the analysts own repressed feelings through identification with the patient's experiences and problems, or through responding in kind to the patient's expressions of love or hostility towards him.

This tendency runs counter to the objective attitude of the therapist, but it may also be a source of insight into the patient: The analyst understands the patient by understanding himself. In any case, he must be aware of countertransference if it occurs, and analyze it (or have someone else analyze it) so that it does not interfere with the therapeutic process."

The two apparently opposite ideas that countertransference is a 'hindrance to be overcome' and that "one unconscious understands another" becomes resolved with Freud's (1910) idea that "in every analysis the analyst will necessarily carry on a continuation of his own analysis constantly overcoming his own resistances in order to make 'observations on his patients' (pp144-5). It is interesting to question whether or not the analyst can ever fully overcome his resistances. To fully address that question is beyond the scope of this paper. Clinically, what is important is that the therapist continue to analyze his own countertransference in order to be less hindered by its unconscious enactments and to be more able to make appropriate use of them. Freud started this dialectic with seemingly contradictory sentiments and, it has been carried on in the psychoanalytic literature.

Classical and Totalistic Conceptions of
Countertransference

Kernberg (1965) classified countertransference in a useful way. He defined two positions: the "classical position" which he defines as, "the unconscious reaction of the psychoanalyst to the patient's transference"(p.38). This position holds that the manifestations of countertransference are out of the consciousness of the therapist, and are therefore manifest in the ways that the unconscious may be manifest, namely, by slips of the tongue, dreams and other symptom-like expressions. That being the case, countertransference can only be understood and used for interpretation after it has occurred and then been analyzed. In fact, only after these responses are analyzed and understood as reactions to the transference of the patient can they be considered to be countertransference reactions, since according to the classical approach countertransference is reserved for those responses of the therapist to the transference of the patient and not any other of the therapists feelings or actions in relation to the patient or the therapeutic situation. Annie Reich(1960)

wrote," Conscious responses should be regarded as countertransference only if they reach an inordinate intensity or are strongly tainted by inappropriate sexual or aggressive feelings, thus revealing themselves to be determined by unconscious infantile strivings" (389-390). Considering the centrality of analysis of transference in psychoanalysis it is understandable that any countertransference responses, which by the classical definition, cloud the therapist's objectivity, need to be guarded against for neutrality to be maintained. Gitelson(1952) wrote, "If the analyst is to see the patient in terms of the latter's history, structure and dynamics, he must himself be emotionally uninvolved" (p.1).

Kernberg called the other approach the "totalistic" one, "here countertransference is viewed as the total emotional reaction of the psychoanalyst to the patient in the treatment situation"(p.38). The therapist's conscious and unconscious responses to the patient, including feelings towards the patient that may be evoked by the "treatment situation" are included in this approach. Because of of this expanded definition, countertransference has been explored in a wider variety of therapist responses within various

treatment situations. Cohen(1952) wrote that therapist's anxiety is the primary indicator of the presence of countertransference. Searles(1959), in describing sources of countertransference referred to how the, "...real and unavoidable circumstance of the closing analytic work tends powerfully to arouse within the analyst feelings of painfully frustrated love which deserves to be compared with the feelings of ungratifiable love which both child and parent experience in the oedipal phase of the child's development" (p.188). Cohen's and Searles' work represents a movement towards understanding a wider range of therapists' feelings in a wider range of situations.

Two Sides: The Ongoing Dialectic Regarding Countertransference

The dialectic regarding the positive and negative aspects of countertransference, its potential for use in treatment and its disruptive effects has been much debated in the literature (Glover, 1927; Reich, 1951, 1960; Balint, 1939; Little, 1951; Gitelson, 1952; Heimann, 1952; Cohen, 1952; Tauber, 1954; Winnicott,

1958; Epstein and Feiner, 1979; Searles, 1959; Racker, 1968; Kernberg, 1965). Each of these authors leaned, somewhat more, in the direction of what Kernberg called the "classical" or the "totalistic" viewpoint. This continuing dialectic promotes research and development of our understanding of the countertransference and its therapeutic uses.

Several authors fall into a position which views countertransference largely as a hindrance to treatment and are prone to guarding against the ill effects of it (Reich, Glover, Gitelson, Balint). On the other hand, there are those who, while warning of the dangers of it seem more concerned with the potential use of countertransference for treatment (Little, Heimann, Cohen, Searles, Winnicott, Racker).

Classical

Glover(1927) acknowledged the importance of countertransference along with the danger," ... the analyst's own difficulties are the more important, because they influence not only his own attitudes and reactions but color his view of the patient's condition and reactions" (p.311). He then went on to describe the

various forms of possible countertransference manifestations in psychosexual and structural language. He presented the unconscious manifesting in symptom-like expressions, such as dreams, parapraxes, etc., and then these manifestations are analyzed in language which appropriately describes the particular unconscious conflict which is demonstrated in that symptom. He emphasized the need to keep the "analytic instrument" in "constant repair" and then, "He will be able to translate these products without reacting to them "(pp505-506). He was saying that timely understanding of countertransference feelings can help the analyst to avoid detrimental acting out of those feelings.

Annie Reich(1951) also was concerned that an analyst's focus on his own thoughts and feelings would detract from his clear view of his patient. "It is obvious what hazards may arise. If the analyst has some reason of his own for being preoccupied, for being unable to associate freely, for shrinking back from certain topics, or if he is unable to identify with the patient, or has to identify to such a degree that he can no longer put himself again outside the patient-- to mention only a few of the possible difficulties-- he

will be unable to listen in this effortless way, to remember, to understand, to respond correctly" (p.25).

In a later paper(1960) Dr.Reich identified some of the ways in which countertransference may be expressed. She suggested that the therapist can only become aware of the countertransference once changes in the therapist's attitude toward the patient have emerged. These changes may manifest as anxiousness, boredom, inattention or an uncharacteristically strong emotional response to the patient. Her attempt seemed to be to maintain a narrow definition of countertransference thereby minimizing confusion. In doing this she saw countertransference as being only those unconscious, infantile aspects of the analyst which are enacted in symptom-like ways. Such enactments are seen as necessarily problematic in treatment and are therefore carefully guarded against. Dr.Reich, who represents the most classical approach, acknowledged the need to acknowledge and understand the countertransference, and all insight and understanding gained from the analysis of countertransference can be useful in helping the therapist to avoid such pitfalls in the future, but she insisted that the countertransference in itself is not useful to the treatment.

Totalistic

Little, Heimann, Cohen, Winnicott, Searles, and Racker extended and refined the meanings and uses of countertransference by their explorations. Margaret Little(1951) noted the various uses of the term 'countertransference' and looked more closely at some of the specific contexts in which it might most likely be manifest. Following are the various uses: 1. analyst's unconscious attitude to the patient, 2. analyst's projections, and transferences onto patient, 3. analyst's attitude or technique regarding patient's transference, 4. analyst's total attitudes and behavior to patient. She went on to identify reasons for the definition difficulty: first, countertransference cannot be observed, but only inferred from its effect; second, complexity of the subject (analyst's total psyche): third, it is impossible to extract countertransference from transference: fourth, paranoia regarding the subject.

She went on to clarify one period in which she feels that countertransference issues may be most difficult, that is nearing the end of analysis. She pointed to the difficulty of loss, and indicated that

it may be beneficial to the analyst to maintain the patient rather than to discharge him. "This unconscious unwillingness on the analyst's part to let his patient leave him can sometimes take very subtle forms, in which the analysis itself can be used as a rationalization.... A patient whose analysis is 'interminable' then may perhaps be the victim of his analyst's (primary) narcissism as much as of his own,"(p.34). She said further that unconscious (and uninterpreted) countertransference may be responsible for the prolonging of analysis. It can equally be responsible for the premature ending, and I feel that it is again in the final stages that most care is needed to avoid these things....Countertransference may perhaps be the deciding factor at this point, and the analyst's willingness to deal with it may be the all-important thing"(p.34). This focus on the problems of countertransference during the highly sensitive period around ending treatment is particularly relevant to this project. Heimann(1952) defined countertransference in a more expansive way, "For the purpose of this paper, I am using the term 'countertransference' to cover all the feelings which the analyst experiences towards his patient" (p.81). She stressed the idea that

countertransference is the most important instrument in analysis. She suggested using countertransference feelings while warning of the dangers of confession and burdening the patient. Countertransference should be used as a barometer of the patient's emotional state as projected onto, received, felt, and discriminated from his own feelings and then used to inform the analyst of the patient's emotional state.

Mabel Blake Cohen(1952) wrote about anxiety as an indicator of countertransference, "The analyst dreads the hours with a particular patient or is uncomfortable during them" (p.239). Dread is an extreme response. If dread indicates countertransference then other feelings that the therapist has in anticipation of a session may also be indicative of countertransference.

Intensity of countertransference has further been examined by those working with more profoundly disturbed patients. Winnicott(1947) pointed out the importance of understanding countertransference feelings when working with these patients because of the primitive nature of the responses that such patients may evoke in a therapist. "Insane patients must always be a heavy emotional burden on those who work with them. One can forgive those engaged in this

.

work if they do awful things" (p.194). He acknowledged the potential for countertransference, and suggested that through analysis and understanding, acting out will be diminished and therapeutic gain made more likely. "However much he loves his patients he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does to his patients"(p.195).

Searles(1959) also stressed the importance of the therapist's feelings in working with psychotic patients, "I have for a very long time speculated that in many-perhaps every-intensive analytic treatment there develops something in the nature of countertransference structures (perhaps even a neurosis) which are essential and inevitable counterparts of the transference neurosis. ...Their understanding by the analyst may be as important for the working through of the transference neurosis as is the analyst's intellectual understanding of the transference neurosis itself, perhaps because they are so to speak, the vehicle of the analyst's emotional understanding of the transference neurosis" (p.182).

These "structures" were further examined, defined and delineated by Heinrich Racker(1968). He defined

countertransference as follows, "Just as the whole of the patient's images, feelings and impulses towards the analyst, insofar as they are determined by the past, is called 'transference' and its pathological expression 'transference neurosis', in the same way the whole of the analyst's images, feelings and impulses towards the patient, insofar as they are determined by the past, are called 'countertransference' and its pathological expression may be called 'countertransference neurosis'" (p.106). Countertransference was then divided into two categories. The first is what Racker called "concordant identification". This refers to countertransference resultant from identification with the patient's ego and id. The second form is "complementary identification" which refers to countertransference resultant from identifications with the patient's internal objects. He stated that, "My main intention in the present paper is to suggest a point of view from which countertransference may be positively regarded" (p.107). However, he presented the positive and negative sides of countertransference in that, "Countertransference may help, distort or hinder perception of the unconscious processes" (p.105). By his clearer delineation of the countertransference

potential he helped to make the countertransference more easily accessible and understandable and therefore more of a help and less of a hindrance.

Termination

I found, in reviewing the literature on termination, that the issues most commonly discussed are the technical aspects of termination and the criteria for terminating. Among the authors who have written on these subjects are: Ferenczi, (1927); Freud, (1937); Klein, (1950); Hoffer, (1950); Milner, (1950); Rickman, (1950); Reich, (1950); Gillman, (1982); and Firestein, (1974 and 1982). The first paper on the topic was Ferenczi's 1927 paper entitled "The Problem of Termination". The second was Freud's 1937, "Analysis Terminable and Interminable". Firestein (1974) reviewed the literature on termination and concluded that there is no unanimity on either the appropriate criteria for termination or the appropriate technique. It is beyond the scope of this paper to describe the varieties of ideas about termination criteria and technique.

Gillman (1982), in a survey of 48 completed cases found that during this final phase there were shifts in

the focus of therapy. There also was a reported shift in transference themes towards issues of separation. Additionally, he implied that the countertransference would take on themes about separation as well. Although most of the literature on termination addresses the problems of technique and criteria, there are indications that the termination phase of treatment may evoke some countertransference problems.

Countertransference During Termination

Countertransference is often mentioned in the papers on termination: Buxbaum, (1950); Balint, (1950); Novick, (1982); Viorst, (1982); Firestein, (1982). Buxbaum(1950) wrote on the specific danger of ignoring the countertransference during this stage of treatment. The bottom line being that, "To resolve the countertransference becomes a major part of the analytic process of termination."(p.190).

