Order Number 9000688

Countertransference of children's therapists toward mothers of children in treatment

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City University of New York, 1989

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COUNTERTRANSFERENCE OF CHILDREN'S THERAPISTS TOWARD MOTHERS OF CHILDREN IN TREATMENT

by

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A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

1989

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirements for the degree of Doctor of Philosophy.

4-27-89
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TABLE OF CONTENTS

LIST OF TABLES

LIST OF DIAGRAMS

Chapter 1

Introduction

In presentations and writings dealing with clinical work with children, one frequently hears statements of the crucial importance of work with parents to the success of the therapeutic work with child patients. Not only must parents often support the therapy on a practical level, e.g., by paying, providing transportation, offering information and ensuring the child's attendance, but parents must also be capable of adapting constructively to changes in the child brought about by the therapy. If parental attitudes or behavior are regarded as pathogenic of the child's difficulties, then work with parents must be done to alter their negative patterns of interaction with the child. All this must be done while protecting the privacy of the therapeutic relationship with the child. Not surprisingly, given the complexity of this task, one often hears child therapists venting their frustration with parents for failing to support, and indeed, actively obstructing, the therapy. Experience talking with children's therapists suggests that very strong feelings tend to be evoked in child therapists toward parents of children they are seeing, and that these feelings sometimes adversely affect the treatment.

There appear to be a number of factors which might contribute to the highly charged and often pitfall-laden

relationship of therapists with parents. On a practical level, parents control the treatment; they can, for the most part, evaluate the therapist's performance, sabotage the treatment, refuse to pay, refuse to participate and ultimately terminate the treatment. Even in a successful treatment the potential for this power is known and probably felt by therapist and parent alike. Unlike a one-to-one relationship with an adult patient, parental feelings, attitudes, and decisions cannot always be interpreted and analyzed; a strong bond between therapist and parent, which would tolerate the ups and downs of the therapeutic work, is not always developed. In addition to the practical considerations, the therapist is emotionally invested in understanding the child's situation and helping the child adapt to and master that situation. Therapists are thus emotionally attuned to what it is like to be the child of these particular parents. In attempting to empathize with the child and to understand the child's situation, the therapist may experience a child's eye set of reactions to the parents, perhaps enhanced by the parents' practical power over the therapeutic relationship. Areas of the therapist's own early issues and conflicts with his or her own parents may be evoked consciously or unconsciously. The particular personality, charateristics, circumstances and interactions of a parent, seen as an individual, of course also elicit

emotional responses in the therapist.

In spite of what seems to be universal acknowledgement in practice of the potential for strong therapist countertransference toward parents, little work of either a theoretical or empirical nature has been done in this area. This dissertation will attempt to explore, theoretically and empirically, the dimensions and impact of therapists' feelings toward mothers of children in treatment. Feelings of therapists toward fathers are undoubtedly of equal importance, and this could be a subject for a future similarly structured study. All relatively recent writers on work with parents recommend attempts to involve both parents (Schaefer and Millman, 1977; Adams, 1982). In a rare empirical study, LaBarbera and Lewis (1980) found that if the father attended the initial interview, there was a greater likelihood that treatment recommendations would be accepted and acted upon by the family. For this initial study, however, the additional complexity of including data relating to fathers was felt to be prohibitive.

As a first study of this area, this dissertation will be broad and exploratory, hopefully pointing toward more discrete areas for future investigation. First, an illustrative case will be presented to raise questions and issues regarding the relationships with mothers of children seen by therapists. Second, the history

of the therapeutic profession's conceptualization of the relationship of children's therapists to parents and the evolution of different structures for handling this relationship will be summarized, with consideration of the implications of each type of structure for countertransference patterns. Third, the concept of countertransference will be discussed, and the literature regarding countertransference toward children and their parents reviewed in detail. The empirical portion of the study will attempt to: (1) survey the types and intensity of countertransference of children's therapists toward mothers; (2) examine the causal impact of therapists' relationships with and feelings about their own mothers on the types and intensity of countertransference toward mothers of children seen; (3) study the comparative causal impact of the practical support of the child's therapy by the child's mother on the types and intensity of countertransference toward mothers of children seen; and (4) trace the causal impact of level of negative countertransference toward mothers of child patients on the outcome of the therapeutic relationship with the child. Finally, an attempt will be made to evolve theory about countertransference in the therapist-mother relationship, based, in part, on the results of the empirical study.

The definition of countertransference will be discussed more extensively at a later point, but it should be

noted at the outset that, for purposes of this study, the totalistic definition of countertransference, i.e., all therapist feelings toward parents, conscious or unconscious, realistically evoked or arising out of the therapist's own past, will be employed (Marshall, 1979). It should also be noted that although the child's mother may not be viewed as a "patient" by the therapist, it is assumed that "countertransference" is the appropriate term to apply to feelings evoked in the therapist through his or her relationship with the child patient's mother. Countertransference also includes both positive and negative dimensions of therapist feelings. This study will not collect data on or analyze the "transference" reactions of parents toward the child's therapist although clearly the parents' transference will influence the nature and degree of the therapist's countertransference.

Chapter 2

Illustrative Case

Case material from my own experience will be presented briefly to illustrate the potential complexities and importance of the relationship between the child therapist and the mother of the patient. This case material (with others) has also been used, in designing the empirical study, as a resource for selection of items for therapist rating scales as discussed in the methodology section.

I saw in treatment for approximately nine months a five-year-old boy who had previously been seen by another therapist for a year and a half. The original diagnosis was of a symbiotic psychotic child, and the work had begun with the mother and child together. At the time I took over the case, however, the child was being seen separately three times a week, and the mother separately perhaps once a month.

The mother had been an abandoned and abused child. She was viewed by the previous therapist and supervisor as borderline, and tended to arouse feelings of hostility in all clinic personnel who had contact with her because of her controlling, intrusive, histrionic and conflict-creating behavior. The mother had been in treatment with another therapist, but had abruptly ended her own therapy at the time of the transfer of her son's treatment to me.

In supervision, it was determined that I should attempt to get the mother to resume her own therapy, but also attempt to resume joint mother-child sessions, as well as see the mother alone once a week.

In terms of the logistics of the relationship, this mother was generally supportive of her son's treatment. Her son attended his sessions regularly except when ill; she paid clinic fees; she provided information which, though often quite distorted, was accurate from her point of view. However, where her own involvement in the treatment was concerned, she was highly erratic about attending sessions with me. Her effort was largely to transform the therapeutic relationship into a relationship between "friends"; she requested sessions outside the clinic and home visits, gave me large presents, and made numerous lengthy phone calls to me. Despite limits set on these overtures, ultimately she articulated feelings of love and sexual longing toward me, and her wish to establish a loving relationship outside the therapy. Interpretations and statements of boundaries were followed by refusal to attend sessions and statements of intent to withdraw her child from treatment. Attempts to involve the father in treatment were met with adamant assertions by the mother that he would refuse any participation. When at long last, I was able to schedule a home visit with father and mother, I arrived only to find the mother alone and a special

dinner prepared for me.

Although I frequently invited the mother to attend her son's sessions once a week, she refused to make a definite commitment, but instead would simply arrive, expecting to stay without any prior notice. In the subsequent sessions with mother and child, she would infantilize him (rocking him and singing a lullaby), over-control and criticize him, think up scary games and fantasies to act out (e.g., a "bull" would attack him as he pretended to deliver a package to her). Finally, she would leave abruptly in the middle of the session, agonizing over her departure and insisting on a requisite number of adequate kisses and hugs from him. Although I would not consider this mother a physically or sexually abusive parent, she was quite seductive with her son. She also personally pulled some of his baby teeth when they became very slightly loose.

During the period of the therapy, I was also attempting to encourage placement of this child in an appropriate educational setting for the following year. The mother refused to take any of the steps I recommended and ultimately placed him in an inappropriate educational setting where he was bound to (and did) fail. She refused to allow me to make contact with relevant school personnel. She also finally withdrew her son from treatment with me at the end of the year, after vacillating back and forth

about it, because of her conviction that her son was now normal and also apparently because of her still persistent fantasy that I could become her friend if her son's treatment were to be concluded.

Obviously, in this context, intense countertransference feelings were evoked in me, no doubt enhanced by my low level of experience at the time; my empathy for her son's plight, my sense of anger and opposition to her controlling behavior, my outrage at her sadism, seductiveness and narcissistic use of her child, in addition to some sense of pleasure in her over-idealization of me. Moreover, my work with her son, although productive, was limited by her refusal to engage in real therapeutic work with me or anyone else. Her approach to me was so intrusive and seductive that it became acutely uncomfortable to me at times, and led to a consideration of deeply personal issues in my own therapy. I not only empathized with her son's plight, but felt myself to be in a somewhat similar plight in attempting to perform my work in an optimal way. While one could conceptualize the situation as allowing the mother to form a new symbiotic relationship with me, thus releasing her son, her participation was so erratic that it was difficult to process or resolve this new relationship.

I struggled to maintain my ability to work constructively with this mother in whatever way she would allow,

to be firm in limiting my involvement yet not wound her to the point of withdrawing her son from treatment, to remain warm and empathic while not adding fuel to the flames of her wishes for a personal relationship with me. I was consciously aware of a great many negative feelings toward her (as well as some compassionate positive ones), and I'm sure many others were harbored in my unconscious. At the conclusion of the child's therapy, I was disheartened. A six-month follow-up call revealed, however, that after the failure of original school plans for her son, the mother had done more or less exactly what I had originally recommended (although without asking for my help), and her son was functioning well in a second and more appropriate setting. Her attitude toward me seemed grateful. At approximately six-month intervals since then, she has called to update me on her son's progress and her own, which are both satisfactory. Perhaps this ultimately happier outcome suggests that the struggle to understand and master countertransference with such a mother can be worthwhile. Certainly, I felt I learned a great deal about myself in the process, both as a therapist and as an individual with child-mother issues of my own.

My discussions with colleagues and my review of the literature suggest that both my quandary with this therapy and my emotional reactions to it are not atypical in their complexity, intensity and extent of impact on the

work with the child patient. The child therapist, experiencing and empathizing with the child's confusion, pain, anger, fear and love begins to see the ways in which the family situation creates these feelings in the child. The therapist cannot simply aid the child to play out his feelings, but leave the surrounding structure untouched if it has been destructive; nor can the therapist satisfy the child's need for a healthier object relationship than he may presently have in his family and then simply depart. In seeking to change the mother's responses, the therapist needs to understand and empathize with the mother's pain and conflicts as well. When the mother controls and frustrates the therapy, and in the therapist's eyes, causes pain to the child, powerful feelings may be evoked in the therapist of empathy with the child, anger with the mother on the therapist's own behalf at her frustration of his/her work, potential rivalry with the mother for best-loved object of the child, as well as mother-child issues from the therapist's own childhood relation with his/her mother. At the same time, if the therapist views the mother as a person in pain and conflict in her own right, then feelings of empathy and understanding of the mother's plight may also be evoked. The therapist and the mother are both adults, after all, and the therapist may have vivid experience from sessions of just how difficult and enraging it is to parent this

particular child. The therapist may feel caught between his understanding of and loyalty to the mother and his understanding of and loyalty to the child. Optimally, of course, the therapist utilizes this awareness of conflict and pain in both parents and child to ameliorate with sensitivity and tact, the difficulties between mother and child that are causing pain to both. This can be a treacherous and difficult course, however, when parents and child each demand the therapist's full loyalty, or when the mother adamantly resists all constructive change and actively frustrates the therapist. If there is trouble in the marital relationship of the parents, or if the therapist is dealing with a single parent, the potential may exist for the parent to seek from the therapist some of the partnering and support he or she is not receiving from the spouse. While this probably arises most frequently in the relationship between a mother and a male therapist, it also arose between a mother and a female therapist in my case, as the mother seemed to seek from me a sexual partner, a co-parent, and perhaps a parent for herself as well. With a healthier mother, the potential for such intense conflictual countertransference is less, of course, although it still probably exists along similar dimensions and may be less recognized because it is more subtle.

Therapists may also react to their perception of

the parent's inadequacies and their own sense of greater knowledge of and competence with children, with feelings of superiority, power and control over the lives of the child and his or her family. Feelings of omnipotence may be evoked, rivalry with the parents for the affections of the child, and reevocations for the therapist of his or her own early issues around omnipotence. The therapist may unconsciously take revenge on the parents for the inadequacies of the therapist's own upbringing.