In writing about the final session with a patient Balint(1950) says "Usually the patient leaves after the last session happy but with tears in his eyes--and, I think I may admit-- the analyst is in a very similar mood"(p197). Novick(1982) said that "With the

termination of the relationship, it may often be, as my patient implied, that termination will be a greater real loss for the analyst than it is for the patient." By real loss he is referring to the fact that the analyst knows his patient as a real person, in terms of the conditions of his extra-analytic life, far better than the patient knows the somewhat anonymous analyst. Therefore in at least that way the loss is greater for the analyst. J.Viorst(1982) explored the feelings of twenty analysts around termination. They generally all expressed variations in feelings of anger, guilt, frustration, disappointment, sorrow and loss.

Countertransference During Forced Termination

Countertransference during what has been referred to as "forced termination" is closely related to the subject that I am studying. "Forced termination" occurs mostly in two situations: One is the case of established analysts leaving a location and a practice (Dewald, 1965, 1966; Aarons, 1975; Hiatt, 1964; Weiss, 1972); The other is the case, more common, in which training rotations cause therapists to leave their patients prematurely (Lenzner, 1955; Pumpian-Mindlin,

1958; Schiff, 1962; Kieth, 1966; Glenn, 1971; Hillman, 1977; Cicchitto, 1982). Mostly these papers focused on the kinds of feelings that therapists have during the period leading up to the end. These feelings include anxiety, grief, sadness, guilt, relief and helplessness. They also point toward the need to have careful supervision during termination in order to manage those feelings.

Summary

Epstein and Feiner(1979) restated the central concept as follows, "These two thematic constructs, countertransference as a hindrance, and the doctor's use of his own unconscious to understand the patient, have intertwined, like a double helix, throughout the historical development of psychoanalytic conceptions of countertransference" (p.490). I have described various attempts to define and clarify the development of the meaning of the term countertransference. Further clarification leads to seeing its manifestations in more specific times and places, such as with more disturbed patients (described by Winnicott and Searles) and at more difficult times, like around termination

.

(as mentioned by Cohen). Menninger(1958) compiled an extensive list of ways in which countertransference might be expressed. These ideas about when and in what ways countertransference might occur suggest ways in which an therapist can remain vigilant regarding his own countertransference enactments. It also suggests methods of research.

I am concerned here with a group of therapists who were is in transition from graduate school to internship training. This is an important stage in the professional life of a therapist. Two articles focused on this period (Lamb,et.al., 1982; Solway, 1985). These authors stressed the problems of making the transition from a university to a clinical setting, the change from seniority to beginner(again), and the personal variables. Solway's thesis was, "the transition between graduate school and professional internship leads to interpersonal and professional changes that are emotionally hazardous" (p.50).

Solway divided the stressors as follows: 1) clinical stresses including the difficulty of adjusting from the role of student who has acheived a high stature in school to the role of professional in which he is a beginner; 2) institutional stresses including

the need to learn an entirely new system ;3) personal stresses which takes into account social, geographical and psychological variables, "It is questionable whether all students expect and prepare for the separation and loss" (p.52). How these therapists felt in anticipating sessions and how well they recalled those sessions are the two ways in which I have attempted to study these therapists during this transitional period.

CHAPTER II

METHODS

Introduction

The intention of this study was to explore therapists' countertransference over a period of time during a potentially difficult year for the therapists in question. The specific academic year was that one during which these therapists applied for internship and ended with them leaving for internship. Countertransference is a difficult subject to study as it is, depending on the definition, mostly unconscious. Countertransference can be inferred, if not directly observed, from certain attitudes and behaviors of the therapists. How the therapists felt in anticipation of each session and how well they recalled each session were the indicators of countertransference that I decided to use in this study.

Cohen(1952) stressed that anxiety was always present in the therapist at times when countertransference was present. Among her list of signals of the presence of countertransference was the following,(p.235) " (5) The analyst dreads the hours with a particular patient or is uncomfortable during

them." Menninger wrote(1958) that "Sudden increase or decrease of interest in a certain case" was a sign of countertransference. Based on these ideas as well as the clinical sense that how a therapist feels in anticipating a session reflects the therapists underlying feelings towards the patient and the therapy I decided to create and use the Anticipation scale (described below) as one measure.

The importance of the relative ability to recall sessions was first noted by Freud(1912). Following a discussion of how "evenly hovering attention" enables an analyst to have complete recall of a session, Freud mentions how recall may be interfered with, (p.113) "Mistakes in this process of remembering occur only at times and places at which one is disturbed by some personal consideration...". It seemed possible that a termination or transition such as that which these therapists were in the midst of may disturb the therapist enough to cause difficulties in recalling sessions. If these therapists were to be effected by the termination process it may be reflected in their ability to recall sessions. Therefore I decided on the Recall scale(described below) as the second indicator of countertransference.

Subjects

At the completion of this study there were a total of 11 cases under observation. Eight therapists completed the study. A total of 459 sessions were recorded. Twelve therapists began in the study. One of them participated with three cases, six with two cases each and five with one case, a total of twenty cases.

Two therapists who were both seeing two patients and regularly participating suddenly stopped turning in data, two months into the project, with no explanation. The therapist who volunteered to participate with three cases actually had no adult case which fit the protocol. Her cases had just begun and none stayed in treatment for the full year. Additionally she stopped turning in data after one month of participation. One therapist who started with two cases had one case end prematurely, in March, and the data preceding this premature ending was too sparse (there were less than 10 sessions over a five month period). The length of time between sessions, the small number of sessions and the fact that this case didn't last to the point of the therapist's dealing with the central issues of the study, made it not usable. One case turned out to have

an average of 20 days between sessions, only 13 sessions for the year and it turned out to have just begun in September. Therefore, it was rejected as a long-term case. That left 11 cases in the study.

All participants were Ph.D. clinical psychology students at the City University of New York. As students in this program, they are also staff psychologists at the City College Psychological Center. Of the therapists, three were male and nine female. All were in their final year in residence at the university. Subjects also met the following criteria: (1) involved in treating adult, outpatient(s) in long term, individual psychotherapy; (2) had stated the intention to apply for internship during this academic year.

Subjects fulfilling the above requirements were contacted in September of their last year in residence. These subjects were requested to participate in a study that would require continual involvement starting in October and ending in August, or whenever they left for their internships. Those who agreed to participate were then given further instructions (Appendix A).

Instruments

In creating the instruments, I sought to tap countertransference in as unintrusive a way as possible. As the study was to be carried on over the course of 10 months, requiring weekly or twice a week participation by the therapists, the instrument had to be simple. The basic instruments of this study were two brief questionnaires: one to be filled out before the other after each session. The questions before each session were: "How do you feel in anticipation of this session?" Responses were solicited on a five point scale of "eagerness", a response of 1= much less eager, 2= less eager, 3= normal, 4= somewhat more eager, 5=especially eager; and, " Why do you think that this is the case?" The questions following each session were: "How well do you recall this session?" Responses were solicited on a five point scale of "recall", a response of 1= much less, 2= somewhat less, 3= normal, 4= somewhat more, 5= much more; and , "Why do you think that this is the case?"

Procedure

Those who agreed to participate were given a set of instructions (Appendix A) which described what they were to do. Each subject was assigned a numerical code representing each case in order to maintain anonymity. Each month a packet of Anticipation and Recall slips, described above (Appendix B) were placed in the subjects' mailboxes and were to be completed before and after each session and placed in my mailbox, which was located in the same room, making drop-off very simple and convenient. The mailboxes were located in the student lounge within the clinic: often student-therapists waited in this room before seeing patients, and also would collect their mail and socialize in this room after seeing patients. As this project required consistent cooperation over an extended period, convenience was important.

The study began in October and continued until the therapists went on internship or the case ended. Preceding each session the therapists filled out an anticipation slip. The responses to the first part were limited to a scale of 1 through 5, but the second question was open-ended and the therapists could

respond as they chose.

Following each session each therapist was asked to respond to the recall question. The therapists again were limited to a 1 through 5 scale for the first question, but were free to respond in any way they chose to the second question.

If the transition to internship or termination of treatment were mentioned in the response it was scored. Either a session would receive a score of Transition or No Transition. This procedure continued from October until the therapists terminated, between 7 and 10 months later.

CHAPTER III

RESULTS

Introduction

The raw data consisted of 918 completed, brief questionnaires, representing 459 therapy sessions with 11 different therapist-patient pairs over a period of time from 10-10-86 to 8-20-87. Each pair of responses (one before and one after each session) was screened for the numerical Anticipation and Recall score on a scale of 1 thru 5. The written response to the 'why' question was scored for content. If the response to either the anticipation or the recall question contained a reference to the transition to internship or separation, Transition was scored. Each session received a score either of Transition or No Transition. This score was taken to indicate whether the therapist was consciously concerned with these issues (Another assessment of the content of these responses was also made. See Appendix E.). A session record consisted of the following scores: Anticipation as scored on a scale of 1 thru 5, Recall as scored on a scale of 1 thru 5 and, Transition or No Transition.

The results have been divided into two sections (I and II) in this chapter. The first section deals primarily with Anticipation and Recall findings. The

second section is primarily an analysis of the response to the second question, the degree to which these subjects are concerned with the transition to internship or termination of this case.

I. Fluctuations Over Time in Anticipation and Recall

The subjects used the full range of scores in response to the Anticipation and Recall questions. These responses are shown in Table 1 below. As can be seen in this table, there were individual differences in the use of the scoring system yet almost every subject used the entire range of scores and scored more 3s than any other score. Table 2 lists the percentages of individual and overall scoring.

The therapists met with their cases in differing numbers of sessions per week, and different total numbers of sessions. Each therapist used the scoring system uniquely, establishing their own means and variances. For these reasons I decided to analyze each case independently and not pool them.

A central question in this study was whether there would be fluctuations in Anticipation and Recall scores at any particular times. If so, then it may be possible

Table 1. Anticipation and Recall Scores

Case	Anticipation					Recall				
	1	2	3	4	5	1	2	3	4	5
1	3	11	41	3	2	13	16	27	3	1
2	0	4	40	7	1	13	15	21	2	1
3	1	17	24	13	0	0	2	24	25	4
4	4	9	15	21	6	3	5	27	12	8
5	4	11	12	23	8	5	5	25	13	10
6	4	5	12	15	2	0	2	22	12	2
7	1	3	12	12	5	1	0	20	10	2
8	6	11	7	5	4	0	1	23	8	1
9	2	5	1	11	3	0	1	10	4	7
10	0	6	6	6	7	2	2	5	8	8
11	0	2	19	6	1	0	2	13	8	5
total	25	84	189	122	39	37	51	217	105	49

Table 2. Percentages of 1 thru 5 Scores for Each Case and Overall

Case #	Anticipation					Recall				
	1	2	3	4	5	1	2	3	4	5
1	5.0	18.3	68.3	5.0	3.3	21.7	26.7	45.0	5.0	1.7
2	0.0	7.7	76.9	13.5	1.9	25.0	28.8	40.4	3.8	1.9
3	1.8	30.9	43.6	23.6	0.0	0.0	3.6	43.6	45.5	7.3
4	7.3	16.4	27.3	38.2	10.9	5.5	9.1	49.1	21.8	14.5
5	6.9	19.0	20.7	39.7	13.8	8.6	8.6	43.1	22.4	17.2
6	10.5	13.2	31.6	39.5	5.3	0.0	5.3	57.9	31.6	5.3
7	3.0	9.1	36.4	36.4	15.2	3.0	0.0	60.6	30.3	6.1
8	18.2	33.3	21.2	15.2	12.1	0.0	3.0	69.7	24.2	3.0
9	9.1	22.7	4.5	50.0	13.6	0.0	4.5	45.5	18.2	31.8
10	0.0	24.0	24.0	24.0	28.0	8.0	8.0	20.0	32.0	32.0
11	0.0	7.1	67.9	21.4	3.6	0.0	7.1	46.4	28.6	17.9
total	5.4	18.3	41.2	26.6	8.5	8.1	11.1	47.3	22.9	10.7

to speculate as to why those changes occurred when they did. Primarily, I found that there was a wide range of patterns of responding among these 11 therapists, with some consistencies (In fact there were 8 different therapists, but 11 therapist-patient pairs. A comparison of the responses of the same therapist with two different patients is in Appendix F.). Additionally, it came to my attention that, not only did the calendar year and the time near to the transition seem to affect Anticipation and Recall scores, but so did the hiatus between sessions. A question also arose as to the comparison between the two scores, Anticipation and Recall, which also was addressed.

The primary findings were that there were changes in Anticipation and Recall scores at particular times. Those times were: at and around day #60, which was the beginning of the Christmas break; at and around day #120, which was the day of internship notification; and as the transition from the University clinic to internship approached. The patterns of the therapists' responses were each quite unique, making generalization difficult, yet some consistencies across subjects were noted.