The therapist's own status as parent or non-parent, his or her age vis-a-vis the parents, and the status of the therapist's own therapy or self-understanding of course may exert a powerful impact on the countertransference reactions in a particular case. A non-parent therapist may unconsciously envy a parent, or may utilize child therapy as a substitute for parenting. A parent therapist experiencing his or her own difficulties in parenting may view the therapy through a distorted filter created by his or her own family situation. A therapist considering sensitive childhood issues in his/her own therapy may be acutely sensitive to certain similar issues in the child-patient's development.

Chapter 3

Review of the Literature

A. Introduction

Since there has been very little published work of either a theoretical or empirical nature on counter-transference of children's therapists toward mothers, I reviewed some of the literature dealing with the relationship between therapists and parents in general, and then more specifically, that dealing with counter-transference phenomena in work with children. Almost every book on child psychotherapy has at least a chapter on work with parents, and many case studies on work with children refer at least briefly to involvement with the parents. With a few exceptions which will be discussed below, however, the literature consists of individual therapists' commenting on the fruits of their experience in working with parents and children.

This review of the literature will be organized as follows: (B) the history of the therapeutic relationship between therapists and parents and its implications for countertransference; (C) the evolution of different structures for handling relationships with parents and their differential implications for countertransference; and (D) the literature on countertransference as it relates to therapist's feelings toward parents of children they are seeing.

B. History of the Relationship between Children's Therapists and Parents of Children in Treatment

Historically, the relationship between a child therapist and the parents of a child in treatment was initially dealt with in the evolving therapeutic profession by having a separate therapist see the mother of the child. The child guidance movement in the 1920's developed a model for work with parents which consisted of having a separate social worker meet with the parent of the child for education, support and guidance, and sometimes help with financial and social problems. (GAP, 1982). These meetings ideally took place simultaneously with the child's therapy sessions. The social worker's effort was not to remodel the parent but to build on the parent's positive qualities, educate the parent about the child's needs, ease the parent's anxieties and tensions, and sometimes aid in the provision of practical necessities (Gartland, 1937). Arguably, this left the child therapist free to explore the child's issues without the intrusion of the parents, but it seems doubtful that the therapists did not develop strong reactions to the parents anyway, through experiencing the child's internalizations of them. Perhaps the social worker, who would be more inclined to see the situation through the parents' eyes, could contribute to a more balanced picture, if the (usually) higher status professional child therapist was willing

to listen. The "countertransference" suggested by this structure is one of a desire to exclude the parent from the special child-therapist relationship, as an undesirable and damaging factor in this relationship.

The early child psychoanalysts in the 1940's did not adopt the child guidance model, but focused almost exclusively on the inner life of the child. Anna Freud (1946), for example, wrote about the need for the child analyst to become the child's "Ego-ideal", and to help the child set standards for acceptable instinctual gratification. If that task were left to the parents, "whose exorbitant requirements drove the child into an excess of repression and into neurosis" (p. 44), the child would be forced once again into a prison of repression. Freud cited the many ways in which parents could endanger the child's analysis and concluded that she would never again analyze a child unless she was sure the parents were sufficiently flexible or sufficiently analyzed to cope constructively with the changes brought about in the child through treatment. Burlingham (1935) echoed these sentiments, stating that even before the analyst ever sees the child, the analyst knows that the parents have had a major causative role in the child's illness. Some analysts refused to know the parents, while others attempted to involve the parents in the analytic process. Still others attempted to remove the child from the home

during the period of the analysis and then replace the child when the work was completed. Burlingham favored the "most difficult" approach of trying to gain parental cooperation and educating them about what to expect. Arguably, the early child analysts were reacting to their strong negative countertransference toward parents as pathogens and frustrators of the work, and as evocative of the analysts' own parents, in seeking to exclude parents from the treatment altogether.

Over time, the therapeutic profession developed increasing awareness that children cannot in general be effectively treated without the child's therapist having some active involvement with the parents. According to the GAP (1982), most therapists who work with children do involve the parents in the child's treatment to some extent, but there is a wide range of variation in the goals and logistics of this involvement. With the evolution of greater involvement of the therapist with parents, there has been greater awareness of the complexity (legal, practical and emotional) of that relationship. Many variations have developed among different therapists for structuring the parent-therapist relationship.

Whatever the structure, the common legal reality is that only the parent can consent to the child's treatment, and that the parent is then obligated to pay for it. This puts parents in control of the child

therapist's livelihood, the child's treatment, and to some extent, the therapist's professional success; this is undoubtedly a strong countertransference-inducing factor. When child welfare agencies, courts, foster parents, or childcare institutions are involved, the obligations and loyalties of the therapist can become even more complicated.

Confidentiality has been the primary legal and ethical issue focused on by those who have written about work with parents and children, i.e., how much information about what the child says and about the treatment process, should be shared with parents and others (e.g., Rosen, 1978). The parents normally are paying for the therapist's services and making the practical arrangements which make therapy possible; yet, the therapist must maintain confidentiality to his or her patient, the child, while at the same time explaining to the parents the nature of the work being done and helping them understand the progressive and regressive changes they are seeing in their child's attitudes and behavior at home. At the same time, the therapist wants a free flow of information from the parents about them, their history and their private lives. Obviously, this is very much a practical issue as well as an ethical one. According to the GAP (1982), one cannot make a flat promise of confidentiality to a child because in situations where the therapist

knows the child is about to do something dangerous, he will feel obligated to report to the parents whether or not the child consents. The GAP recommends in general, however, that the therapist attempt to get the child's consent before any other type of disclosure. Adams (1982) believes that the therapist should make it clear at the outset of therapy that the parents should not question the child about his or her therapy or suggest that the child report certain things to the therapist. Cooper (1974) feels that the therapist can find ways of reporting to the parents on the content and progress of therapeutic work with the child, thus reassuring them, satisfying their curiosity and enlisting their aid without violating the child's confidentiality. The need to "keep secrets" from the parents without offending the parents or engendering guilt in the child is probably another source of countertransference toward mothers of children in treatment. In parents' sessions, information may be revealed which the parents do not want communicated to the child. The therapist may experience conflict and anxiety about his/her role as a repository of sensitive information and his/her potential collusion in a variety of ways with difficult behavior of either parent or child.

C. Structuring the Parent-Therapist Relationship and the Implications of Structure for Countertransference

At present, although most child mental health

professionals probably assume that there has been some parental contribution to the child's psychopathology, they differ widely in what they expect of the parents in terms of their active participation in the treatment program beyond transportation and financial arrangements (GAP, 1982). Carek (1972) characterizes the profession as divided between two extremes: (1) those who believe that parent involvement beyond paying the fee and transporting is unnecessary since the focus is on the internalized conflicts of the child, and (2) those who believe that change in the child is impossible without change in the environment, and that parents must thus be treated to eliminate the pathological influences which have engendered the child's problems and which will prevent the success of the therapy unless they are modified. Chethik (1976) sees the dichotomy as between educational and supportive work with the parents on the one hand and in-depth modification of parental pathology on the other. Both Chethik and Carek, having set up these extremes, counsel a variety of middle-range approaches, depending on the circumstances.

The variation of approaches reflects different emphases on the possibility and importance of intrapsychic change as a goal of therapy versus more "superficial" interpersonal and behavioral changes. A few therapists

still prefer not to know the parents, nor to have them report on the child. This attitude no doubt reflects fundamental feelings about parents or comfort in dealing with them, as well as convictions about the nature of therapy. The majority try to take in the child, his parents, and surroundings as part of the treatment procedure, either throughtheir own sessions with the parents or through the use of an intermediary co-therapist who regularly meets with the parents. Finally, family therapists see all members of the family in their effort to help the entire family system function more adaptively.

There is a very broad range of choices in structuring the relationship with parents of children in therapy, each of which may have implications for likely counter-transference reactions. Options include:

1. removal of the child from the parents (e.g., in the case of abuse)
2. group work with parents (same therapist as the child's or different therapist)
   a. full-fledged psychotherapy group
   b. group counseling focused on parent-child issues only
   c. educational and supportive guidance groups
   d. groups for parents and children together
3. Individual work with parents
   a. psychotherapy of parents aimed at extensive

modifications of psychic structure

b. therapeutic focus on parent-child relationship only

c. education and support

4. tripartite therapy with mother and child seen together

5. family therapy

6. filial therapy (parent trained as therapist for child)

7. parent guidance only - no involvement of child with therapist

8. no involvement of parent in child's therapy

Since the empirical portion of this dissertation will deal exclusively with situations in which the child is being treated separately by a therapist while some type of therapeutic relationship is being carried on with the mother by the child's therapist simultaneously, not all of these alternatives are relevant. However, I will cover them briefly here, to give an idea of the breadth of choices available to a child therapist when he or she originates relationships with a child and his or her parents, and to speculate about countertransference considerations arising within each structure. Also, some of the alternatives, such as group or family work, are often carried on simultaneously with individual work with the child and occasional visits with the parents.

A child therapist's core attitudes toward parental causation of pathology, and his or her personal comfort dealing with people in a parental role may well play a significant part in determining how he or she chooses to structure the relationship with the parents of the child at the outset of treatment. Similarly the structure of such a relationship may have a strong impact on the type and intensity of countertransference which develops. In other words, countertransference and structure are probably interdependent.

1. Removal of the child from the parents

This radical step, necessitated when parental care is neglectful or abusive, does not really fall into the category of work with the parents, although a child therapist may continue to work with parents during a period of foster placement. Child therapists may have special difficulty maintaining a therapeutic stance if their feelings have been aroused by circumstances of abuse. In child therapy in which an issue regarding abuse arises, the therapist has the duty and the power to bring in child welfare agencies which may ultimately remove the child from the home. The potential power of the therapist in this regard undoubtedly strongly affects the relationship with parents in this type of case. In these situations, the therapist may suffer conlficts about his or her wish to preserve the family versus

the wish to protect the child. Since fine distinctions sometimes exist about what is or is not reportable abuse, the potential exists for acting out by the therapist of personal conflicts and wishes regarding his or her own parents as well, either by not reporting an instance of abuse or by reporting something which is not really abuse.

2. Group work with the parents

Ginott (1961) is the source of the three-level categorization of types of group work with parents: psychotherapy, counseling, and guidance. Group psychotherapy seeks to bring about lasting structural change in the parents through the use of psychoanalytic techniques. Group counseling is equivalent to social casework with individual parents; "it is to help clients rid themselves of annoying symptoms, increase mastery of reality, and achieve a more comfortable social adaptation" (Ginott, p. 171). Interpretation of transference is not done, and basic personality changes are not aspired to. The counselor keeps the focus on parent-child relationships and away from unconscious conflicts. Group guidance offers parents information about children's physical and emotional needs and normal developmental progression. If the child's therapist conducts a group for several parents of children he or she sees, arguably intensity of countertransference reactions of the therapist to

parents would vary directly with the depth of the level of the group work. In fact, this may not be the case, however, since deeper level work might engender greater understanding by the therapist of the parents' own conflicts and aspirations, and therefore lead to less negative counter-transference arising out of the view of the parents presented through the child's eyes. Perhaps, seeing the parents in a group of whatever size, defuses some of the intensity of the meeting with the parents of one child at a time, however.

Slavson (1952) feels that fundamental personality change in the parents is not necessary for the child to make gains. However, once therapeutic guidance with parents begins, it often leads to more profound and lasting changes in the parent. The parents learn from the therapist what a good parent-child relationship is like because the therapist is in the role of a parent toward them. The parents are allowed to voice their anger and frustration in an accepting climate, and this "ventilation" clears the air at home for the child. Many parents also are quite ignorant about children's physical and emotional needs and motivations, and need basic guidance. The therapist should try to stimulate self-discovery in the parent rather than laying down the law.

3. Individual work with parents

A key issue in individual work with parents, in addition to the psychological level at which such work

should be done, is whether the work can or should be done by the same therapist who sees the child. There are those who adhere to some of the earlier models of child therapy. Moustakas (1959), for example, says that the best model is to have another therapist see the parents every time the child is seen. Adams (1982) also feels that the best arrangement is to have a social worker see the parents separately, allowing the therapist-child relationship to be more "dyadic and private" than when the child's therapist also sees the parents. In part, this treatment approach may reflect an awareness of the potential intensity of countertransference toward parents and a wish to avoid or defend against it by insulating the therapist from the parents. It may also reflect the therapist's lower degree of comfort in confronting parent-child issues directly. Cooper (1974) discusses the pros and cons of each of these positions. When more than one therapist is involved, there are often competetive or territorial difficulties in relationships between or among the therapists. The GAP (1982) also cites this problem, presenting several graphic examples of dysfunctional rivalry, status jockeying and confusion on hospital staff collaborative teams. Adolescents are regarded as the group most likely to develop distrust and suspicion if their therapist also

sees the parents.