Patterns of Anticipation and Recall Scoring: Two Groups

Although there were wide ranging individual differences the results yielded two groups of cases (Group A and Group B). In each of these groups the scoring fluctuated somewhat differently around the days previously specified as having significance. Category A is a group of cases which have noticeable fluctuations in scoring of Anticipation and/or Recall during, just before or just after the three aforementioned times (day 60, the beginning of Christmas vacation; day 120, the day of notification of internship placements and; the ending of treatment at the clinic). Category B includes those cases whose scores fluctuated at or around day #120 and near the end, but not at day #60.

Fluctuations in scoring patterns varied from case to case. These are represented graphically (Figures 1 through 11). The graphs were generated in the following way: Running averages of Anticipation and Recall scores were made. These averages were made by pooling 4 sessions in twice a week cases (cases #1 thru #6) and 2 sessions in once a week cases (cases #7 thru #11) in order to better observe the trends in each case. By pooling in this way individual session to session fluctuation was reduced, and trends over a two

week period became more apparent. The graphs are somewhat smoother than if each session was reported because of the pooling of sessions.

On the graphs the Anticipation scores are represented by a solid line and the Recall scores by a dotted line. The Anticipation and Recall scores in each case were converted to Z scores and then to SAT type scores. In this scoring 500 is the mean for each and 100 points is equal to one standard deviation. These scores are on the y axis. The x axis is time. 0 on the x axis is October 10. The cases vary in duration, from the earliest termination, case #6, at 199 days to the longest, case #11, which ended 319 days from the beginning of the study. The remaining 9 cases all ended at around 240 days from the beginning.

Group A. The following cases (case #1, #6, #8 and #10) had fluctuations in scoring at or around day 60, 120 and as the termination approached.

Case #1: In this case the mean Anticipation score was 2.83 with a standard deviation of .74. The mean Recall score was 2.38, the standard deviation .94. Both the Anticipation and Recall scores drop at day 60 followed by a 35 day period of stabilizing. Then in mid-January (day 100) the therapist reported a drop in ability to recall. After day 120 (Feb. 10) there was restabilization in both which, except for minor fluctuations, remained fairly stable until the end. The final thirty days of treatment were marked by decreases in the therapist's reported ability to recall. This is represented in figure 1.

Case #6: In this case the mean Anticipation score was 3.16 with a standard deviation of 1.08. The mean Recall score was 3.37, the standard deviation .67. There were peaks in the therapist's reported feelings of anticipation and ability to recall at day 60, valleys at 100, and another peak at 120. In Anticipation there is another valley at 165 and a peak at the end, while Recall stays stable near the end. This is represented in figure 2.

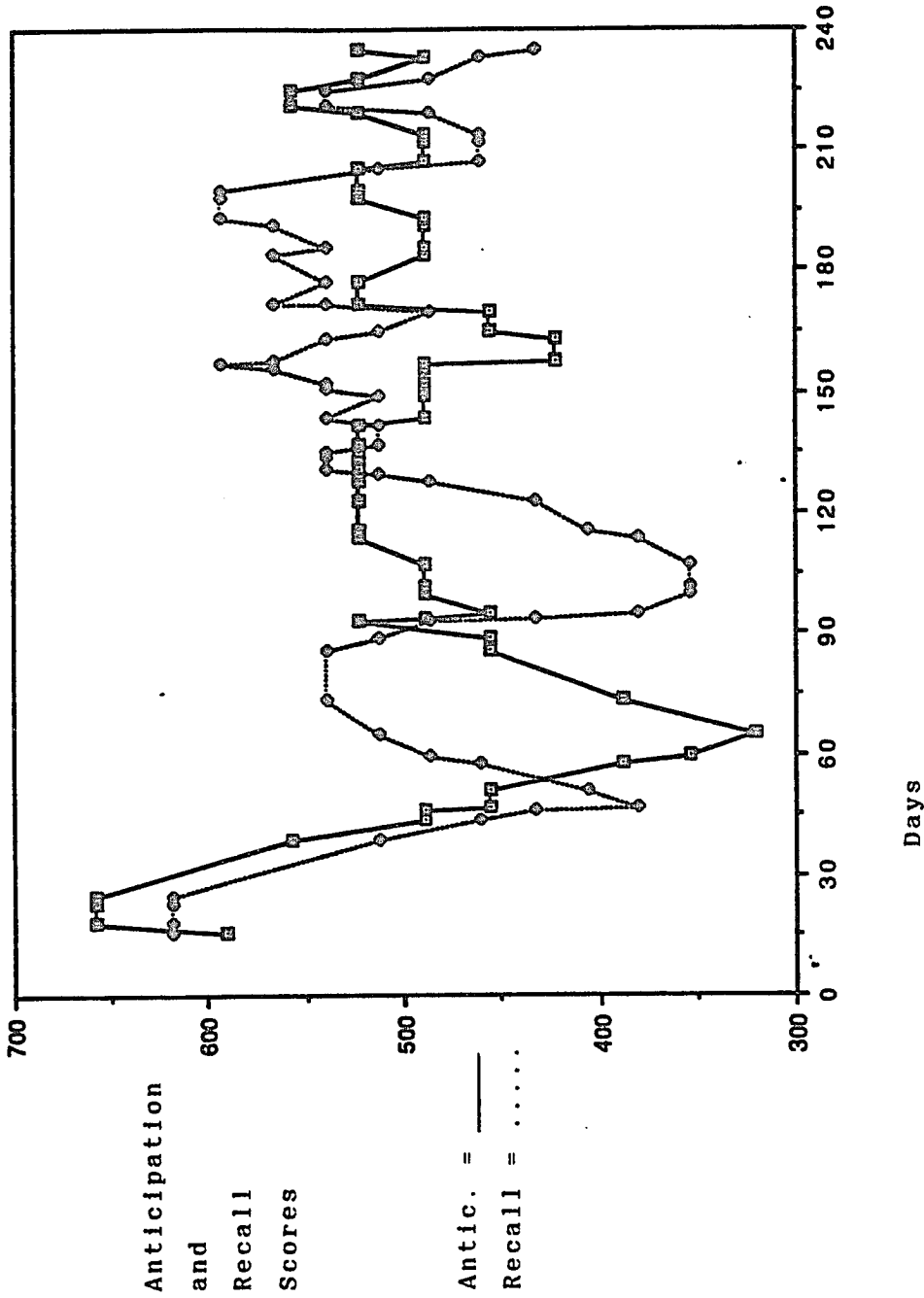


Figure 1. Case #1
Anticipation and Recall in Relation to Time.

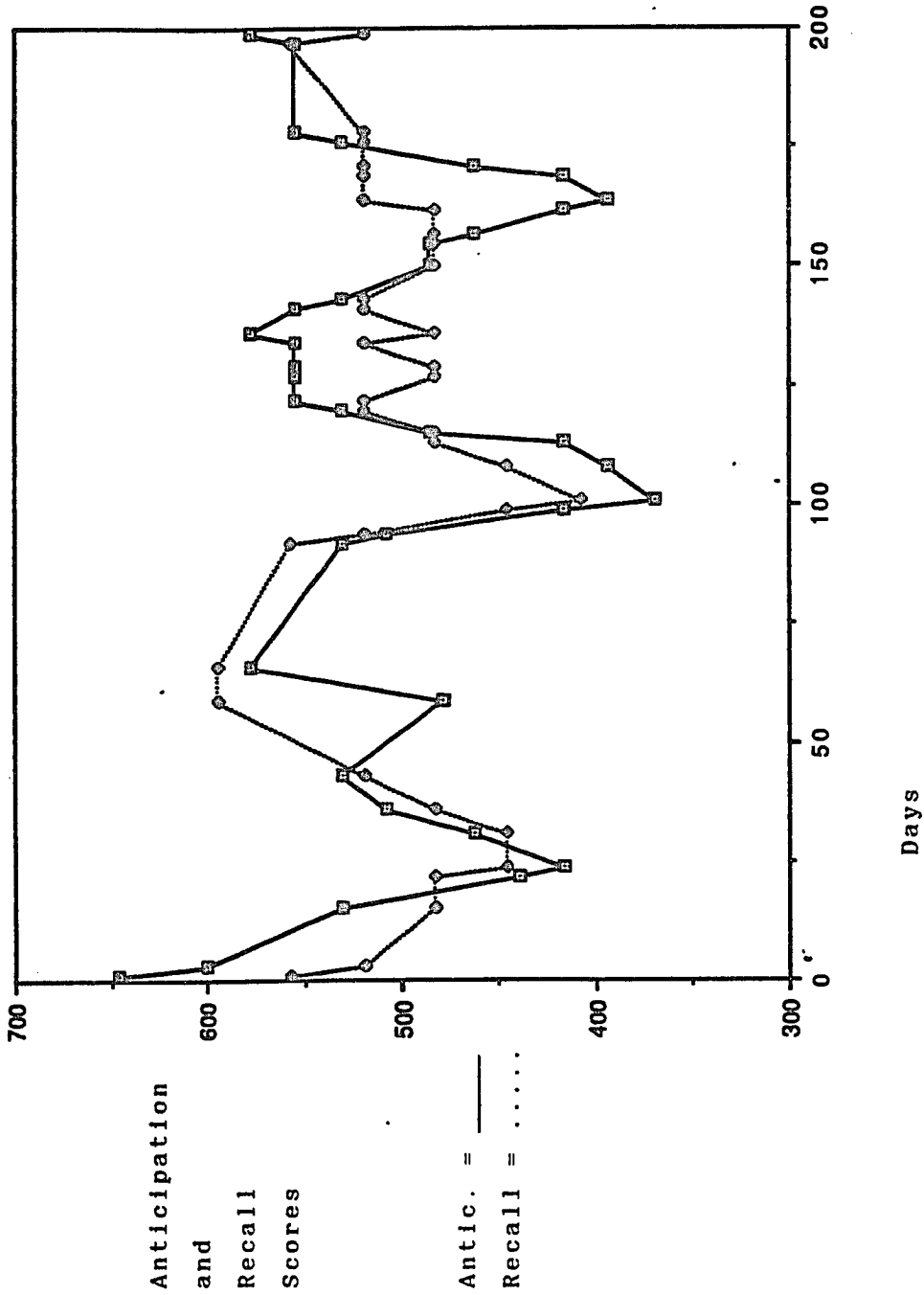


Figure 2. Case #6
Anticipation and Recall in Relation to Time.

Case #7: In this case the mean Anticipation score was 3.52 with a standard deviation of .97. The mean Recall score was 3.36, the standard deviation .74. This therapist seemed to have diminished abilities to recall sessions when his feelings of anticipation were higher than normal and increased ability to recall when his anticipation was lower than normal. At day 60 Anticipation was peaking while Recall was quite low. At 90 days Anticipation was low while Recall was up. Day 120 to 135 was the most stable period for both scores followed by elevation in both. The peak in Anticipation scoring occurred at day 165. A decrease in Anticipation preceded the end. Just at the end there was a slight increase in both Anticipation and Recall. This is represented in figure 3.