As with group therapy, at least three levels of psychotherapeutic work with parents exist: education and guidance, counseling as to the parent-child relati n-ship, and separate psychotherapy for the parent. As with group work, the level of the work may affect the type and intensity of therapist countertransference which evolves. The therapist's countertransference reactions to parents in general or to a particular set of parents may determine the level at which the therapist decides to work with the parents. A therapist with unresolved conflicts regarding his/her own parents may be uncomfortable with parents in general and may consistently refer to another therapist or work at a more superficial level, with the therapist as the distanced, didactic expert. The psychodynamic level of the work done with parents obviously also depends on a multitude of other factors: the extent of the parents' perceived role in causing and perpetuating the child's disturbance, the beliefs of the therapist about such causality, the skills of the therapist, the availability of others to work with the parents, the type and severity of the child's pathology, and the willingness of parents to participate in any of the levels of individual therapeutic intervention.

Chethik (1976) recommends the development of a range

of approaches between the two extremes of complete personality restructuring for the parents and simple educational and supportive measures. His preferred middle-range approach, called "treatment of the parent-child relationship" is psychoanalytically oriented and uses interpretation of unconscious phenomena, but these techniques are always focused on aspects of the parents which are relevant to his or her relationship to the child.

Carek (1972) argues for keeping work with parents centered on the child and not immediately assuming that the parents necessarily need extensive therapy. Not all children are "emissary" patients for family pathology. Carek believes that most parents respond to simple advice-giving and education about children's therapy and developmental needs. Even if parental handling caused the pathology in the past, the parents may be functioning well now, and even if they're not, the entrenched pathology in the child may only be responsive to individual therapy. If the parents go into therapy for themselves, their therapist's primary focus will not be on the relationship with the child so that key aspects of the parent-child relationship may go untouched. Carek thus seems to be recommending the counseling level of involvement with parents.

Chess (1969) feels that fixed pathology in the parents may necessitate separate extensive psychotherapy. However, with less pronounced pathology, the therapist's guidance of the parent will be sufficient to enable the parent to eliminate harmful patterns of interaction with the child and to support the child's growth. The focus should be on specific aspects of the parent-child relationship not on the parents' underlying psychodynamics.

Allen (1953), however, feels that simple guidance or teaching behavioral methods to parents is not effective. Specific advice and suggestions generally don't work, he says. This approach, he argues, simply helps the parents avoid facing their own problems which are causing pathology in the child. The therapist should direct his or her attention to the family situation as a whole, including the marital relationship. The behavior of the child cannot be changed without "altering the factors that have contributed to its development".

Moustakas (1959) argues against trying to give parents simple advice and specific answers to questions. The therapist's goal should be to get parents to face their own feelings and grow through therapy. If parents are not interested, the therapist should accept this and simply ask to see them once in a while to get information about events and to report on the progress of their child's therapy.

Few empirical outcome studies have been conducted on the differential impact of ways of structuring relationships with parents when the child is the identified patient. Levitt (1971) cites three studies on the question of whether therapeutic outcome for children is more positive when parents are involved. The three studies found that the least effective treatments involved the child alone or the mother alone, while the most effective were with the mother and child, or even more effective, with both parents (with or without the child). Levitt expresses some skepticism about these studies, and his discussion does not describe further the nature of the work with the families involved. Other studies cited by Levitt tend to show that therapeutic intervention with children can be successful when there is no parent involvement.

Each of these points of view about what works best with parents evolves from implicit countertransference forces and tends to promote particular countertransference configurations. A therapist who sees the parents as responsible for pathology in the child and as needing major change theselves may be vulnerable to inappropriate feelings of omnipotence and control vis-a-vis the family. A therapist who consistently takes this view toward every family, even when other obvious causal factors exist for the child's difficulties, may be acting out

his/her own struggles with parents. Regarding the parents as peripheral figures or seeing them only for "guidance" occasionally might also reflect countertransference in terms of avoidance of difficult issues, discomfort with parental figures, acting out of fantasies of having the child all to oneself, etc.

4. Tripartite therapy with mother and child together

Fraiberg (1980) has written extensively on work with parents of infants at risk for emotional deprivation. "Infant-parent psychotherapy" is appropriate when there are severe emotional problems in the parent endangering the physical and emotional health of the baby. Although the work is obviously primarily through talking with the parent (in most cases, the mother), Fraiberg has found that the presence of the baby in the room is crucial to focus the treatment and set the emotional climate. The therapeutic approach is a combination of modeling, teaching parenting skills, and exploring the unconscious meaning the infant has for the mother in light of her own past. Considerable successes are claimed without overall restructuring of the mother's personality, and Fraiberg emphasizes the need of the therapist not to intrude on the mother-child relationship by, e.g., literally picking up the baby, taking over for the parent's inadequate mothering.

Furer (1971) and others have developed a system of

tripartite therapy with symbiotic psychotic children and their mothers. The therapist works with mother and child together to create a "corrective symbiotic experience". The mother becomes ultimately an "auxiliary therapist" in helping the child make up for missed developmental stages.

Proponents for this type of intervention would no doubt argue that it represents a means of preventing countertransference of a possessive, jealous or competetive kind from interfering in the healthy growth of the mother-child relationship.

5. Family Therapy

The empirical study reported on in this dissertation will deal with parent-therapist relationships in situations where family therapy has not been selected as the exclusive or primary treatment of choice. Family therapists might contend that a choice against family therapy might represent negative countertransference against parents, or in favor of an exclusive therapist-child bond. Family therapy seems most appropriate when communication or interactional patterns within the family are the primary difficulty (Carek, 1972; Rutter, 1975). Family therapy is not appropriate when the child's pathology comes from within him or from factors not intrinsic to family functioning. Particularly with younger children, family therapy with all family members present can become

a discussion among adults which is not directly beneficial to the child (GAP, 1982). While the child is sometimes the "emissary patient" (Gartland, 1935), or the sacrificial lamb for the rest of the family, this is by no means always true. Sometimes, work with the child improves his behavior so that family interaction as a whole improves as a result. The choice of individual therapy with a child as opposed to family therapy may reflect the therapist's countertransference toward these particular parents or toward parents in general. Interestingly, a choice of individual work with the child rather than family work might reflect either a conviction that the parents are not responsible for the child's difficulties and therefore need not be so involved, or alternatively, a conviction that the parents are so destructive that separate reparative work needs to be done individually with the child while the parents' problems are addressed in another setting.

6. Filial therapy

Filial therapy, or using the parent as a therapist has been utilized by client-centered, psychodynamically oriented therapists. (See, e.g., Ullman & Krasner, 1965). Andronico et al (1967) have developed a system of teaching parents to conduct a special play period with their child in which the child is completely free to determine the activity (within reasonable limits) in

a set-aside room and with special toys. The parent attempts to empathize with the child and express his or her understanding of the child's feelings. The parent-therapists meet for group supervision. On the one hand, parents learn a special mode of relating to their child which often generalizes to other aspects of their relationship. In the group supervisions, discussion of parents' difficulties in sticking to the prescribed regimen often leads to consideration of the parents' inner life and conflicts. The proponents of this method feel that it has led to successful results with many disturbed children and their parents, obviously at considerable saving in cost and therapist time. Proponents feel that the method represents a more respectful approach to parents, in which therapist over-identification with the child or other harmful reactions tend not to develop.

Zacker (1979) has done a less structured version of parent training based on psychodynamic principles. He believes that this approach has seven advantages: (1) the parent and the therapist develop a working relationship as collaborators without the suspicion or competetiveness which often otherwise develop in parent-therapist relationships; (2) parents by definition have greater influence on children at any time in children's lives than do therapists; (3) therapy takes place in the home, leading to greater generalization; (4) parents

control reinforcers for children's behavior changes; (5) parents are the child's natural model; (6) parents are not treated as patients; (7) it costs less and takes less time. Parents may need to be relatively psychologically intact and highly motivated, and the child's problems not overly severe. The respect the therapist shows to the parent as a co-therapist and the sense of competence engendered in the parent through performing a therapeutic role, have obvious implications for the development of countertransference. Filial therapy might be chosen by a therapist with fewer conflicts around control, omnipotence and power.

7. Parent Guidance Only

In the treatment of pre-school children, counseling of the parents alone can often be effective (GAP, 1982). Chess (1969) mentions a study in which considerable success was achieved with parent guidance alone in cases of children with behavioral problems. Donofrio (1976) argues that child psychotherapy has in general not been demonstrated to be effective. Donofrio found that the majority of children referred as having psychogenic problems actually had "constitutional" problems such as hyperactivity. A combination of medication, distribution of educational pamphlets to parents and an average of 2.1 parent counseling sessions led to sustained improvement in 57 out of 66 cases. Donofrio refers to the idea

that parents make better therapists, although the program he used was not specifically designed to train parents as therapists. Arguably, a recommendation for parent counseling only implies a more respectful posture vis-a-vis the parents; it may of course also represent countertransferential difficulty working directly with children.

8. No Involvement of the Parents

Although I found little material on this point, I feel sure that extensive therapeutic work with children often takes place in the absence or near absence of meaningful parental participation. In residential settings, for example, parent involvement is often relatively minimal. On an outpatient basis, perhaps these cases are seldom reported on because the therapists feel they represent a failure on their part to induce parental cooperation. Buxbaum (1954) cites three cases of children whose therapy was successful essentially without parental involvement (although not without parental permission, obviously). Arguably, to refuse to work with a child without parental participation reflects a hostile countertransference response to a sense of abandonment. Working with a child when the parents refuseto participate as the therapist wishes may induce feelings of helplessness, frustration and/or abandonment.

Clearly, it would be fatuous to assume that choices in structuring parent-therapist relationships are made solely or even largely due to countertransference factors. In choosing among approaches, many factors may be considered by the therapist, including age of the child, goals of work with parents and/or child, type of pathology of child and parent, aetiology of child's pathology, willingness and ability of parents to participate in any type of arrangement, orientation and skills of the therapist, the availability of other mental health professionals, the amount of time and money available, and the therapist's convictions about the nature of the therapeutic process. Buxbaum (1954), for example, attempts to make specific differential recommendations for handling the relationship with parents depending on the age and pathology of the child and parents. While rational assessment and evaluation hopefully guide most treatment planning attempts, if one accepts the premise that countertransference reactions are ubiquitous and powerful factors in therapist relationships with children and their parents, countertransference issues around distance, control, omnipotence, superiority, envy and many others may well play a significant role in leading therapists to choose one method of structuring the relationship with a child's parents over others.

D. Countertransference

Any attempt to study countertransference empirically is complicated by the lack of a universally accepted definition of countertransference. While the large literature on countertransference in working with adults in their own treatment will not be comprehensively reviewed, it is necessary to present a variety of conceptual and definitional issues in the development of the idea of countertransference in order to explain the particular definitional stance taken for the purposes of this study.

Langs (1976), who has written extensively on the history of the concept of countertransference, states that Freud saw countertransference as the undesirable unconscious stirrings in the analyst evoked by the patient's material and as something to be struggled against and rooted out through further analysis of the analyst. Other early writers saw countertransference as a reevocation by the patient of the analyst's past feelings and conflicts regarding important persons in his or her early life. Countertransference was seen as a primary source of error in analytic intervention. Some later writers (e.g., Herman, Kernberg), however, saw countertransference as encompassing all the feelings, conscious and unconscious, appropriate and inappropriate, of an analyst toward a

patient. Winnicot (described in Langs, 1976), for example, felt that in addition to unconscious neurotic countertransference, an analyst could expect to have realistically based feelings of love and hate toward particular patients, as well as the characteristic responses, attitudes and feelings for the analysand's personality in general. Moreover, a substantial body of opinion developed that the inevitability of counter-transference of analysts could be useful diagnostically and therapeutically with patients. Some counselled sharing countertransference reactions with patients. Those who saw analysis more as an interaction between two persons whose feelings and conflicts are equally present in the analytic situation (e.g., Wolstein, 1985, 1975), theorized that the analyst's countertransference is consciously or unconsciously registered by the patient and responded to in a variety of ways, some destructive and some constructive. There can develop a cycle of projective identification between analyst and patient. The debate among holders of these different views has continued actively.

Epstein and Feiner (1979) see the debate as among three major schools: (1) those seeing countertransference as the total of all the therapist's feelings and attitudes; (2) those holding the classical view that countertransference is the unconscious evocation of

transferential reactions in the analyst, and (3) those viewing countertransference as the inevitable, valuable "complement" to the transference of the patient in the interaction between the two people. More severely disturbed patients tend to evoke more intensive and potentially difficult countertransference reactions. In the authors' view, countertransference can be an extremely useful therapeutic too, but is still seen as potentially damaging and a reason for the therapist to exercise vigilant self-analysis over his or her reactions.