Case #8: In this case the mean Anticipation score was 2.70 with a standard deviation of 1.29. The mean Recall score was 3.27, the standard deviation .57. At day 60 the therapist reported an elevation in feelings of anticipation and a decrease of ability to recall sessions. There was a decrease in both approaching day 120. From day 120 Anticipation increased and Recall remained constant. As the end approached Anticipation

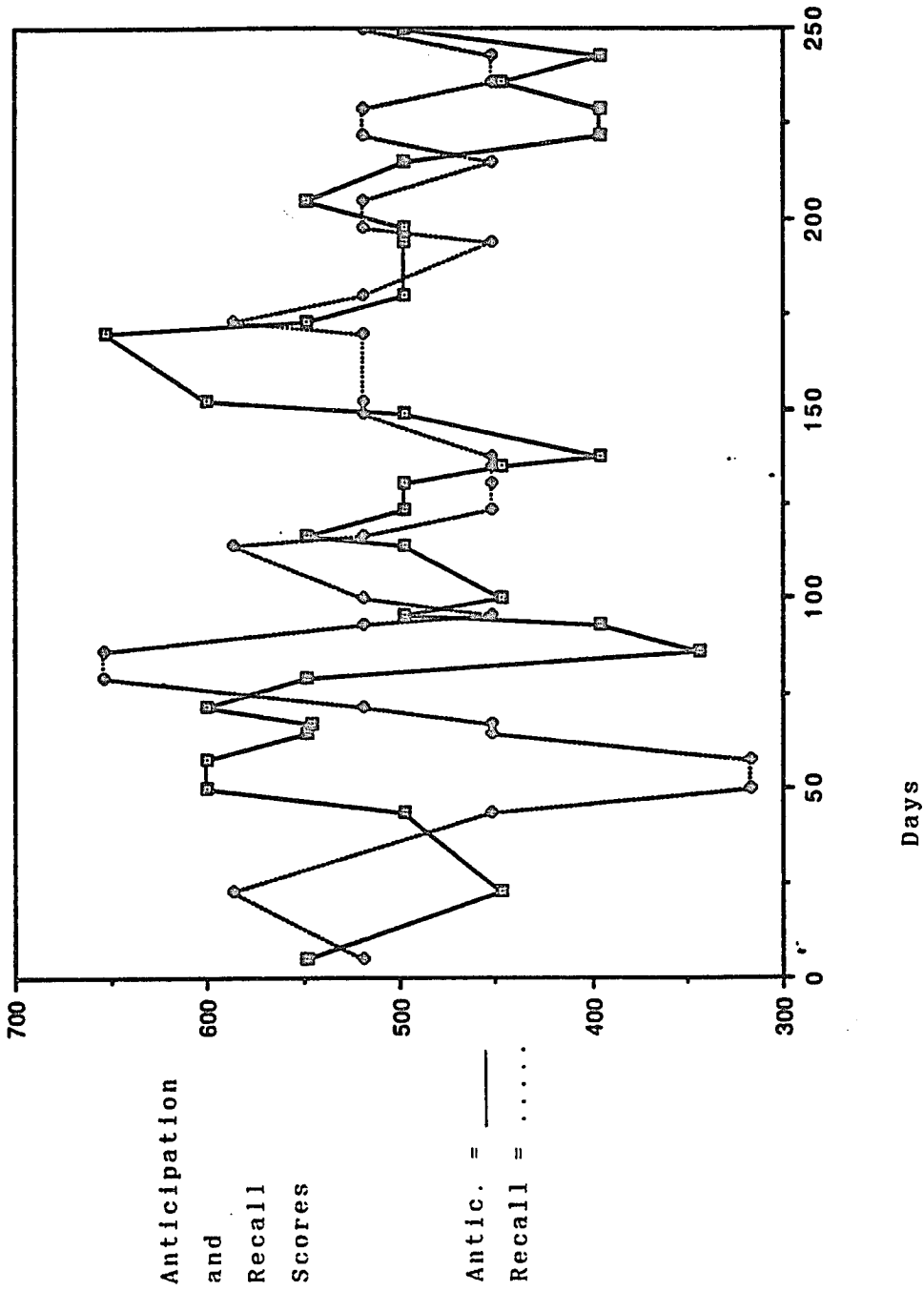


Figure 3. Case #7
 Anticipation and Recall in Relation to Time.

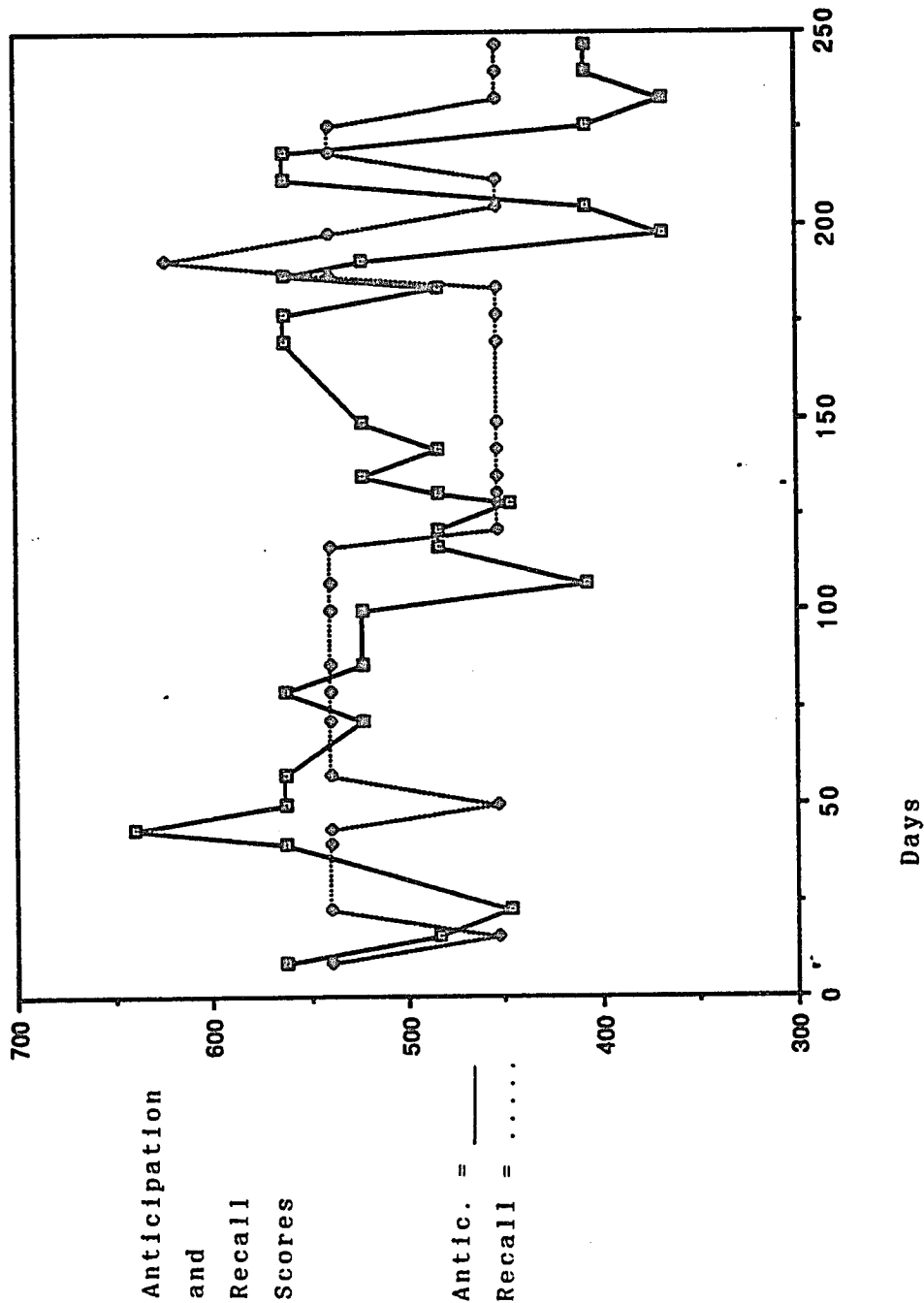


Figure 4. Case #8
Anticipation and Recall in Relation to Time.

peaked then fell then peaked again and fell to the finish while Recall elevated somewhat approaching the end. This is represented in figure 4.

Case #10: In this case the mean Anticipation score was 3.56 with a standard deviation of 1.16. The mean Recall score was 3.72, the standard deviation 1.24. This therapist reported feelings of anticipation and ability to recall which paralleled almost perfectly. They peaked at 60 and 120. Then they decreased to 150, increased again to 180 decreased to 210. Then they increased again prior to ending, both ended on a downward trend. This is represented in figure 5.

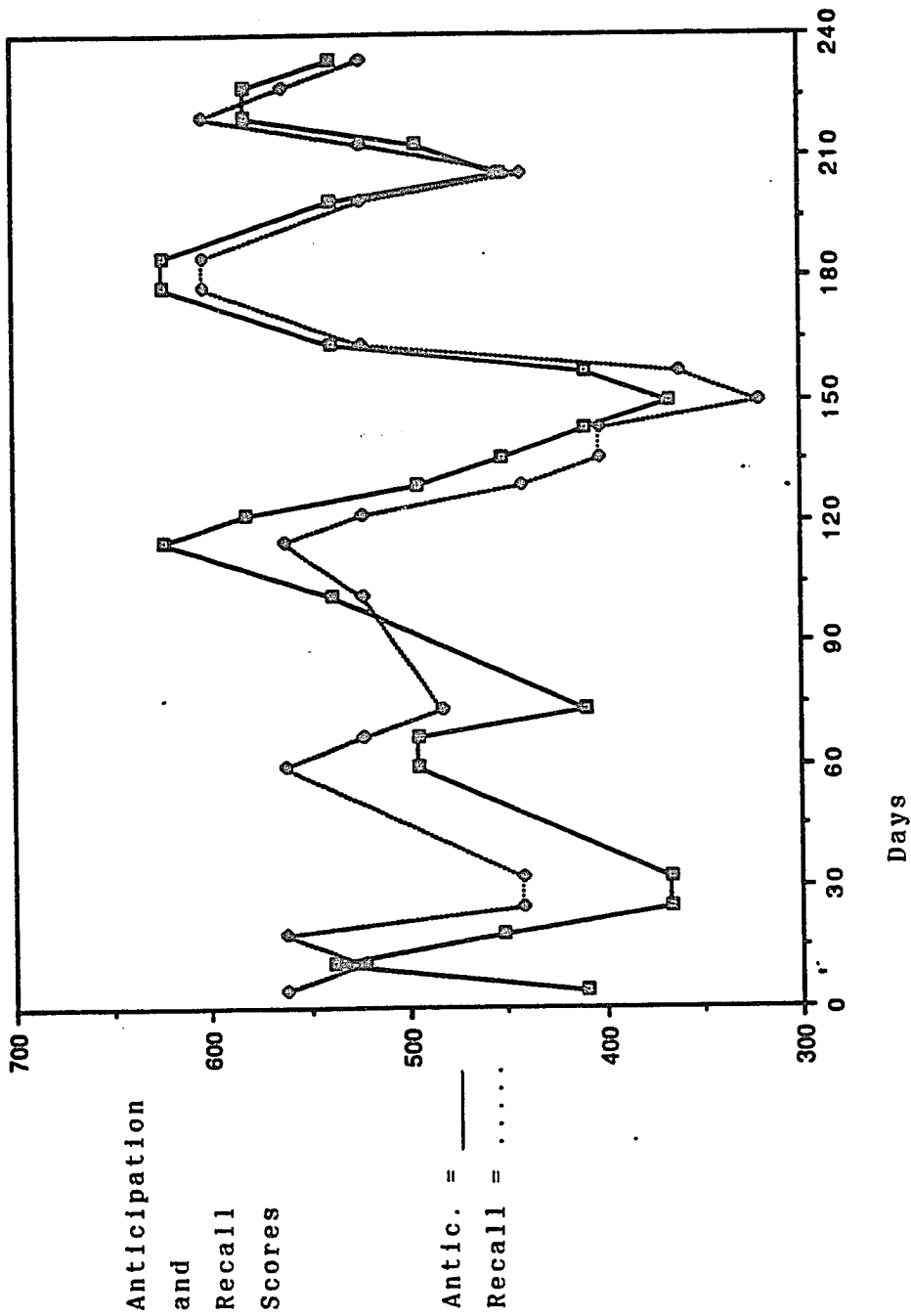


Figure 5. Case #10
Anticipation and Recall in Relation to Time.

Group B. The following cases (case #2, #3, #4, #5, #9 and #11) had changes in scoring at or around day 120 and as termination approached.

Case #2: In this case the mean Anticipation score was 3.10 with a standard deviation of .53. The mean Recall score was 2.29, the standard deviation .96. The therapist reported that both anticipation and recall decreased until day 60 followed by constant scores in Anticipation until day 150 at which point there was some fluctuation until the end. This therapist's reported ability to recall sessions was less consistent. A radical drop in score occurred from day 90 to 110 followed by ever increasing scores until day 150. At this point the Recall scores began to drop getting lower until the end. This is represented in figure 6.