Beitman (1983) has written on signs of countertransference which may alert a therapist to the existence of unrecognized countertransference forces at work. These include "any exaggerated inappropriate feelings, behaviors, thoughts and fantasies about patients. . ." (p. 83). Feelings suggestive of countertransference difficulty include "anxiety, guilt, anger, sexual stirrings. fear disapproval, despair, shame, boredom, indifference, helplessness, envy, awe and excessive pride in the patient's accomplishments or praise." Behavioral manifestations may include lateness, overuse of silence, changes in the fee, nonverbal communications. Empathy and therapeutic caring are not countertransference, however, according to Beitman. Some types of countertransference spring more from the therapist's own inner life and history, while others are more properly seen as evoked by the patient's

pathology and responses.

Arlow (1985) believes that countertransference does not necessarily encompass any sexual or aggressive feeling evoked in the analyst. They are to be labelled counter-transference only when their intensity is inappropriate. In the effort to identify with the patient, the analyst attempts to empathize but may cross the line into over-identification with the patient's emotional state, and thus become unable to perceive and interpret objectively. Jafee (1986) argues that overidentification with the patient can lead to regression in the analyst to infantile issues. A balance must be maintained between empathy and "trial identification" on the one hand, and the maintenance of mature objectivity and cognitive clarity on the other.

Marshall (1979) divided countertransference along two dimensions (and thus into four categories): (1) whether it is "induced primarily by external (patient) behavior" or "comprised primarily of internal promptings of the therapist"; and (2) the degree of consciousness of the therapist of his countertransference. Thus, countertransference can be conscious and externally induced, conscious and internally generated, unconscious and externally induced, or unconscious and internally generated.

It is beyond the scope of this dissertation to formulate a coherent definition and theory of counter-transference as a whole. Since an empirical study was

designed in which therapist self-report was the primary methodology, employment of a definition of countertransference which limited this concept to unconscious phenomena seemed impracticable. Moreover it is this author's opinion that what is conscious and what is unconscious in relationships with patients and their parents probably fluctuates over time depending on the ongoing process and the particular associations it conjures up in the therapist. It might never be possible empirically to disentangle which of the therapist's feelings about a parent are externally induced and which are internally generated, as these sources of countertransference probably cross-stimulate each other in a complex, living web of connections. Even the distinction between "negative" and "positive" countertransference probably blurs when pressed to the limit, as therapists, like everyone else, are capable of strongly ambivalent, complex reactions to others. For all these reasons, the broadest definition of countertransference has been adopted for purposes of this paper: i.e., conscious and unconscious feelings of the therapist toward the mother of a child in treatment, whether externally or internally generated. It is assumed that feelings of the therapist toward the mother of the child in treatment which closely correspond to feelings of the therapist toward his/her own mother can be perceived as more internally generated, whereas

feelings of the therapist about the child's mother's actions in regard to support or non-support of the therapy are more properly conceptualized as externally induced. It is also assumed that countertransference is not always necessarily an evil in therapy; one of the goals of this study is to uncover to what extent countertransference has an impact on outcome.

Although there is much less literature on counter-transference phenomena involving work with children than regarding work with adults, there have been a number of interesting articles in recent years. No articles found exclusively concern countertransference toward parents, although this is often mentioned as a side-light in articles on countertransference toward children.

Bernstein (1958) described desirable characteristics of parents of children in analysis. Given children's lesser ability to free associate, to develop therapeutic transference, or to give up the gratification of their symptoms, Bernstein concluded that parents needed to have some minimal combination of the following attributes in order to support a successful child analysis: (1) sensitivity to the sufferings of the child; (2) the ability to accpet the narcissistic wound of letting an outside person help the child; (3) a desire for the child to give up the dysfunctional patterns which bring him or her to treatment; (4) some capacity for objectivity and

restraint in dealing with the child; (5) a value system which places mental health high enough to outweigh the inconveniences of therapy. While this article does not specifically relate to countertransference, it gives some sense of the rather high expectations therapists may have of parents, and therefore of potential sources of anger, frustration and blame if these expectations are not met. According to Kabcenell (1974), Bernstein viewed child patients as potentially frightening to therapists because they are highly emotional, closer to primary process thinking, and unpredictable. In a fundamental way, every child represents a threat to culture and civilization, a raw passionate force which must be subdued and socialized. Such feelings can lead to rigidity, or through reaction formation, to overtolerance toward child patients. The child's primitiveness and investment in play tends to promote regressive pulls in the therapist, against which he or she may erect defenses which prevent an optimal therapeutic position. The therapist's perception of the child's sense of rage and hurt toward parents may lead the therapist to criticize the parents or to harbor the wish to take over the child. An abused child may evoke this syndrome especially strongly. In addition to this direct impact of countertransference toward children on the therapist's feelings toward parents, it would seem the evocation of

regressive emotions in the therapist might lead the therapist either to become more childlike and/or rebellious vis-a-vis the parents, or defensively, to identify over-repressively with parental authority.

Korner (1961) writes of the strong tendency of many parents to take total responsibility for the causation of their child's problems. Many child therapists support this view, ignoring the existence of other causative forces such as biological and genetic factors, unavoidable environmental insults, and of course, the impact of the child's unique personality on the parents. Commonly, parents are made to feel guilty by child therapists. Clearly, a child therapist's understanding of causality of a child's problem will have a profound impact on feelings and attitudes toward parents.

Jarvis (1964) discussed the phenomenon of adult hostility evoked by school phobic children in particular, theorizing that the child's unconscious oral aggression and rage evoke hostile counterreactions in parents, school personnel and sometimes mental health professionals as well. In this instance, one might anticipate a stronger likelihood of an alliance of authoritarianism to develop among adults including therapists in whom such counter-reactions are evoked.

Kohrman et al. (1971) cite the as yet unexplored complexities of countertransference in work with children

and parents, especially with regard to the analyst's becoming a real object for children, and to the involvement of parents in therapy. Trauma experienced by the child can reawaken infantile conflict in the therapist and lead to dysfunctional hostility toward the parents. The analyst can wish to take over as parent. Particularly with abusive parents, powerful countertransference forces can be brought into play which distort the analytic process. Historically, the first child analysts were educators and viewed themselves as appropriately taking on some parental functions, protecting and educating children, and teaching them social values. Gifts were often given to children, and the analyst was seen as becoming a real object for children. This tended to obscure the operation and impact of countertransference. Traditionally, child analysts have been regarded as more typically childlike and yet also more maternal than adult analysts. If true, this would perhaps lend itself both to a tendency to take over the parental role, and to a tendency to regress to the child's level. Analysts can sometimes develop rescue fantasies about children in treatment, or alternatively, overidentify with the parents. Of the relationship with parents, Kohrman et al. (1971) state:

> Except possibly for those living in an institution, children cannot be treated without considering their parents. This provides one more

> series of encounters with which the child analyst must cope. The younger the child, the greater the number of children's activities which must be supported or managed by the parents as alter ego. As with any relationships which cannot be dealt with through interpretation, there is the constant pressure and opportunity for mutual manipulation . . . Especially if counteridentification has taken place with the child, the likelihood of counter-reaction to the parents is very great." (p. 494)

Examples of the "great range" of countertransference problems which may arise are (1) overidealization of the analyst by the parents, which stimulates the therapist either to accept the idealized image or to work at convincing the parents that he or she is less than ideal, or (2) acting out by the child of his oedipal fantasies with the analyst as one parental figure and a real parent as the other, leading to the development of inappropriate feelings in the analyst toward that parent.

Suchar (1978), while not referring to countertransference per se, believes that mental health professionals engage in a process of "codeviant labeling" in assessing children with mental illness, establishing the existence of parental pathology because of the existence of pathology in the child and then, in a process of

circular reasoning, assuming that the parental pathology is the cause of the child's mental illness.

Marshall (1979) compiled an extensive literature review and analysis of countertransference in the psychoanalytic process with children. Literature on countertransference toward the children themselves is sparse, Marshall says (although it should be noted that at least eight articles on this subject have been published since Marshall complained about this); and he speculates that there are several reasons for this phenomenon: (1) early child analysts such as Anna Freud believed that active transference neurosis could not develop in analytic treatment of children (although she later modified this view); (2) countertransference had been historically viewed only as an obstacle to treatment which had to be rooted out, and it is only more recently that countertransference has been characterized as an inevitable phenomenon which can have constructive uses in analytic therapy; (3) there's too much of it" -- countertransference in work with children can be massive or primitive and less controlled than in work with adults, and sexual and aggressive feelings toward children are more strongly defended against than in the case of adults; (4) therapists may defend against recognition of their own countertransference with children on the grounds that since the children are smaller, countertransference problems will be smaller; and (5) the often used client-centered play therapy

approach with children suggests that total acceptance of the child's feelings and expressions is necessary, thus perhaps making the therapist feel that his/her negative reactions toward children are professionally unacceptable.

Marshall suggests that countertransference in therapeutic relationships with children may be especially powerful and especially difficult to recognize and control. Reactions of the therapist toward parents are equally powerful and even less explored. Because the topic is so complex, Marshall does not discuss it at length in his paper, but does describe countertransference in the relationship of a therapist to a symbiotic mother-child pair. The therapist may have an initial urge to separate the dyad and limit the mother's control of the therapeutic relationships because of the therapist's own healthy impulses toward autonomy, dating back to his or her own separation-individuation phase. This can frighten the mother right out of therapy and needs to be avoided. The therapist should attempt to win the mother's trust and become a symbiotic object for her so that the child's bond to the mother can gradually be loosened, and both mother and child can achieve a higher level of object relationships. The therapist can also become caught up in the mother's exclusion of the father from a significant role in the child's life,

and this obviously should also be avoided.

Marshall feels that there are important signals which child therapists can recognize as symptoms of unconscious countertransference reactions arising from within the therapist. In the relationship with children, these include physical contact, excessive gratification of the child, too much play and no talk, etc. In the case of the relationship with parents, unrecognized therapist countertransference reactions can be signalled by:

8. Allowing parents to use the child's time;
9. Consultation with parents or others without the child's involvement or agreement;
10. Strong, unresolved feelings regarding the parents;
11. Inability to involve parents appropriately
12. Preoccupation with changing behavior, especially as desired by parents or school (p. 604).

Marcus (1980) has also enumerated some of the special countertransference phenomena which may arise with children. While child or adolescent patients may indeed view the therapist as a real object in their lives, the therapist should maintain neutrality. Common foci of countertransference include "transference factors, projective identification, a revival of omnipotent feelings and sibling or oedipal rivalry with the patient's parents."

Especially with pre-oedipal children, the analyst must form a therapeutic alliance with the mother and child pair together. However, Marcus goes on to cite a case example of his dislike for the mother of a 3 1/2 year old boy, who revived in him an old childhood fear of a bear lurking in the darkness. He eventually referred the mother to another analyst. Another countertransference-inducing situation occurs when the child resists treatment, and the parents must actively promote the therapy to keep it going.

The GAP (1982) also lists numerous common sources of undesirable countertransference reactions in the therapist: cultural and socioeconomic differences between the therapist and parents, overidentification with the child, counterphobic over-tolerance or over-protectiveness toward the child, aggressive expressions, an assumption that all parents of children in treatment are bad, rescue fantasies regarding the child, a childish need to win approval of the parents, excessive attempts to induce good behavior in the child to win parental approval, inability to tolerate ambiguity reflected in attempting to overdefine the relationship, over-dedication to work reflecting a fear of abandonment.

Perkins and Hornsby (1974) have written on common countertransference patterns in inpatient child treatment. Adopting the Sullivanian, interpersonal view of

countertransference as an inevitable and potentially useful part of the therapeutic intervention, and Marshall's four-cell classification of countertransference types, Perkins and Hornsby describe some typical patterns of institutional countertransference: "benign exploitation" by mental health workers who become overly nurturant or intrusive, which may lead to rivalry with parents; projection onto children and their parents of unresolved childhood wishes and conflicts; evocation of guilt, anger and sexual arousal by abused children; and instigation of intense staff conflict through manipulative behavior.

Palombo (1985) considers the possibility of using countertransference toward children in a constructive manner, much as many recent authors in adult therapy have suggested. A child therapist may develop "concordant" positions and responses toward child patients, i.e., those that result when the therapist attempts to understand the patient's position by empathizing with his or her feelings and experience. In contrast, "complementary" countertransference is evoked when the therapist develops feelings which the patient's parents have toward that patient, or which the patient wishes his or her parents would feel. A third type of countertransference results when the therapist's feelings have more to do with his or her own past conflicts and experiences. Palombo

conceptualizes therapy in a Kohutian sense as the creation of a holding environment for the patient. With narcissistic disorders, mirror transference or idealizing transferences may evoke strong countertransference in therapists; mirroring transferences may make the therapist feel unseen as a real person, or exploited, bored or withdrawn, or conversely, inspired to make up to the child for deprivation in the past. Idealizing transferences can stimulate the therapist's omnipotence or, conversely, stimulate the therapist to compensate overly by de-idealizing him or herself. A child who devalues the therapist may evoke humiliation and rage. Palombo does not discuss the implications of each of these patterns for the therapist's feelings toward parents, but one could imagine that a devalued therapist may over-compensate by self-inflation vis-a-vis the parents, or giving up on the child, or by increasing blame and criticism of the parents. An idealized therapist may engage in rivalry with parents, or speak to them from a pinnacle of superiority.

Frankiel (1985) has eloquently elaborated on the oft-stated idea that child therapists often develop fantasies of "stealing" a child patient away, with attendant feelings of guilt or rivalry vis-a-vis the child's real parents. She traces the extensive occurrence of such themes in Western literature, finding psycho-analytic support in the existence of early childhood

wishes to have or steal a baby on the one hand, and on "family romance" fantasies of belonging to a new and better set of parents on the other. The child treatment situation, Frankiel says, is geared to stimulate in the analyst, the child and the parents, fantasies about babies, stealing children and obtaining new parents. The parents, by seeking treatment are often admitting defeat. The therapist is the expert who knows better and will save them or at least save the child. Competition inevitably develops between therapist and parents with unconscious or conscious fears by parents of loss of loyalty or love of the child. The therapist develops the wish to rescue or steal the child, which leads to conflict with, especially, the mother, and/or guilt-induced defenses and inhibition which adversely affect the conduct of the treatment. Vivid case material illustrates the evolution and impact of these dynamic forces, which often become apparent and thus resolvable in a well-conducted supervision.

Gartner (1985), writing on countertransference toward adolescents, comments on the impact of countertransference toward adolescent patients on relationships with the patients' parents in a way which is clearly relevant to child patients as well. Commonly, a therapist will be idealized by an adolescent and may then overidentify with the role of an ideal parent. Inevitably, this leads

to tension in the relationship with the parents, whether because of guilt over fantasies of replacing the parents, exclusion of parents from the treatment, or patronizing lectures on parenting which are dysfunctional and sometimes fatal for the adolescents' therapy.

Schowalter (1986), retracing the historical reasons for the lack of literature on countertransference regarding children, adds little to the articles already described.

Most recently, Bornstein and Glen (1988), have distinguished among many types of therapist responses to child patients and their parents, e.g., countertransference in the narrow, classical sense, therapist transference, identification, "real" reactions, narcissistic uses of patients, etc. In keeping with other commentators on the subject, Bornstein and Glen acknowledge the greater difficulty of the child analyst in keeping a proper analytic stance due to the child's propensity to action in session even to the point of physically attacking the therapist or behaving in a sexually stimulating way. Analysts may develop parental wishes in regard to child patients, may unconsciously view the child as their own damaged, childlike self which they will seek to repair through the child's analysis. Oedipal wishes of children acted out in the analysis may frighten analysts to the point of preventing them from accurately perceiving the nature of the material. Vis-a-vis the analyst's relationship

with the parents, a subject to which little space is devoted in this article, Bornstein and Glen also see potential problem areas in over-identification with the sufferings of the child, or alternatively, over-identification with parental concerns to the point of seeking to control the child to please the parents.

E. Summary

The structure of parent-therapist relationships varies greatly in its external characteristics and in its therapeutic scope, method and depth. Within whatever structure is chosen or possible, practical and dynamic factors and forces evoke responses in the therapist which influence the future course of treatment. Clinical experience and the relevant articles in the literature suggest that the therapist countertransference toward parents of children in treatment tends to be a powerful, often largely unexplored factor in treatment outcome. Some often-mentioned possible elements of such counter-transference include: automatic condemnation of the parents, overidentification with the child against the parents, overidentification with the parents against the child, excessive attempts to separate parent and child, competition with the parents for the child, a wish to take over as parent, acting out of oedipal triangles with the therapist playing the role of one parent,

overtolerance of the child's behavior, the stirring up of feelings about the therapist's own parents in respect of the parents of the child.

In evolving a theory of the origins and dynamics of countertransference toward mothers of children in treatment, it seems likely that at least three sets of factors are implicated; (1) the therapist's unique emotional sensitivities and conflicts arising out of his or her historic childhood relationships with his or her own mother will lead to special areas of sensitivity and difficulty in dealing with patients' mothers, because of general transference phenomena but especially intensely in this relationship because of the often-cited tendency of children's therapists to identify with the child patient; (2) the special legal and practical nature of the relationship between therapists and parents of children in treatment will tend to create certain characteristic types of countertransference in children's therapists, e.g., feelings of being controlled, criticized, frustrated or powerless; (3) the structure of a particular parent-therapist relationship will also have an impact on therapist countertransference toward mothers, and, when the therapist is free to establish that structure, that therapist characteristic countertransference patterns will influence the choice of structure.

Chapter 4

Introduction to Empirical Study and Hypotheses

The articles which have discussed feelings toward child patients' mothers tend to repeat the same ideas about rescue fantasies, over-identification, therapists' parental wishes, etc. There is, however, little empirical basis for asserting that therapists (analysts or non-analysts) commonly feel these feelings. As a first goal of the empirical study, therapists were simply asked to respond to questionnaires about their feelings about mothers of children they work with, in order to provide actual descriptive evidence for what therapists are willing to acknowledge they feel when working with the mother of a child in treatment. The study also attempted to distinguish between therapists' perceptions about the mother's practical support of the therapy (i.e., paying the bill, getting the child there on time) and more subjective emotional responses to the mother of the child patient. Data was also collected on therapists' feelings about their own mothers along the same dimensions. At the end of a year-long period, case outcome was rated, again by the therapists themselves.

The following hypotheses were developed:

Hypothesis I. A significant relationship will exist between therapists' feelings about their own mothers and their feelings about the mothers of children in treatment; the more negatively therapists feel about their own mothers, the more negatively they will feel about the mothers of the children they are treating.

Hypothesis II. A significant relationship will exist between therapists' feelings about their own mothers' practical support of them as children and their perceptions of child patients' mothers' practical support of the therapy; the more negatively therapists rate their own mothers' practical support of them, the more negatively they will tend to rate the children's mothers' support of the therapy. It is predicted that this relationship, though significant, will be weaker than the relationship described in Hypothesis I.

Hypothesis III. The more negatively therapists feel about the mothers of the children they are treating, and the more negatively they rate the children's mothers' practical contributions toward the therapy, the lower the outcome will be rated (after taking into account demographic variables which might also affect the results).

The methodology described below was designed to test these hypotheses. It was hoped that enough subjects

would be obtained to perform a multiple regression analysis, to make it possible to explore the interrelationships and comparative impacts of many factors (e.g., negative countertransference, outcome, socioeconomic variables, years of therapist experience, et.). It did not seem practicable at this point to study the interaction of structure and countertransference considered at length earlier in this paper., i.e., whether different structuring of the parent-therapist relationship (separate therapy for parent, group therapy, filial therapy, etc.) would lead to different types and intensities of therapist countertransference. For the study reported on here, in order to enable statistical treatment, cases were sought in which the structure of the therapeutic relationships would be quite similar - the same therapist would see the mother (and father if available) separately from the child.

Chapter 5

Method

A. General Considerations

As always, the testing of hypotheses relating to psychodynamic concepts poses a considerable methodological challenge. With respect to countertransference, researchers have attempted to use Q-sorts by patient and therapist to measure distortions in therapist evaluations of the patient which were interpreted as "countertransference" (Fiedler, 1951). Snyder and Snyder (1968) also used the idea of differences in therapist ratings of the patient and the patient's own self-evaluation as an index of countertransference distortions by the therapist. Most recently, McClure and Hodge (1987) attempted to study the interrelationship between countertransference, therapist "attitudes" toward patients (defined as therapist feelings of like or dislike for the patient), and treatment outcome. Using the Taylor-Johnson Temperament Analysis Scale, they concluded that novice therapists who evaluated their patients as being more like themselves liked the patient better and vice versa. They then interpreted discrepancy between therapist evaluations of patients and the patients' own evaluations of themselves as reflecting "countertransference". This seems a highly

questionable procedure since it appears to assume that patients evaluated themselves objectively, so that therapists are necessarily distorting if they see patients differently than patients see themselves. In any event, McClure and Hodges" data led them to the conclusion that strong positive or negative attitudes toward patients lead to greater countertransference, which in turn leads to a less favorable outcome.

As existing methodologies for empirically studying countertransference relationships did not seem adequate to the goals of this study, an innovative methodology was developed. The adoption of the "totalistic" definition of countertransference meant that it was methodologically possible to simply ask therapists for their feelings about mothers, since the conscious component of therapist feelings was relevant. To get at the unconscious component , the technique devised was to ask, at a different point in time, for therapist responses to questions about their own mothers, with the assumption being that there should not be a statistically demonstrable relationship between therapist feelings about their own mother and feelings about the mother of a child they were seeing unless unconscious connections exist between the two sets of feelings. This study expected to find a relationship between therapist feelings about their own mothers and feelings about the mother of the child they were seeing.

This study also expected, however, to find a strong relationship between the practical parameters of the therapeutic relationship between the therapist and the mother (e.g., whether the child attends regularly; whether the therapist gets paid) and the outcome of the case. This methodology has not been used before, and relies on the creation of novel instruments; as such it is subject to the weaknesses of all research which does not have well-documented and standardized methods and instruments to support it.

B. Subjects

As subjects, therapists working with children in psychodynamically oriented play therapy were sought, with the goal of fifty or more subjects. Subjects were sought from the following populations in the following sequence: students and alumnae of the City University Clinical Psychology Program, professional colleagues of City University child faculty members, child therapists in local suburban communities, and finally, psychologists listed in the child and family division of the American Psychological Association Directory. Materials were sent to prospective subjects with a cover letter recommending their participation. They were advised that their participation would take approximately 1 1/2 hours, with three sets of materials to be completed at roughly six-month intervals. Confidentiality of responses was guaranteed by the use of a code system, the master

of which was held by a research assistant who did not have access to the raw data itself.

C. Materials

The materials used consisted of two Information Statements and four rating scales, all constructed by me. A sample of each instrument is appended to this dissertation. These instruments were developed based on the preceding review of the literature regarding counter-transference in work with children and their parents, and on my own clinical experience. Questions asked were deemed to represent common dimensions of therapist feelings and concerns about mothers of children with whom they are working.

The first Information Statement asked for information about therapist age, sex, race, socioeconomic group, level of education, length of experience as a children's therapist, number of children seen in treatment, personal experience as a parent, number of siblings and number of years of personal therapy. The instructions provided a mechanism for each therapist to identify one child from his /her practice, and all subsequent instruments were answered with respect to the work with this child and his or her mother. The instructions asked the therapist to identify a child: (i) not older than 12 years 0 months; (ii) who had been seen individually for at least two months, (iii) one whose diagnosis did not consist

solely of learning delays or disabilities; (iv) one whose mother had been for significant portions of the child's life and continued to be, his or her primary custodian; and (v) one with whose mother there had been some direct individual contact with the therapist, which would continue during the course of the child's therapy. If more than one child patient met these criteria, the child whose treatment began most recently was to be selected. The purpose of these criteria was to provide a method of selection (without therapist choice) of a child seen in psychotherapy whose mother had sufficient contact with the therapist to justify the expectation that the therapist would develop feelings about her other than solely through contact with the child. No particular additional criteria (e.g., type of pathology of the child, clinical setting) were felt to be necessary, since mechanisms of countertransference are assumed to be operational in therapy with children of all types of pathologies and in different types of settings.

With respect to the selected child, Information Statement 1 asked for date of first meeting, the child's age, sex, race, socioeconomic group, level of education, diagnosis, number of sessions to date, number of sessions planned per week, previous treatment, three clearly stated primary treatment goals, and a rating of the level

of the child's emotional disturbance (ranging from almost none to extremely severe on a seven point scale). With respect to the parents of the child, the Information Statement asked for the number of times parents had been seen, the nature of the relationship between the parents, the three primary treatment goals of the therapist's work with the mother, the rationale for the nature and structure of the work to be done with the mother, the therapist's rating of the mother's level of emotional disturbance, and other therapeutic work being pursued with the mother (e.g., by another therapist, or family or group treatment).