Case #3: In this case the mean Anticipation score was 2.89 with a standard deviation of .78. The mean Recall score was 3.56, the standard deviation .69. The therapist reported that both feelings of anticipation and ability to recall sessions dipped slightly at day 51 then again at day 114. Then there was a continual increase in both from 114 to 135. A valley occurs in

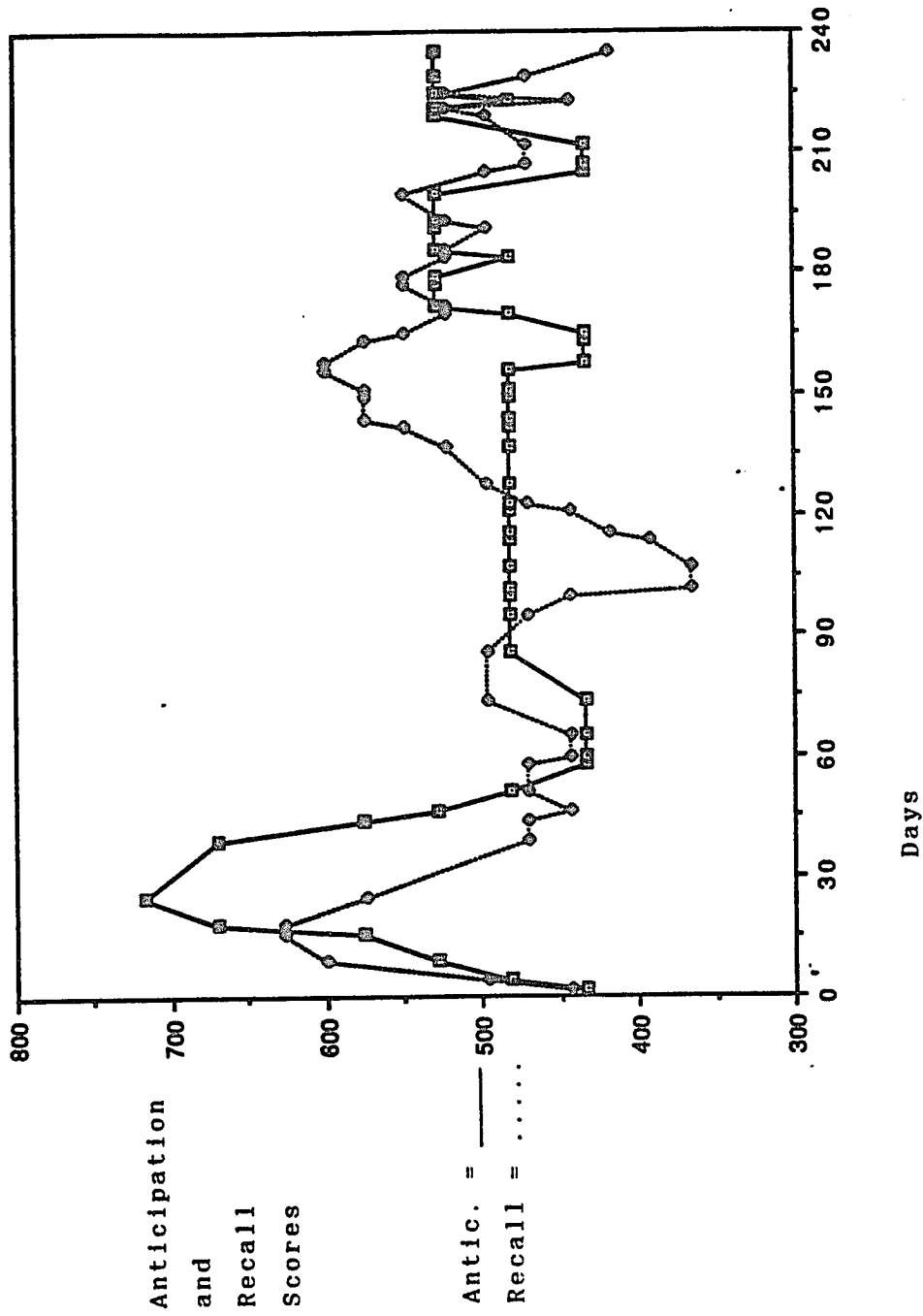


Figure 6. Case #2
Anticipation and Recall in Relation to Time.

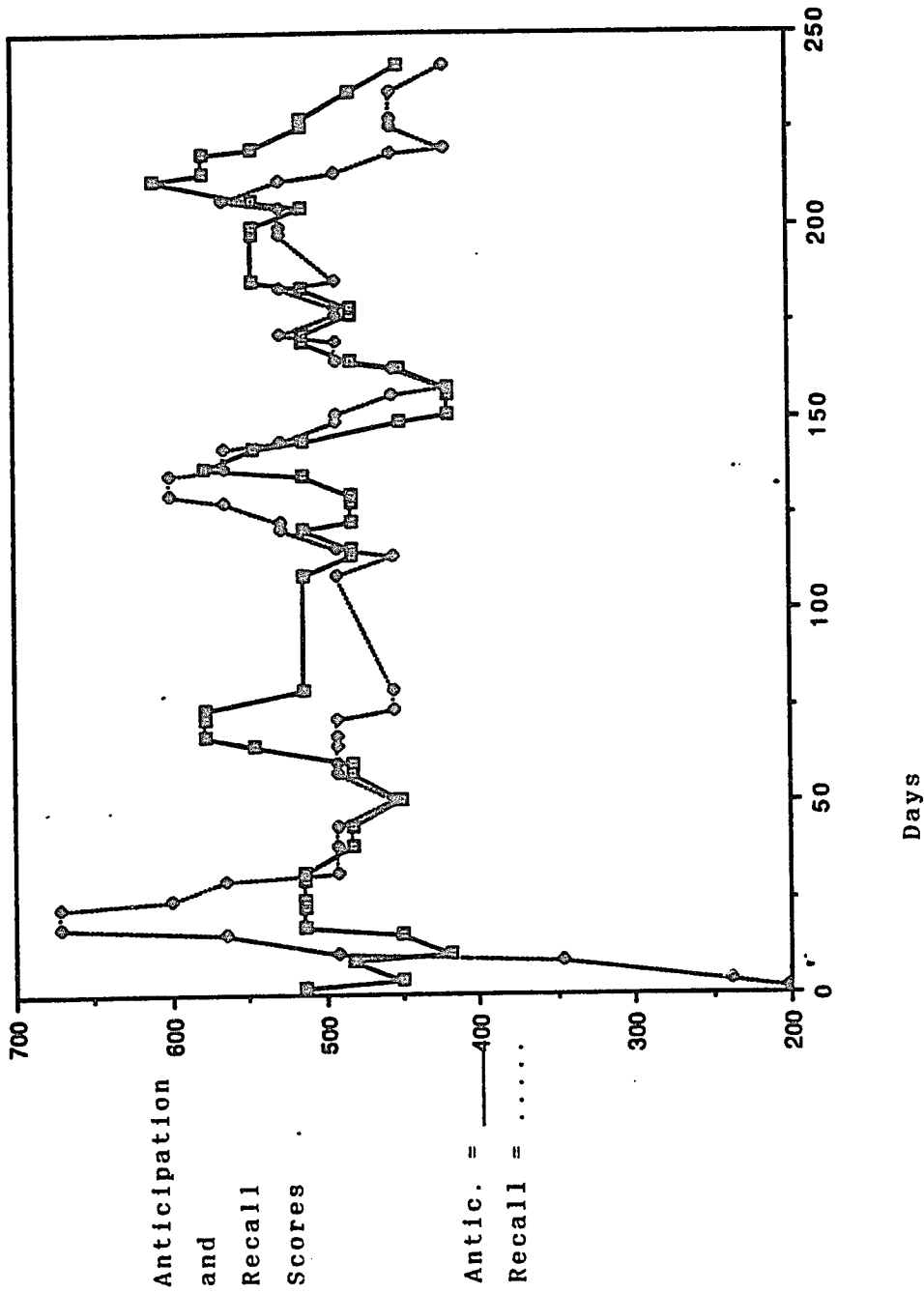


Figure 7. Case #3
Anticipation and Recall in Relation to Time.

both at around 150 then increases gradually until 200. The final month was represented by diminishing scores in both. This is represented in figure 7.

Case #4: In this case the mean Anticipation score was 3.29 with a standard deviation of 1.10. The mean Recall score was 3.31, the standard deviation 1.02. The therapist reported that feelings of anticipation elevated slightly at day 65 while the ability to recall sessions was very stable. Starting at day 96 there was a lot of movement in both Anticipation and Recall culminating in a peak at day 123 reported concern with transition. As Anticipation went down over the next month Recall went up. Nearing the end both climbed together. This is represented in figure 8.

Case #5: In this case the mean Anticipation score was 3.34 with a standard deviation of 1.15. The mean Recall score was 3.31, the standard deviation 1.13. Between days 60 and 90 the therapist reported an elevation in feelings of anticipation and a decreased ability to recall sessions. At day 120 the therapist reported decreases in anticipation and recall. There was another decrease in both at 190 followed by general increase for

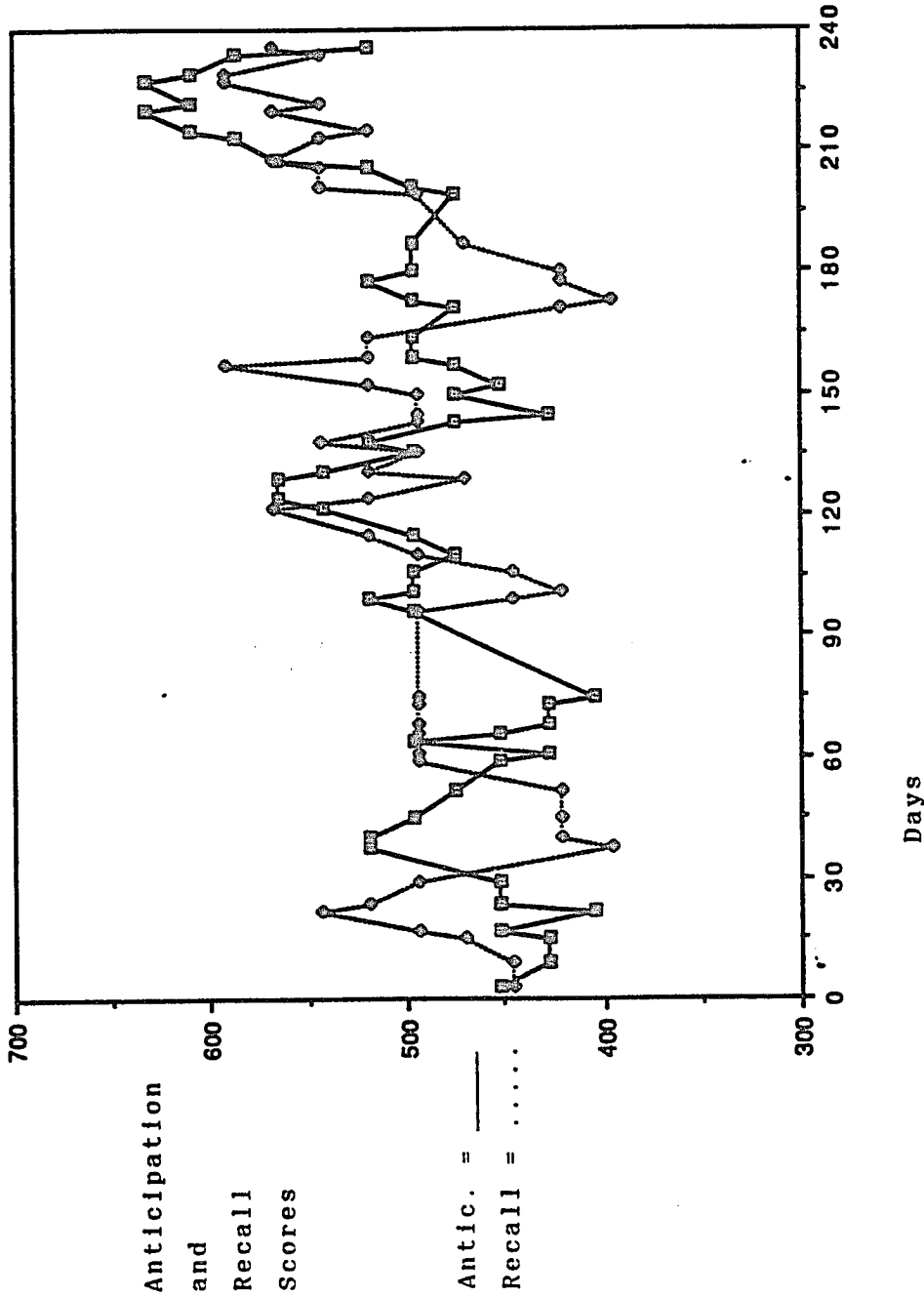


Figure 8. Case #4
Anticipation and Recall in Relation to Time.