Rating Scales 1 and 2 accompanied Information Statement 1. As discussed above, these instruments were designed in light of the totalistic definition of countertransference. It was assumed that countertransference toward mothers of children in treatment, i.e., the sum total of therapists' feelings about them, would have sources both in the reality of the relationship among therapist, child and mother, and in the therapist's own personality and experience as a child with his or her own mother. It was also assumed that some of these reactions would be conscious to the therapist, and some would not. The therapists' responses to these instruments primarily tapped conscious components of their reactions

to mothers of child patients and to their own mothers. The unconscious interrelationships between therapists' reactions to patients' mothers and their own mothers would be explored in the data analysis by looking at the statistical connections between therapists' feelings about patients' mothers and their own mothers.

Therapist reactions to mothers of children in treatment were divided into two major categories: first, therapists' ratings of the mother's practical support of the therapy, and second, therapists' feelings about the mother arising from the therapists' sense of the relationship between the mother and the child and the evolving therapy.

Rating Scale 1 was designed as the measure of the mother's practical and logistical support of her child's treatment. It contained ten statements about the mother's involvement with the treatment: provision of information for assessment, facilitation of the child's regular attendance of sessions, ongoing provision of information helpful to the therapist, attendance of the mother's own appointments, cooperation in allowing contact with other relevant people in the child's life (e.g., relatives, teachers, etc.), acceptance of changes in the child brought about by the therapy, payment of the fee, expression of approval of the therapist's work, response to the therapist's suggestions for change in behavior toward

the child, and finally, the mother's overall cooperation in fostering the therapy. Some statements were phrased in negative terms and some in positive terms. The subjects were to respond on a seven point scale ranging from "strongly agree" to "strongly disagree".

Rating Scale 2 solicited the therapist's emotional responses and attitudes toward the mother of the child patient. There were nineteen items: mother's perceived causative role in her child's pathology, her attempt to control the therapy, her relative dependency on the therapist, her induction of a sense of helplessness in the therapist, her seductive behavior toward the therapist, her rivalry with the therapist for the affection of the child, the mother's frustration of the therapist's attempts to help the child, the therapist's idea that he/she could be a better parent than the child's mother, the mother's fostering of the separation and individuation of the child, the therapist's feeling of like/dislike for the mother, the therapist's feelings of comfort and relaxation dealing with the mother, the therapist's wish to compensate to the child for past emotional deprivation, the therapist's sense or the mother's placing value on the therapist's work, the therapist's sense of the mother as physically abusive, the mother's adaptability and flexibility in dealing with the child, the mother's intrusiveness regarding the therapy, and the therapist's sense

of the mother as emotionally abusive toward the child. About one half the items were phrased in positive terms and one half in negative terms. The therapists were asked to respond on a seven point rating scale, ranging from strongly agree to strongly disagree. As with Rating Scale 1, as this measure was uniquely constructed to measure feelings that have not been empirically researched before, it was difficult to know how a meaningful measure of concurrent validity could be devised. As counter-transference is defined as feelings of the therapist toward the mother, and each item solicits a therapist feeling, the face validity of the scale is strong. It should be noted that the scales measure those aspects, and only those aspects, of therapist feelings toward the mother about which questions are asked. Other dimensions of countertransference may exist which are not included.

Approximately six months after the administration of Information Statement 1 and Rating Scales 1 and 2, Rating Scales 3 and 4 were administered. These scales dealt with aspects of the therapists' perceptions of and feelings about theirown mothers during childhood. Rating Scale 3 attempted to provide a measure of the therapist's mother's support of her child's growth and development along practical behavioral dimensions equivalent to those of Rating Scale 1 (the measure of the child

patient's mother's practical support of the treatment). In other words, the scale asked the therapist to rate his/her mother's provision of information, facilitation of contact with others, provision of material resources, etc. during childhood. For example, Rating Scale 1, Item 4 stated, "The mother of this child has kept her appointments with me whenever possible", while Rating Scale 3 Item 4 stated: "My mother reliably and consistently had time to be with me and talk to me as I was growing up." There was obviously not an exact correspondence between the scales since the contexts are so different, but Rating Scale 3 attempted to get at the same dimensions of behavior in the therapist's own mother as Rating Scale 1 got at in the child patient's mother. The theory behind this was that the therapist's perceptions and level of sensitivity to the child's mother's behavior regarding the therapy might be influenced by his/her experiences of his/her own mother's behavior along the same dimensions during childhood. For example, a therapist whose mother rarely had time to be with him, might rate a non-attending patient's mother more severely than a therapist who felt more secure with his own mother. If the therapists were objectively evaluating the child's mother's practical support of the treatment, there should be no significant overall relationship between scores on Rating Scale 1 and Rating Scale 3. It was expected

that, at most, a weak relationship would exist since the patient's mother's support of the child's treatment related to rather clear, observable criteria that could be more objectively evaluated than could the feelings stirred up in the therapist by the child's mother around the substance of the child's pathology (as on Rating Scale 2).

Rating Scale 4 similarly solicited therapist feelings and attitudes about their own mothers along the same dimensions assessed with respect to the child patient's mother on Rating Scale 2. The correspondence item for item between Rating Scales 2 and 4 was much more exact than with respect to Rating Scales 1 and 3. For example, Rating Scale 2 Item 1 stated: "This mother's attitudes, behavior and pathology have not played a strong causative role in this child's emotional difficulties." Rating Scale 4 Item 1 read: "My mother's attitudes, behavior and pathology have not played a strong causative role in my emotional difficulties." Theoretically the therapist's own experiences as a child would influence the pattern of response to mothers of children in treatment, both in terms of overall negative or positive countertransference, and in terms of item-by-item correspondence of response. A therapist who has dealt with and resolved his/her feelings about his/her own mother should not show a relationship between responses on Rating Scales 2 and 4.

A therapist who was unconsciously acting out childhood conflicts in the therapeutic relationship with the child's mother would show a stronger correspondence between Rating Scales 2 and 4. If the therapist attitudes and feelings toward the patient's mother were not influenced by personal maternal experience, then one would predict no correlation between the two scales.

With respect to the validity of Rating Scales 3 and 4, of course numerous other measures of feelings exist. However, Rating Scales 1 and 2 were specifically designed to tap the most salient aspects of the relationships between children's therapists and mothers of children in treatment. Rating Scales 3 and 4 were then designed to tap identical or equivalent dimensions of the relationship between therapists and their own mothers to allow effective comparison and statistical analysis. Thus, Rating Scales 3 and 4 do not purport to be measures of the overall relationship between therapists and their mothers, but only of the dimensions of that relationships which correspond to the most sensitive and salient aspects of therapists' relationships to child patients' mothers.

One year following the administration of Information Statement 1 and Rating Scales 1 and 2, Information Statement 2 and Rating Scales 5 and 6 were administered. This Information Statement asked about the current status of treatment of the child, number of sessions during the

year, number of sessions with the mother, and reasons for termination of the therapy if this had occurred during the past year. Taking the six treatment goals from the earlier Information Statement (three for the child and three for the mother), the form then asked for a therapist rating of degree of attainment of each goal, based on a five point scale ranging from not attained to totally attained. The form also called for a brief description of major changes in the child's life over the year, a rating of the child's current level of emotional disturbance, a rating of the mother's current level of emotional disturbance, a rating of the therapist's degree of satisfaction with the work with the child over the past year, and a similar rating of degree of satisfaction with the work with the child's mother. Therapist perception of case outcome was measured by a 10-point composite consisting of degree of attainment of the 6 treatment goals, change in the rating of degree of emotional disturbance of mother and child over the year, and the degree of satisfaction of the therapist with the work with mother and child over the year.

Rating Scales 5 and 6 were identical to Rating Scales 1 and 2, to allow for both a measure of therapist perceptions of and feelings toward the mother of the child patient at the end of the year (or at time of termination if earlier), and for a measure of change in therapist perceptions of and feelings toward that mother over

the course of that time period.

This methodology was designed to provide a significant exploration of the relationship between children's therapists and mothers of children in treatment, to allow for the testing of hypotheses about the impact of therapists' childhood experiences with maternal care on their therapeutic relationships, the relative contributions of practical and emotional factors to the development of negative countertransference toward patients' mothers, and the impact of negative countertransference, on the one hand, and of practical factors in the therapist-mother relationship, on the other, on outcome of treatment. The study was designed to permit the analysis of these questions in spite of the various obvious weaknesses of the data collection techniques. As the study was envisioned, therapists used as subjects could come from a variety of settings and backgrounds; they could work in different ways with children and mothers with widely different problems and reactions to therapy, and these differences could not be completely assessed or controlled for. The assumption was that countertransference is such a powerful and universal phenomenon within the therapist-parent relationships, that these differences would not prevent the drawing of conclusions about the interrelationship of the variables being studied. The most salient dynamic processes between children's

therapists and mothers of children in treatment probably occur regardless of clinical setting and regardless of specific pathology or treatment method. The study did not attempt to research the mothers' views of and feelings toward the therapists; although this would indeed be of interest, I felt such an attempt would be intrusive and potentially damaging to the therapeutic relationship. The unique transferential patterns of each mother are of course reflected in the pattern of therapist responses to the rating scales, and variance unexplained by measured factors can be attributed to the unique behavioral and transferential aspects of each therapist-patient-mother relationship. Since all the data provided came from the factual knowledge and subjective impressions of the therapist, conclusions reached can only be stated in terms of therapists' views of the mothers of patients, their own mothers, and treatment outcome. Since therapist feelings and impressions are the primary subject of study, however, this methodology seems not only justifiable but appropriate. An additional limitation of the study is the lack of external validation of the rating scales. As already stated, this was felt to be justified both because of the difficulty of finding a way to validate them, and because the rating scales purport to measure only exactly what the questions represent, i.e., therapist perceptions and attitudes along the specific dimensions

of each item. As to reliability, the Spearman-Brown prophecy formula yielded the following split-half reliability coefficients: Rating Scale 1 = .87; Rating Scale 2 = .95; Rating Scale 3 = .95; Rating Scale 4 = .90, Outcome = .79. These reliability coefficients equal or exceed those conventionally accepted as adequate for measures of this type.

D. Procedure

As has already been described, Information Statement 1 and Rating Scales 1 and 2 were administered at the beginning of the study, with instructions as appended to this dissertation. After six months, Rating Scales 3 and 4, dealing with the therapist's relationship with his/her own mother, were administered. It was felt that a measure of therapist attitudes and feelings toward the mother of the child in treatment should precede the therapist's realization that similar items would be given regarding his/her own mother, and that the rating scales dealing with the therapist's own mother should be separated by the greatest possible expanse of time from either of the two administrations of the ratings scales regarding the mother of the child in treatment, to decrease the chances that therapists would remember their earlier responses and thereby distort their responses on subsequent scales. Rating Scales 5 and 6 and Information Statement 2 were administered one year from the

original solicitation.

E. Pilot Study

A pilot study was conducted in the following manner: ten members of the Research class of the City University of New York Clinical Psychology Program (third and fourth year doctoral candidates) were asked to fill out Information Statement 1 and Rating Scales 1 through 4 on a confidential basis. The purposes of the study were: (1) to explore therapist reactions to being asked to provide so much information, some of a very personal nature, (2) to solicit therapist criticisms and suggestions regarding the rating scales in light of their specific clinical data, and (3) to see if the instruments designed elicited useful data for discussion and analysis of therapist countertransference toward mothers of children in treatment.

As a result of the written and verbal comments and criticisms provided by those who responded, the instruments were modified and refined in a number of ways. There was significant therapist resistance to completing some of the materials, especially the more personal scales; and only four of the ten actually completely filled out the scales as requested. This suggested the need for a very large solicitation of therapists in order to get a sufficient subject pool.

Data obtained from the pilot study were analyzed for correlations among the four rating scales used (both

with an N of 4). Rating Scale 1 totals (therapist ratings of child's mother's practical support of the therapy) correlated .66 (p=.3447) with Rating Scale 3 (therapist ratings of their own mother's support of their development in childhood). Rating Scale 2 totals (therapist feelings toward the mother of the child patient) correlated .45 (p=.5510) with Rating Scale 4 totals (therapist feeling regarding own mother). These findings, though not statistically significant, and unrelated to outcome data, suggested the possible existence of discoverable relationships among the rating scales.

Chapter 6

Results

Approximately 160 copies of the first set of materials, accompanied by the distinguished psychologist's letter requesting therapist participation, were sent out. Twenty-nine therapists responded to the first set of materials; twenty-seven of these completed the second set; and twenty-two of these completed the third set. Of the original 29 subjects respondeing, their ages ranged from 25 to 62, with the mean age being 38 (SD = 9.3) Ten of the therapists (34%) were male; 18 (66%) were female. Twenty-eight (96%) were Caucasian; one (4%) was Hispanic. Asked about their parents' socioeconomic group, 2 therapists (7%) said "Upper"; 14 (48%) said "upper middle"; 12 (41%) reported "lower middle"; and 1 (3%) said "lower" class. Twenty-eight (96%) were clinical psychologists or psychologists in training; one was a social worker. Eighteen (62%) had Ph.D. degrees, and eight of these (28% of all therapists) had post-doctoral training. Ten of the psychologists (34% of all therapists) were in various stages of completing their training. Years of experience in working with children and their families ranged from 1.5. to 30, with mean years of experience being 10.2 (SD = 7). Numbers of children treated by each therapist over the course of their career ranged from 2 to 500. Twenty therapists (75%) had seen 50 or fewer children. Eleven subjects (41%) were parents

themselves; one was a stepparent, and 17 (63%) had no parental experience. All therapists except one had had personal psychotherapy, the mean length of which was 6.4 years (S.D. = 4.4).

Of the children selected for study by the therapists, using the prescribed selection method, 18 (62%) were being seen in private practice; 6 (21%) at a clinic and 5 (17%) at a university clinic. Children ranged in age from 4 to 13 with the mean age being 8.1. Eighty-six per cent of the children were between 6 and 11 years old. At the commencement of the study, the therapists had already been seeing the children for periods ranging from 2 months to more than two years. The number of sessions already held with the child ranged from 4 to 350, with the majority being under 100. Eighteen (62%) of the children reported on were male; eleven (38%) were female. Twenty of the children (68%) were white; 3 (10%) were black; 4 (13%) were Hispanic; 2 (7%) were of mixed racial heritage. Sixteen of the children (55%) were reported to come from upper middle class families; 10 (34%) from lower middle class families; and 3 (10%) from lower class families.

Many different diagnoses were reported for the children seen, some phrased in DSM III terms and others in more psychodynamic language. Thirteen children (45%) were described as primarily suffering from anxiety disorders; 3 (10%) from depression; 3 (10%) from personality disorders;

4 (14%) from adjustment disorders; 2 (7%) from post-traumatic stress disorders; 2 (7%) from Attention Deficit Disorder with Hyperactivity; 1 (3%) from gender disturbance and 1 (3%) from Pervasive Developmental Disorder.

The therapists were asked to specify three treatment goals for the children. Twenty-three percent of these stated goals related to improved behavior (e.g., decreased impulsivity, less aggression, fewer trantrums). Thirteen percent related to increasing the child's understanding of his or her feelings. Thirteen percent related to improving parent-child relationships. Eleven percent of stated goalsrelated to decreasing the child's anxiety. Eight percent related to increasing the child's separation from his or her mother. Five percent related to reducing gender dissatisfaction or inappropriate gender behavior. Four percent related to improved peer relationships. Other stated goasl included improving reality testing, increasing the therapeutic alliance, providing a role model for children, increasing assertiveness, and increasing the child's tolerance for competition.

Fifteen of the therapists (52%) planned to see children once a week; 13 (45%) planned to see the children twice a week; and one planned three times a week sessions.

Parents of the children had been seen a mean of 13 times prior to the beginning of the study. Thirty-eight percent of the parents had intact marriages with positive relationships. Seventeen percent had intact marriages

with considerable conflict. Twenty percent were separated or divorced with considerable conflict. Seven percent were separated or divorced with primarily a cooperative relationship. Fourteen percent of the children had no relationship at all with their fathers. Three percent had a reconstituted family with a step-parent.

Asked how often they planned to see the mothers of children being treated, 15% of the therapists planned to see the mother once a week; 37% every two weeks; 37% once a month; 3% once every two months, and 7%) on an indefinite schedule as needed. Regarding therapist goals for treatment of the mother, 31% of stated goals were phrased in terms of educating parents, increasing their empathy for the child and their understanding of the child's problems, and building appropriate developmental expectations. Twenty-three percent of stated goals were described in terms of improving specific parenting skills such as decreased yelling, adherence to behavioral plans, setting limits, etc. Nineteen percent of goals were stated in psychodynamic terms, e.g., fostering separation-individuation, decreasing seductiveness, increasing ability to soothe the child. Nine percent of goasl were focused on alleviating parental guilt and increasing parental self-esteem. Nine percent were phrased in terms of the mother's own needs, e.g., getting the mother into her own therapy. Eight percent of goals were related to changing negative family dyramics.

Asked for their rationale for the structure of the planned treatment, most therapists said thay felt a need to include parents in treatment in some way; those who had considered family therapy as an option rejected it because the child's problems were viewed as too entrenched in his or her personality for this modality to be effective. Most of the therapists wanted to work with fathers as well. Twelve of the mothers were also receiving individual treatment with another therapist; no contact was reported between any of the mothers' therapists and the children's therapists. Alternative modalities other than family therapy did not appear to have been considered.

As to Rating Scale 1, which examined therapists' perceptions of the child's mother's practical support of the therapy at the beginning of the year, therapists overall rated the mothers positively (i.e., they agreed with more positive statements about the mothers, and disagreed with more negative statements). If a therapist had responded neutrally to each question (i.e., neither agree nor disagree), the total score for all ten items would have been 40; in fact, only 1 of 29 therapists gave a total score exceeding 40. Nonetheless, the therapists as a group did express more negative evaluations of certain aspects of the mothers' practical support of the therapy. Items which evoked the most negative responses were related to the mother's resistance to changes in the child brought about by the therapy, the mother's failure to provide

regular information about the child, and her failure to pay the fee promptly. These mothers were most positively rated as to their support of the child's regular attendance of sessions, the mother keeping her own appointments, and overall cooperativeness with the therapy. Table 1 shows the percentage of therapists ascribing to the ten statements about the patients' mothers.

On Rating Scale 2, which solicited therapist feelings about the child's mother at the beginning of the year, again the therapists overall rated the mothers positively; only 3 of 29 therapists gave an overall score which was more negative than a neutral evaluation. Individual items responded to more negatively by the therapists as a group were related to the mother's causative role in the child's pathology, the mother's failure to foster the separation and individuation of her child, the mother's dependency on the therapist, and the therapist's feeling that he/she could be a better parent than the mother. Table 2 shows the percentage of therapists ascribing to the 19 statements about the children's mothers.

In evaluating the therapists' perceptions of their own mothers' practical support of the therapists' growth and development as children, 13 out of 27 (48%) gave their own mother a rating which was more negative than a neutral score. Thus, the therapists as a group viewed their own mothers as offering significantly less practical support of them as children than they viewed the child-patients' mothers' practical support of the child's treatment.

($t = -4.101$, $p = .0005$). The most negative responses the therapists gave as a group were related to their mothers' unreliability in helping them solve problems, their mothers' failure to provide honest information about family matters, their mothers' non-adaptability to their changing needs, and their mothers' failure to provide praise and encouragement for them as children. Table 3 shows the percentage of therapists ascribing to each of the 10 statements on Rating Scale 3. Therapists' responses to Rating Scale 3 regarding their own mothers' practical support correlated only .03 ($p = .8256$) with Rating Scale 1 (patients' mothers' practical support of the therapy), but correlated .90 ($p = .0001$) with Rating Scale 4 (therapists' feelings about their own mothers), suggesting that the attempt to separate therapist ratings of their own mother' practical support of them from general therapist feelings about their own mothers was not successful. Rating Scales 3 and 4 were probably largely measurements of the same set of therapist feelings about their own mothers. (This finding is in contrast to Ratings Scales 1 and 2, which were less strongly correlated with each other ($r = .51$; $p = .0052$), suggesting that different aspects of the therapist-mother relationship were indeed being measured.)

Rating Scale 4, which assessed therapist feelings about their own mothers along the same dimensions as Rating Scale 2 regarding the child patients' mothers, was also responded to significantly more negatively than Rating

Scale 2. The mean score was 14 points more negative ($t = -3.22$; $p = .0036$) for therapists' mothers. Forty-four percent of therapists gave total rating scores more negative than neutral regarding their own mothers, while only 10% of therapists gave overall negative ratings of the children's mothers. Items responded to most negatively by therapists related to their mothers' causal role in their own emotional problems, their mother's dependency on them as a child, the belief that the therapist could be a better parent than their own mother, the mothers seen as not flexible or adaptable regarding their children, the therapists' feeling of not being comfortable and relaxed with their own mothers as children, and the failure of the mothers to foster separation and individuation of their children. Table 4 shows the percentage of therapists ascribing to each of the nineteen statements on Rating Scale 4.

No significant differences were found between therapist responses to Rating Scale 1 and Rating Scale 5, which assessed therapist evaluation of the child's mother's practical support of the child's therapy at the end of the year; nor was there a significant difference between therapist responses to Rating Scale 2 and Rating Scale 6, which assessed therapist feelings about the child's mother at the end of the year.

Of the 22 therapists responding to the final set of

materials, 17 (77%) reported that the cases studied had been terminated during the past year, while 5 of the children were still in treatment. During the year of the study, the number of sessions held with the child ranged from 5 to 119 with the mean being 44. Mothers had been seen a mean of 10.7 times. Reasons cited for the termination of cases were: improvement of the child - 9 cases (52%), therapist leaving the clinical setting - 4 cases (23%), family moved - 2 cases (12%), other reasons (financial necessity, divorced father's threats to prevent therapy) - 2 cases (12%). Outcomes of 22 cases were rated by the therapist. A therapist who was moderately satisfied with the attainment of all six treatment goals, with the degree of change in rated level of emotional disturbance for mother and child, and with overall outcome of the work with both mother and child, would have obtained an outcome score of 32. The mean actual outcome score was 31.95 (SD = 7.69); scores ranged from 16 to 47.

Chapter 7

Data Analysis

Due to insufficient numbers of subjects, neither a multiple regression analysis nor an item analysis could justifiably be performed. Therefore, in order to analyze the relationships among therapist evaluation of child's mother's practical support of the therapy, therapist feelings about the child's mother, therapist feelings about their own mothers' practical support of their development, therapists' feelings about their own mothers, and case outcome, a causal model was constructed. Causal modeling has been utilized as a statistical tool for clinically meaningful analysis of complex, psychodynamically conceptualized relationships. See, e.g., Glassman, 1986). In this model, the interrelationships among Rating Scales 1, 2, 3, 4 and Outcome were studied. It was assumed in constructing the model (illustrated in Diagram 1), that therapists' feelings about experiences with their own mothers' practical support of their growth might have an impact on therapists' evaluations of the practical support of therapy by mothers of children they are treating, and that this relationship might in turn have an impact on case outcome. It was also assumed that therapists' general feelings about their own mother might have an impact on therapists' feelings about mothers

of children they are treating, and that this relationship might also have an impact on case outcome.

In constructing the model, therapist ratings of patients' mothers (Rating Scales 1 and 2) at the beginning of the study were used rather than therapist ratings of patients' mothers at the end of the study. Rating Scales 5 and 6 (identical in language to Rating Scales 1 and 2) were not utilized; these measures were, as expected, more highly correlated with outcome measures ($r = -.63$, $p = .0019$; $r = -.59$, $p = .0037$, respectively) than Rating Scales 1 and 2 ($r = -.56$, $p = .0007$; $r = -.23$, $p = .3003$, respectively), presumably since they were solicited at the same time as the outcome measures and in light of the knowledge of outcome. It was felt that, causally, therapist feelings about the patients' mothers at the beginning of the period of study would have more impact on outcome and also exist more independently of outcome measures. Chronologically, Rating Scales 3 and 4 (therapists' ratings of their own mothers) were taken after Rating Scales 1 and 2; however, it was felt that adult therapists' feelings and perceptions about their own mothers in childhood would be more or less longstanding and permanent, and that therefore, the construction of a model in which Rating Scales 3 and 4 causally precede Rating Scales 1 and 2 was justified. (Rating Scales 3 and 4 were administered approximately six months after Rating Scales

1 and 2 in order to provide the maximum possible time separation between questionnaires about parents of children in therapy and the therapists' own parent.)