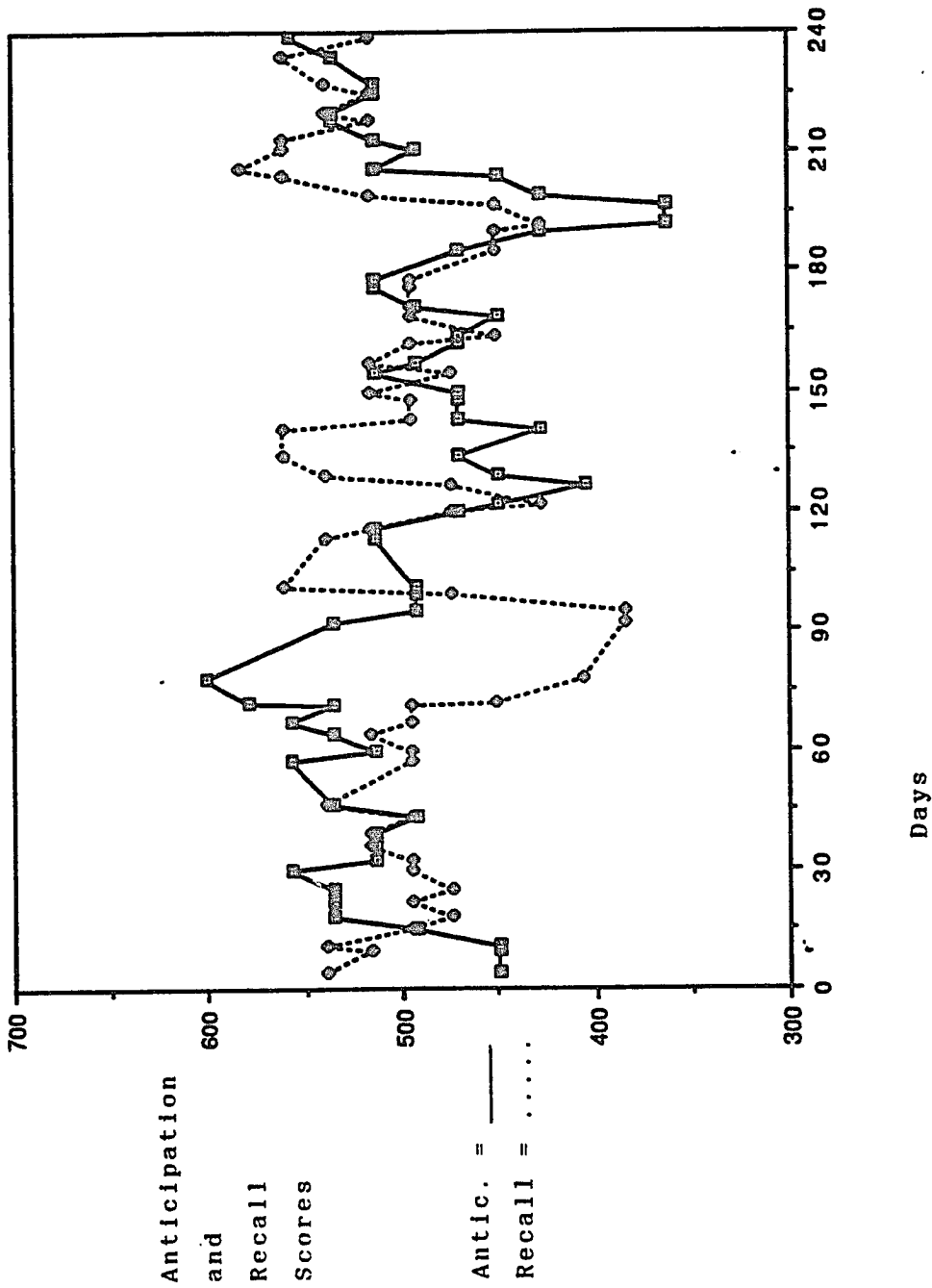


Figure 9. Case #5
Anticipation and Recall in Relation to Time.

one month and then elevated scores for the final month. This is represented in figure 9.

Case #9: In this case the mean Anticipation score was 3.36 with a standard deviation of 1.26. The mean Recall score was 3.77, the standard deviation .97. Around day 120 the the therapist reported an enhanced ability to recall sessions. Immediately after 120 both scores began to fall bottoming out from 150 to 180. From that point to the end there were rapid increases in both. At the end Anticipation dropped off for the final session while Recall remained at its apex. This is represented in figure 10.

Case #11: In this case the mean Anticipation score was 3.21 with a standard deviation of .63. The mean Recall score was 3.57, the standard deviation .88. The therapist reported parallel decreases in feelings of anticipation and ability to recall around day 110. Then both scores increased to a peak at 135 followed by stable but slight decreases in both until about 190 in Recall and 200 in Anticipation there was another depression followed by a gradual increase and slight peak in both at the end. This is represented in figure 11.

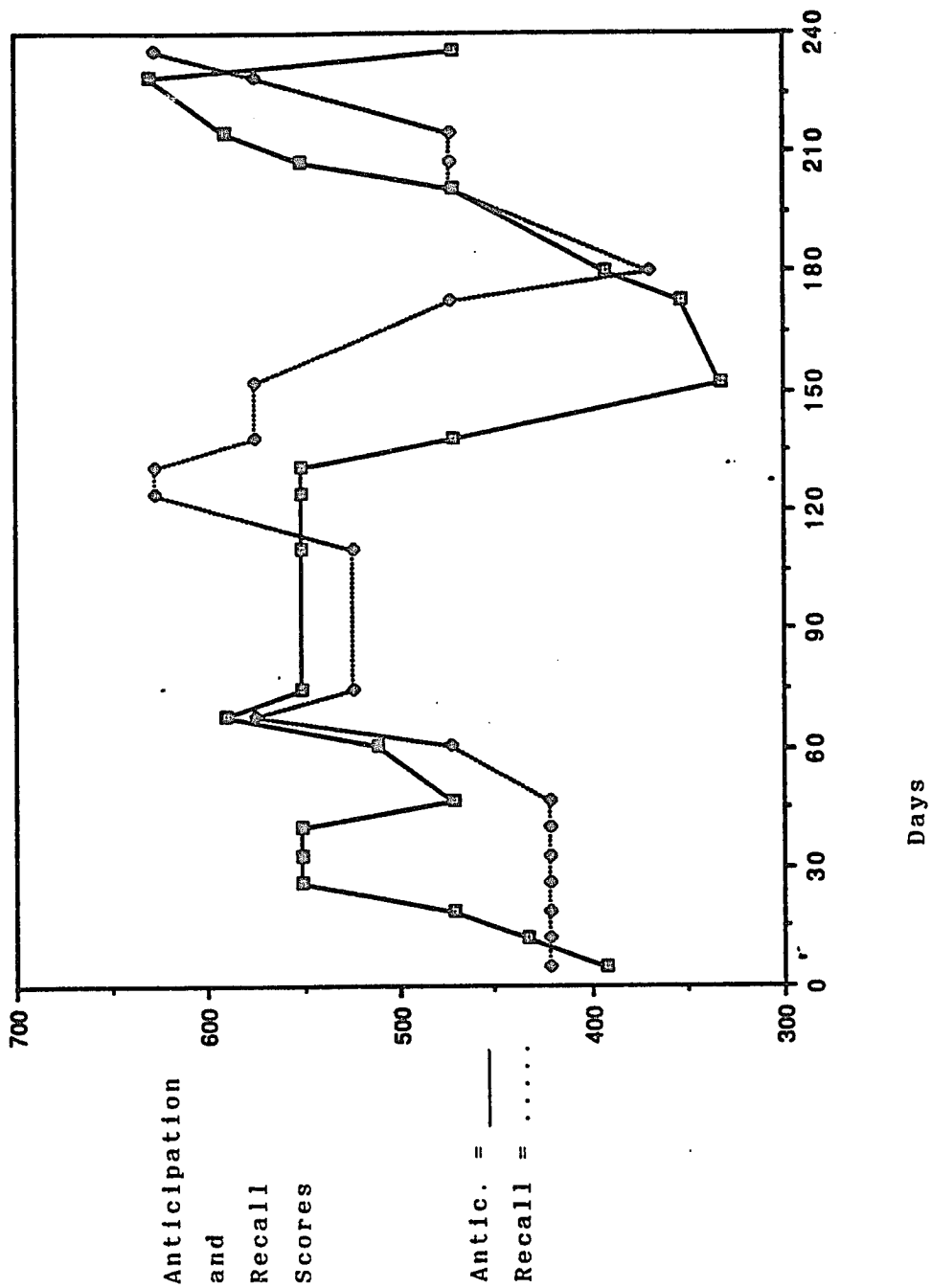


Figure 10. Case #9
Anticipation and Recall in Relation to Time.

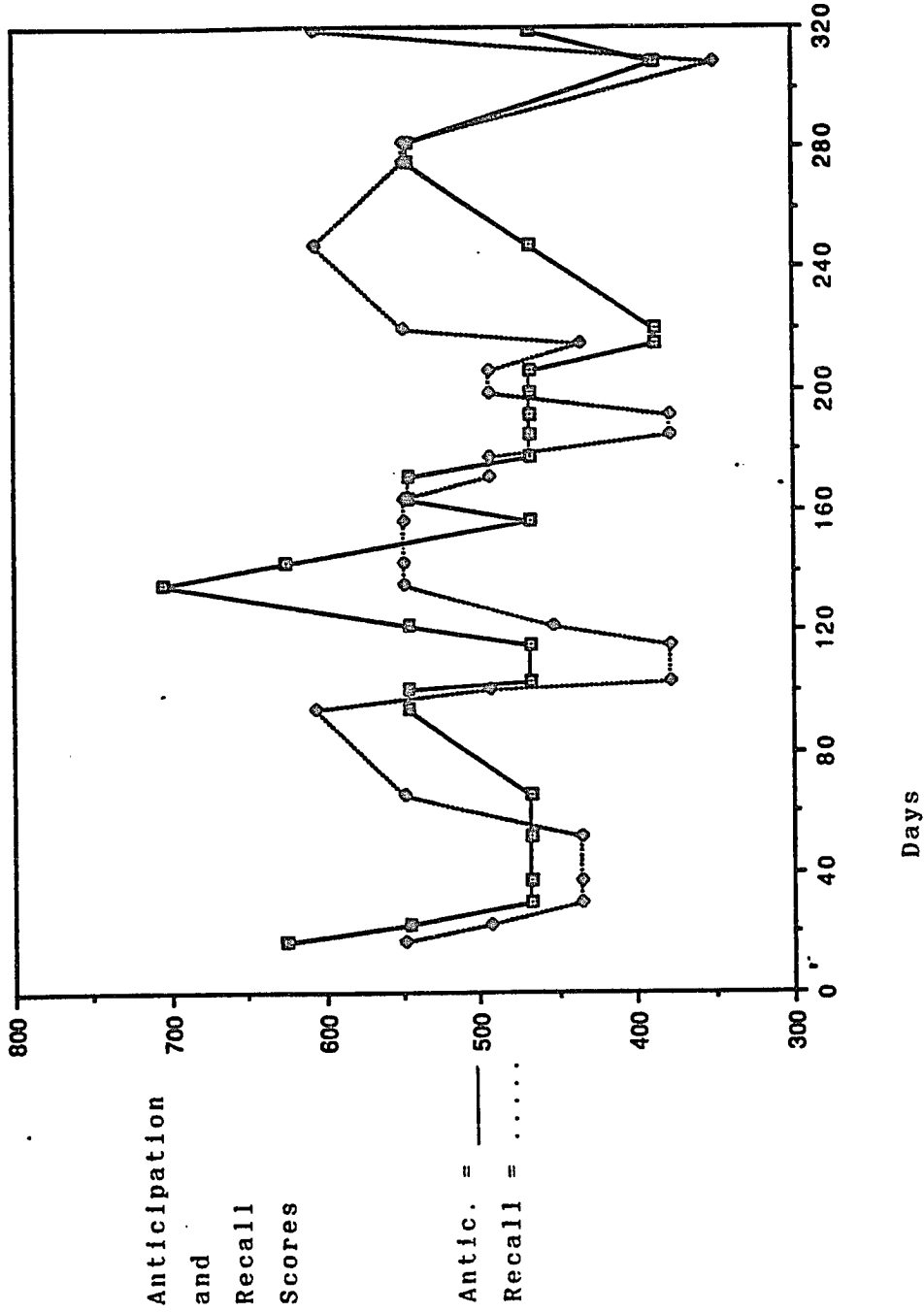


Figure 11. Case #11
Anticipation and Recall in Relation to Time.

In summary, the scoring of Anticipation and Recall fluctuated over the course of sessions. Some patterns emerged. It seems that some times are more significant than others, and among those times are the three which I pointed out (Christmas break, internship notification and termination). The time of internship notification and of transition from the clinic co-occurred with fluctuations in therapists' reported feelings of anticipation and abilities to recall sessions in every case. Whereas fluctuations around the time of the Christmas holiday occurred in 4 cases.

Anticipation and Recall Scores When The Time Between Sessions Exceeded a Week

The data seemed to indicate that there may be differences in Anticipation and Recall scores when the time between sessions was different. Intuitively it made sense that an extended hiatus between sessions would impact on therapists' feelings about the session and the patient. Cases 1 thru 6 met twice a week and cases 7 thru 11 met once a week. In cases 1 thru 6 there were far fewer occurrences of extensive interruptions in treatment. In cases 7 thru 11 the means were greater in

both Anticipation scores and Recall scores in sessions which met after an interruption exceeding 7 days. The Anticipation scores in case #11 were significantly higher when the hiatus between sessions exceeded seven days. The Recall scores were significantly higher in case #6 when the hiatus between sessions exceeded seven days. That the scores tended to be higher and in some cases significantly higher when the hiatus between sessions exceeded 7 days is suggested by these data.

(Appendix C)

The Relationship Between Anticipation and Recall Scores

There was generally a weak, positive correlation between the Anticipation and Recall scores, except for case #10 in which the correlation was quite strong and case #7 in which the correlation was weak and negative (see Table 3). In 3 cases the mean Recall scores were higher than the Anticipation scores. In 2 cases the Anticipation scores were higher and in the remaining 6 cases the scores were virtually the same (see table 1). In fact the average overall Anticipation score was 3.14 and the average Recall score was 3.17.

In some cases the scoring on Anticipation seemed to

Table 3. Means, Standard Deviations, and the Correlation Between Anticipation and Recall in Each Case

Case Number	Anticipation		Recall		Pearson's r	
	Mean	Standard Deviation	Mean	Standard Deviation		
1	60	2.83	.74	2.38	.94	.26*
2	52	3.10	.53	2.29	.96	.18
3	55	2.89	.78	3.56	.69	.32**
4	55	3.29	1.10	3.31	1.02	.12
5	58	3.34	1.15	3.31	1.13	.28*
6	38	3.16	1.08	3.37	.67	.18
7	33	3.52	.97	3.36	.74	-.18
8	33	2.70	1.29	3.27	.57	.29
9	22	3.36	1.26	3.77	.97	.11
10	25	3.56	1.16	3.72	1.24	.61***
11	28	3.21	.63	3.57	.88	.31

* $p < .05$, ** $p < .01$, *** $p < .001$

have little relation to that on Recall, while in others they seemed to be related. A correlation was carried out to determine the degree of relatedness of these two measures in order to see to what degree these two questions were tapping the same or similar therapist experiences as well as to see if it was possible and to what degree possible to predict one score from knowledge of the other.

Therapists' Concern with Transition and Termination

The central question of this study is whether or not and how the complications of making a transition to internship and terminating would affect the therapists' countertransference. Therapists' conscious expression of concern over issues related to this or other transitions occurred rather frequently as an explanation of their score on the Anticipation and Recall question. It was important to understand how important these concerns were. One measure of this degree of importance could be found in the percentage of occurrence. Also of primary importance was the question of: when are the therapists most affected by issues related to transition?

The Amount of Transition Scores

In 23% of the session records mention was made of transition or termination by the therapist as one of the reasons for them anticipating and/or recalling the session as they did (see table 4 below). For a Transition score to occur in 23% of the records suggests that issues of transition and termination are very important. The range of the appearance of the Transition score is from 38% in case #1 to 11% in case #3 with an average percentage of 23%.

Transition Scores in Relation to Time

I expected that there would be increased concern with transition and termination as the end of therapy at the clinic grew near. The data show that Transition scores increased in frequency as the end approached. Figure #12, below, shows the occurrences of Transition in the entire sample in time as related to the termination. The number of Transition scores increases as the transition to internship approaches. Between 130 and 110 days prior

Table 4. Percentage of Transition and No Transition Scores in Each Case and Overall

Case	Total	No Transition	Transition	% Transition
1	60	37	23	38%
2	52	45	7	14%
3	55	49	6	11%
4	55	40	15	27%
5	58	45	13	22%
6	38	30	8	21%
7	33	24	9	27%
8	33	28	5	15%
9	22	15	7	32%
10	25	19	6	24%
11	28	21	7	25%
Totals	459	353	106	23%

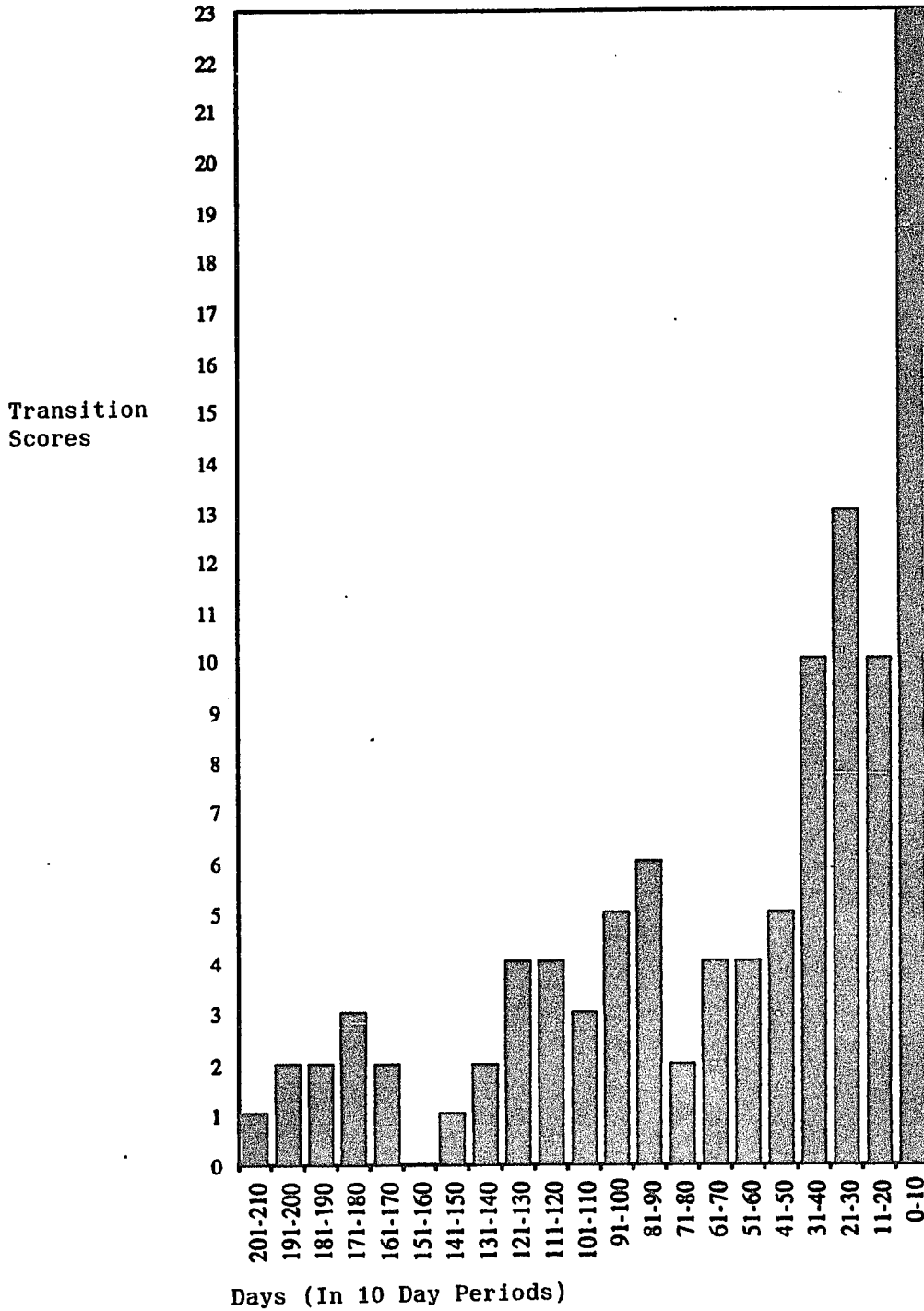


Figure 12. Number of Transition Scores in Relation to Number of Days Until Termination.

to the transition from the clinic there was an elevation in Transition scores. This time frame represents early February and could be partially accounted for by the internship notification date being February 10. All 11 cases expressed concern with transition in the final session. The implications of that fact are that these therapists are all aware of the importance of this transition and that they are willing and able to express that concern within the frame of this study. In fact 50% of the total of Transition scores occurred within 36 days of the final session at the clinic (A complete listing of Transition scores and cumulative percentages of scores in relation to the end of treatment can be seen in Appendix D.). There were occurrences of Transition scores as early in the record as 208 days before the last session. There was a gradual increase in concern with issues of transition as the end approached.

CHAPTER IV

DISCUSSION

SUMMARY OF RESULTS

Anticipation and Recall were measured over a ten month period of time by the administration of brief questionnaires to 11 student/therapists before and after each psychotherapy session. Most subjects used the entire range of scoring possibilities, from 1 to 5, on both the Anticipation and the Recall questions. These therapists also responded to a question as to how they accounted for the aforementioned variation on their score. Their responses to that question were scored as to whether or not they mentioned termination or the transition to internship as a factor in their response.

Countertransference Reflected in Anticipation and Recall Scores

The responses to the Anticipation and to the Recall questions varied within and between subjects. Still, some general patterns emerged through an analysis of the response patterns. The patterns

suggested that there were countertransference fluctuations, as evidenced by changes in Anticipation and Recall scores, at and around Christmas vacation, the internship notification, and as the time to leave the University clinic drew near. Two categories emerged: Category I showed changes at all three times mentioned above, while category II showed changes primarily at the time of internship notification and near the end.

Additionally, there were changes in Anticipation and Recall scores, in some cases, when there was a substantial hiatus between sessions. This tended to be the case when the therapy was conducted on a once a week basis as compared with twice a week. When the hiatus exceeded one week there were countertransference fluctuations in some cases. All of these cases, those within which these fluctuations occurred, regularly met once a week. Whereas in the twice a week cases there was less fluctuation when a hiatus occurred, these hiatuses also were less frequently occurring in twice a week cases.

A question arose as to how the Anticipation and Recall scores were related. In one instance the Anticipation and Recall scores were highly, positively

correlated and in another they were weak and negative. But, in the remaining nine cases the correlations between these two scores was weak, but positive. Overall, average scores between these two were nearly identical. The average scores for Anticipation and for Recall were slightly higher than 3 (3.14 and 3.17).

Concern With Transition and Termination

All therapists expressed some concern about transitions and the approaching internship placement. On 106 of 459 session records or 23% transition was mentioned. In the sessions in which Transition was scored the correlation between the Anticipation and Recall scores was much less.

The Transition score increased in incidence over time as the transition to internship approached. The pattern of this increase, overall, is gradual, except for Transition being scored a bit more around Christmas and somewhat more substantially around the internship notification, until about six weeks prior to ending, at which point the concern with the transition and/or termination became pervasive.

IMPLICATIONS OF RESULTS

Countertransference Reflected in Anticipation and
Recall Scores

That there were indications of changes in countertransference feelings at times which are fraught with meaning for the ongoing treatment of this particular patient and/or for the career of the therapist is intuitively sensible. The implications of these findings are that these student-therapists and their supervisors need to be aware of the ramifications of the timing of their professional changes as those changes do impact on their approach to their patients. These changes may be manifest in exacerbation or diminution of anticipatory feelings or enhanced or diminished abilities to recall sessions. They may be manifest before, after or during a particular time. These individual differences make generalization difficult. Still this countertransference was not so overwhelming as to significantly fluctuate at any specific time. This means either that the instrument was not sensitive enough to pick up the subtler countertransference phenomena or that this group of

therapists as a whole was well enough supervised or in good enough control of themselves to manage without being dominated by countertransference during this potentially difficult year.

There did appear to be times that the countertransference fluctuated, yet when analysed statistically there were trends but no statistical significance. The statistical insignificance may be attributable to the differing individual styles of each therapist, to the small sample size, or perhaps there simply were not measureable countertransference fluctuations at those times. Nonetheless, there appeared to be movement around the time that therapists break for Christmas vacation, at and around the time that they were notified about internship placement, as the transition from the clinic approached, and at times when there was a hiatus of longer than 7 days between sessions. When these trends are taken to be meaningful then the following implications may apply.

Countertransference changes at particular times may indicate that outside events are influencing the therapists' attitudes. Approaching the Christmas holiday may cause an upset in the therapists as they

may feel that patients will have difficulty managing on their own for even this brief hiatus. The therapists may be reminded of other difficult separations in their own lives or in those of their patients. The therapists may experience this as a precursor to the more difficult separation to occur at the end of their stay at the clinic.

Around the time that these student-therapists were notified of their internship placements there was a fluctuation in countertransference in all the subjects. This fluctuation indicates the importance of this time in the professional careers of these student-therapists. It officially marks the beginning of the next phase of their road towards becoming clinical psychologists. Prior to notification therapists may be preoccupied with interviews and constant self-evaluation while being evaluated by supervisors and future supervisors. Once accepted some therapists seemed to settle back into doing the work while others were, perhaps, more involved in their futures than in the here and now of the psychotherapeutic experience. The implication here is that therapists and supervisors alike might pay attention to these possible complications during this year.

The countertransference also changed as the end of the therapists' tenure at the clinic drew near. It is expectable that terminations and transitions, such as this one, would result in countertransference fluctuations. It is noteworthy here that these changes were not so great as to be statistically significant. Still, the termination of therapy at the clinic impacted on these therapists. From the beginning of doing psychotherapy under these conditions the fact of leaving for internship looms in the future. This is complicated since these students don't know where they will be interning, if they can take their patients with them on internship, if the cases will last that long, etc.. The culmination of all these questions arises at the point of departure. Perhaps active delineation of these problems by the supervisors and the student-therapists themselves could be useful in managing countertransference around this time.

That a prolonged (greater than 7 days) break between sessions can effect the countertransference, and that those breaks occur much more frequently in therapies which meet once a week as compared to twice a week has practical implications. Consistency and

regularity of meetings seems to help a therapist to maintain a greater degree of neutrality. There was no difference in sessions that met within 7 days however, so the implication is that a missed session for a therapy that is meeting once a week is perhaps, more significant in its impact on the therapist than is a missed session in a twice a week therapy.

Concern with Transition and Termination

In terms of how these therapists accounted for their score, in 23% of the responses they stated that thoughts about transitions impacted. This indicates the importance to these therapists of the fact that they are in the process of leaving the University setting for internship. This concern was expressed more at some times than at others. Specifically, there was some concern expressed preceding the Christmas break, some at and around internship notification, and continual increase as the transition approached culminating in Transition being the central theme for the final six weeks.

I have previously noted that the Transition scores were recorded at some significant times. Although the

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countertransference was difficult to measure as changing in time, the Transition scores clearly fell at particular times. In almost every case there were Transition scores at or very close to day 120. Day 120 was the day that these student-therapists were notified of their internship placement. At that time it is sensible that these therapists could begin to discuss the future with their patients in concrete terms; such as where they will be and whether or not the therapy would continue. For these reasons it makes sense that issues about transition would take the forefront at this time. Following this period there is a continually increasing mention of transition in the records until it becomes the dominant theme with about six weeks to go in the treatment at the clinic. The consistent concern expressed by most of these therapists regarding the transition indicates the degree of importance that this transition has. It also indicates that these therapists are, for the most part, acutely aware of that importance and that they were able and willing to express that concern within the context of this study.

It is additionally possible to speculate that the conscious awareness of the importance of transition as an issue in the therapists' attitude towards their

patients was a factor in maintaining a degree of neutrality, making measuring countertransference more difficult. Transition was simply diminished as a factor in causing countertransference due to the therapists' conscious awareness of it. It seems that this group of therapists has managed to maintain a high degree of professionalism through a tumultuous professional transition.

LIMITATIONS OF THE RESEARCH

I thought that because of the length of the study that these therapists would establish their own norms and serve as controls for themselves. However it may be that this entire 10 months of therapy represents a different period of time in these "long-term" cases in which case a control group of some kind might have been useful. Either the study could have gone for a longer period of time, or a comparable group which was not leaving on internship could have served as a control. In that way the fluctuations of countertransference could have been more definitively proven or disproven to exist.

Another problem was that the therapists rated

themselves. The therapists' feelings in anticipation of the session were not rated. What was scored was the therapists' perceptions of their feeling states. This develops validity over time as the therapists' changes in self-rating must reflect something, but exactly what remains somewhat speculative. Actual memory was not rated. What was rated was the therapists' perception of their memory of the session in question. Certainly, if a therapist is having difficulty remembering a session, is blocked in some way or is suddenly remembering more vividly than usual, some countertransference is at work.

This study was an attempt explore the feelings of a therapist in the least intrusive way possible over an extended period of time. Other instruments may be superior to this one in assessing countertransference at any given moment, but the idea here was to take a continual pulse of the therapists' countertransference over time. The instruments used to this end were certainly unintrusive, thereby useful and have face validity as well as a certain validity developed by use of the rating scale over time.

The scoring of Transition was based on the mention by the therapists of transition to internship, leaving

or termination of therapy. Endings occur in every relationship. Therefore there is always the potential that separation or termination is an issue. Although this group of therapists recorded it as an issue 23% of the time, that represents only a fraction of the times that it may have been present as an issue either consciously and simply not mentioned or unconsciously and out of awareness. To ascertain with a greater degree of assurance the times that transition was an issue, again would have required a more elaborate method, which may have been too cumbersome for this study.

The conditions that made this study possible were that it was done within a clinical training program which; has its' own clinic, and encourages and trains therapists in doing long-term psychotherapy. It may be, therefore, that these data are not generalizable to other psychotherapists who are in one sort of transition or other. In fact, they may not even be generalizable to clinical training programs without internal clinics and a focus on long-term therapy. Nonetheless, it is certainly possible that these results can be generalized and that psychotherapists in training and their supervisors might be aware of the

potential pitfalls of their training calendars.

IDEAS FOR FURTHER RESEARCH

1. The data base contains a comment from each therapist on each session regarding the reason they scored the 1 through 5 scale as they did. In this project these comments were assessed only for whether or not they made reference to transition or termination. I next will develop a scale for analyzing the content of these comments and see if those comments are related to fluctuations in the 1 through 5 scales as well as to time.

2. This project could be seen as a model for psychotherapy research in training settings or clinics, where there are several therapists working in the same place. By using the "brief questionnaire", asking a simple question before and/or after each session, various aspects of psychotherapy could be studied, including more extensive studies of countertransference in a variety of situations.

Appendix A. Instructions to participants

You have agreed to participate in this research project. I greatly appreciate your cooperation. In order for this project to work, please consistently report the requested information. All of this data is in relation to your adult 'long-term' case(s). You should complete #1 (the Anticipation question) prior to each meeting. #2 (the Recall question) should be completed after each session. I have requested that you indicate, briefly, what you feel is the reason for your level of anticipation of the session, and the reason for the level of recall. Please put the paper in my mailbox when it is completed.

Appendix B. The brief questionnaires

1. Anticipation

THERAPIST-

DATE-

How do you feel in anticipation of this session?

much less eager-less eager-normal-somewhat more eager -

1

2

3

4

especially eager

5

Why do you think that this is the case?

2. Recall

THERAPIST-

DATE-

How well do you recall this session?

much less-somewhat less-normal-somewhat more-much more

1

2

3

4

5

Why do you think that this is the case?

Appendix C. Comparison of mean Anticipation and Recall scores from sessions seen within 7 days (Group 1) and with a hiatus between sessions longer than 7 days (group 2).

Case #1

	<u>N</u>	<u>Mean</u>	<u>probability</u>
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Anticipation

Group 1	57	2.82	.33
Group 2	3	3.00	

Recall

Group 1	53	3.55	.10
Group 2	3	2.33	

Case #2

	<u>N</u>	<u>Mean</u>	<u>probability</u>
--	----------	-------------	--------------------

Anticipation

Group 1	47	3.11	1.00
Group 2	5	3.00	

Recall

Group 1	47	2.32	.13
Group 2	5	2.00	

Case #3

	<u>N</u>	<u>Mean</u>	<u>probability</u>
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Anticipation

Group 1	53	2.91	
			1.00
Group 2	2	2.50	

Recall

Group 1	57	2.39	
			.46
Group 2	2	4.00	

Case #4

	<u>N</u>	<u>Mean</u>	<u>probability</u>
--	----------	-------------	--------------------

Anticipation

Group 1	53	3.26	
			.40
Group 2	2	4.00	

Recall

Group 1	53	3.30	
			1.00
Group 2	2	3.50	

Case #5

	<u>N</u>	<u>Mean</u>	<u>probability</u>
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Anticipation

Group 1	55	3.35	.35
Group 2	3	3.33	

Recall

Group 1	55	3.35	.45
Group 2	3	2.67	

Case #6

	<u>N</u>	<u>Mean</u>	<u>probability</u>
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Anticipation

Group 1	34	3.18	
			.06
Group 2	4	3.00	

Recall

Group 1	34	3.29	
			.03
Group 2	4	4.00	

Case #7

	<u>N</u>	<u>Mean</u>	<u>probability</u>
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Anticipation

Group 1	25	3.44	
			.29
Group 2	8	3.75	

Recall

Group 1	25	3.36	
			.22
Group 2	8	3.38	

Case #8

	<u>N</u>	<u>Mean</u>	<u>probability</u>
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Anticipation

Group 1	27	2.59	
			.79
Group 2	6	3.17	

Recall

Group 1	27	3.22	
			1.00
Group 2	6	3.50	

Case #9

	<u>N</u>	<u>Mean</u>	<u>probability</u>
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Anticipation

Group 1	15	3.26	
			.39
Group 2	7	3.57	

Recall

Group 1	15	3.53	
			.35
Group 2	7	4.29	

Case #10

	<u>N</u>	<u>Mean</u>	<u>probability</u>
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Anticipation

Group 1	20	3.30	
			.78
Group 2	5	4.60	

Recall

Group 1	20	3.60	
			.40
Group 2	5	4.20	

Case #11

	<u>N</u>	<u>Mean</u>	<u>probability</u>
Anticipation			
Group 1	18	3.17	
			.001
Group 2	10	3.30	
Recall			
Group 1	18	3.22	
			.75
Group 2	10	4.20	

Appendix D. Frequency and cumulative percentage of Transition scores from the final day (1) backwards to Transition's first appearance in the data (208).

Day Freq. Cum.(%)			Day Freq. Cum.(%)			Day Freq. Cum.(%)		
1	11	10.4	52	1	58.5	113	2	83.0
3	4	14.2	57	2	60.4	115	1	84.0
6	1	15.1	59	1	61.3	120	1	84.9
7	1	16.0	61	1	62.3	124	1	85.8
8	5	20.8	64	2	64.2	129	2	87.7
10	1	21.7	66	1	65.1	134	1	88.7
11	3	24.5	71	1	66.0	136	1	89.6
15	4	28.3	78	1	67.0	141	1	90.6
17	2	30.2	81	1	67.9	161	1	91.5
20	1	31.1	84	1	68.9	162	1	92.5
22	7	37.7	85	3	71.7	171	1	93.4
24	3	40.6	87	1	72.6	173	1	94.3
29	3	43.4	92	1	73.6	176	1	95.2
31	3	46.2	94	1	74.5	184	1	96.2
36	4	50.0	99	3	77.4	185	1	97.2
38	3	52.8	102	1	78.3	192	1	98.1
43	1	53.8	105	1	79.2	198	1	99.1
45	3	56.6	108	1	80.2	208	1	100.0
46	1	57.5	111	1	81.1			

Appendix E. Content analysis of the question, "Why do you think that this is the case?"

In attempting to analyze this question beyond the question of whether or not the subject made reference to transition or termination, I devised the following scoring system.

Each response (918) was scored regarding four possibilities. Was the response about the treatment or not, and was it about the patient or the therapist. Each response was then given any one or possibly all four scores. The scores were: IT which referred to a response about the therapist and in the treatment; IP, about the patient and in the treatment; ET, about the therapist and outside of the treatment; and EP, about the patient and outside of the treatment.

These scores were studied, the results of which showed IT to be more frequently occurring when Transit was scored. Under further scrutiny, this result appeared to be tautological as if the therapist were discussing the termination of treatment then the therapist necessarily was discussing his concerns about the treatment, or IT.

Appendix F. A Comparison of Responses from Cases with the Same Therapist.

There were three therapists who carried two patients each during this study. Below is a table with the correlations of their Anticipation and Recall scores which occurred on the same day, but with two different patients. Also included in this table is a correlation of the responses of two different therapists on matched days (this is the final comparison 1,3).

Case	N(matched pairs)	r Anticipation	r Recall
7,8	15	.32	.27
5,10	17	.16	.43*
1,2	47	.46**	.45**
1,3	41	.23	.26

* $p < .05$

** $p < .01$

In this sample there are wide individual differences, yet there is a tendency towards a positive correlation, somewhat stronger with the same therapist across different patients than with different therapists.

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