In conducting the causal analysis, an attempt was made to partial out the impact of demographic variables in the correlation matrix. The correlations of the measured demographic variables are shown in Table 5. Given the relatively small number of cases, it was not possible to partial out all possible major demographic variables. For Rating Scales 1 and 1 and Outcome, therapists who were older, had more years of experience or were parents themselves tended to have lower levels of negative evaluation of mothers of children in treatment and higher outcome ratings. These three characteristics were the most highly correlated demographic variables. (See Table 5.) Since these three variables were also significantly correlated with each other (for therapist age and years of experience, $r = .89$, $p = .0001$; for therapist age and parental status, $r = -.50$, $p = .005$; for years of experience and therapist parental status, $r = -.55$, $p = .002$), and since therapist years of experience was the most strongly correlated with the dependent variables of interest, it was decided to use therapist years of experience to partial out. In addition, mothers of children with darker skin or with lower socioeconomic status were more negatively rated

by therapists, and the children's therapy had less highly rated outcomes (see Table 5). Again, since the two variables of race and socioeconomic status were significantly correlated with each other ($r = .50$, $p = .0054$), and since only one could be chosen to partial out, socioeconomic status was chosen primarily because there was more variability of socioeconomic status than of race in this particular sample of child patients. Rating Scales 3 and 4, relating to therapists' comments about their own mothers, did not correlate strongly with any of the major demographic variables, although there was a low-to-moderate correlation of therapist negative feelings about their own mothers with therapist age and years of therapy, with therapists of greater age or with more years of therapy tending to have more negative feelings about their own mothers (see Table 5). These relationships were not taken into account in the data analysis. Table 6 shows the mean, standard deviation, range and reliability coefficients for Rating Scales 1 through 4 and Outcome.

Diagram 1 shows the standardized partial regression coefficients for the interrelationships of the variables of interest. Direct and Indirect effects of the path model are shows in Table 7. The implications of this data for the hypotheses of this study are as follows:

Hypothesis I. A significant relationship will exist

between therapist feelings about their own mothers and their feelings about the mothers of children in treatment; the more negatively therapists feel about their own mothers, the more negatively they will feel about the mother of the child they are treating.

Therapists' feelings about their own mothers (Rating Scale 2) had a strong signficiant causal impact on therapist feelings about the mother of the child in treatment, i.e., the more negatively a therapist felt about his or her own mother, the more negatively he or she tended to view the mother of the child in treatment (Beta = .60; p = .004). The proportion of the variance in therapist negative feelings toward the child's mother explained by variance in therapist feelings about their own mothers was .362. This hypothesis was confirmed.

Hypothesis II. A significant relationship will exist between therapists' ratings of their own mother's practical support of them as children and their perceptions of the children's mothers' practical support of the therapy; the more negatively therapists rate their own mothers' practical support of them, the more negatively they will tend to rate the children's mothers' support of the therapy. This relationship was predicted to be weaker than that described in Hypothesis I.

Therapists' evaluations of their own mothers'

practical support of their own development (Rating Scale 3) were not related to therapist evaluations of patients' mothers' practical support of the therapy (Beta = -.04; p = .87). This hypothesis was not confirmed.

Hypothesis III. The more negatively therapists feel about the mothers of the children they are seeing, and the lower therapists rate the children's mothers' practical contribution toward the therapy, the lower outcome will be rated (after taking into account demographic variables which might also affect the results).

Therapist negative feelings about the children's mothers did not lead to a more negative outcome. There was in fact a weak non-significant relationship (Beta = .16; p = .56) between negative therapist feelings about the mother and a more positive outcome. Therapists' negative perceptions about the patient's mother's practical support of the therapy, however, did have a strong causal impact on outcome (Beta = -.54; p = .025); in other words, the more negatively therapists rated the child-patients' mothers' practical support of the therapy, the more negative the outcome of the case after a year. It should be noted that this result was obtained after partialling out socioeconomic status and therapist years of experience so that the relationship cannot be seen as due to phenomena such as lower income mothers' inability to follow through on support of a child's therapy, or to novice therapists'

possible tendency to blame mothers more harshly for treatment problems. This hypothesis was partially confirmed.

Overall, the causal factors studied in the model (Rating Scales 1, 2, 3, and 4) explained 30% of the variability of Outcome (R^2 = 30). Direct and indirect effects of therapist ratings of their own mothers on outcome were very small (see Table 7). Gratifyingly for the therapists, their negative countertransference toward mothers of children in treatment, while demonstrably related to their experience with their own mothers, did not adversely affect therapist-rated outcome in this study.

Although the use of the statistical techniques employed in the above analysis are not strictly justified due to the relatively small number of cases, the model as applied makes inherent sense conceptually and empirically. Given the size of the sample, the model seems the most parsimonious and sensible means of analyzing the data. While absolute confidence cannot be placed in the results of the analysis, these results are quite suggestive of causal relationships of conscious and unconscious therapist countertransference toward mothers of children in treatment.

Chapter 8
Discussion

In assessing the generalizability of the findings of this study to the general population of child therapists and their patients, several important facts about the sample should be noted. The sample of therapists was a heavily middle class, Caucasian group, almost all trained in clinical psychology and many seeing children through private practice rather than in a clinic. The majority of the children seen were also white and from a middle class background although there was somewhat more racial and socioeconomic variety among the sample of children treated. A sample with more racial and socioeconomic variability among therapists and patients might have yielded different results. For the most part, large socioeconomic differences between therapists and their patients' mothers did not exist in this group. It may be argued that the findings therefore represent the impact of countertransference less complicated by factors of race and class. A rather high proportion of the children reported on were being treated for anxiety disorders. Therapists working in urban clinics with a greater socioeconomic and racial mix might be expected to treat a higher percentage of conduct disordered children from single parent families than were represented by this sample. A much higher percentage of children might be

expected to have little or no relationship with their fathers and fewer fathers might be expected to be involved in the therapy. Countertransference toward single mothers of lower socioeconomic background might be expected to differ from that toward a mother in an intact marriage and from a socioeconomic group similar to the therapist's own.

As a group, these therapists planned to see the mothers of the children relatively infrequently (only 15% planned to see the mothers as often as once a week). This implies a relatively unintense evolution of feelings toward the mothers. In light of the strong tendency of these therapists to attribute causation of the children's problems to the mothers, this fact is rather hard to understand. Presumably, this group of therapists was relatively highly committed to the idea that the key part of the work with children takes place in the individual sessions with the child, without the necessity of making major changes in the parents even when parents are seen as strong causal agents of the child's difficulties. Moreover, this group of therapists seemed committed to individual psychodynamic psychotherapy without strong consideration of other modalities, except for family therapy.

A striking and rather unexpected finding of the study is that this group of therapists rated the mothers of children seen relatively positively, much more positively

in fact than they rated their own mothers. Considerably more negative ratings of child patients' mothers had been expected. Had I for example, completed the study materials regarding the illustrative case reported on in the beginning of this dissertation, I would have rated the mother of that child relatively positively on practical support of the therapy, but highly negatively as to Rating Scale 2 (my feelings about the mother). This rating would have been much more negative than my ratings of my own mother. My sense from many conferences with other professionals is that these therapists underplayed their negative feelings about the patients' mothers. Also, therapists who tend to work more intensely with mothers of children they treat than was the norm for this group, may well experience more strongly evoked feelings about mothers.

Possibly therapists in the study gave such positive responses because they were aware that negative counter-transference toward mothers is a bad thing and were therefore less than honest about their responses. Certainly, therapist resistance to completing these forms seemed rather high, judging both from the pilot study and the percentage of therapists responding to the request for participation. Therapists who felt comfortable filling out the forms may also have been therapists who would not tend to be the most soul-searching or direct

about their negative feelings, or therapists who happened to have less negative countertransference toward mothers than those who failed to respond. Alternatively, the sample may have been biased in such a way that therapists were responding quite honestly about a group of quite cooperative and relatively high-functioning mothers.

In any event, these therapists were much more willing to rate their own mothers negatively. Perhaps this finding supports the speculation that child therapy is unconsciously (or consciously) sought out as a profession in an attempt to make reparations to one's child self for perceived bad parenting of one's own. Child patient's mothers, on the other hand, are doing something which the therapists' own mothers may well not have done, which is to bring their children for treatment, implicitly recognizing a need for change and help for the child. In addition, they have brought their children to these therapists for help, which is a gesture of respect and confidence in the therapists. Perhaps this combination of factors allows therapists to view patients' mothers with a more kindly eye than their own mothers whose faults they have explored for the most part in lengthy therapies of their own. Another possible explanation of the discrepancy between negativity ratings of therapists' mothers and childpatients' mothers is that the relationships between therapists and their patients' mothers were

relatively unintense, so that the heat of negativity could not arise so strongly.

In spite of the differences in the level of negative feelings of therapists toward patients' mothers and their own mothers, however, therapist feelings about their own mothers appeared to have a demonstrable significant relationship to their feelings about mothers of children in treatment, as already described in the data analysis. It had been expected that this relationship would in turn lead to a more negative outcome for the case, but in fact therapists who felt more negatively about their own mothers and in turn more negatively about child patients' mothers had a weak and nonsignificant tendency to have more positive outcomes. Since as a group these therapists focused more heavily on the child in treatment, perhaps the therapists' sense of compassion for the child in dealing with a more negatively perceived mother led to greater effort with and more empathy for the child and thus to a more positive outcome. Therapists may also tend to rate outcome more positively in light of their sense of having been more needed by or emotionally connected to the child.

Therapists' negative ratings of the children's mothers' practical support of the therapy were not related to therapists' feelings about their own mothers' practical support of them, but were strongly related to therapists'

perception of case outcome. The less the therapist perceived the child's mother as supporting the therapy, the more negatively the therapist rated case outcome. This finding supports the idea that the practical realities of the relationship between child patients' mothers and the therapist (e.g., the mother's control over the relationship and ability to frustrate its purposes) is more significant to case outcome than the conscious and unconscious elements of therapist feelings about the mother as a person or as a parent outside the therapeutic relationship.

Some of the speculations of writers on the nature of common countertransference responses of child therapists toward patients' mothers seem borne out by these therapists' responses to Rating Scale 2, which may be seen as representing some consciously held elements of countertransference. Although the therapists tended overall to see mothers in a positive light, certain items evoked much stronger, negatively tinged responses. For example, these therapists as a group strongly perceived the mothers as causal agents of the children's pathology, which would support the often-stated idea that mothers are blamed by therapists for their children's difficulties. A substantial sub-group of therapists also saw the mothers as emotionally abusive toward their children. The therapists also tended to see the mothers as strongly dependent on them, and as not adequately supporting the

separation and individuation of their child. This might reflect the therapists' own tendency to see themselves somewhat grandiosely as crucial objects to the families they treat, or it might reflect a tendency of mothers who seek out child therapists to have more dependent personality types.

Alternatively, the therapists, many of whom were themselves concerned about separation issues and maternal dependency with their own mothers, may have tended to see these mothers in a similar light. There was little evidence in the data for any therapist overidentification with a parent against a child, although the instruments probably did not directly elicit this. The therapists' tendency to blame the mothers may be seen, however, as some evidence of what many writers have thought to be a tendency to overidentify with the child. A substantial number (38%) of the therapists acknowledged the wish to be the parent of the child they were treating, as predicted by authors on countertransference toward children. However, only 17% claimed that they were sure they could be a better parent. Relatively common therapist perceptions were that the patients' mothers were seductive toward them, or made them feel helpless in attaining their treatment goals. Interestingly, almost no therapists said they didn't like the mother of the child, or that they felt engaged in rivalry with the mother of the child; and no therapist ascribed to the statement that his or

her work was not valued by the parents. Therapists who had open wishes to be the child's parent thus obviously denied any sense of rivalry between themselves and the parent, which seems intuitively somewhat improbable. That therapists who saw mothers as emotionally abusive denied that they didn't like the mother also seems rather unliekly. Therapist responses in the study thus suggest that areas of unconscious countertransference toward patients' mothers exist which are strongly defended against by children' therapists, at least when they know their responses will be read by a fellow professional. This underscores the difficulty of researching this area and perhaps explains the absence of previous empirical work on this question.

Overall, the results of this study suggest that countertransference is indeed an important factor in children's therapy. Before a therapy even begins, therapists have made countertransference-loaded decisions about the optimal intensity and distance of their involvement with parents, often opting for a relatively infrequent and distant relationship even when causality of the child's problems is ascribed to parental factors. Once the relationship is established, therapists' personal experiences and feelings about their own mothers are activated and influence their perceptions of the child patients' mothers to some extent, although this does not necessarily adversely

affect case outcome. Therapists who perceive mothers as giving weak or no practical support to the therapy, however, tend to rate case outcome significantly more poorly - a rating, it should be noted, that does not correlate with the therapists' perception of their own mothers' practical support of them, suggesting that the more objective realities of the therapist's relationship with the mother of the child patient may ultimately have a greater impact on success or failure of the treatment than the more complex and less discoverable forces of unconscious countertransference. This finding implies that therapists need to focus especially heavily in their work with parents on the parents' actions in regard to support of the child' therapy, as these factors are crucial in determining the potential for a positively perceived result. Establishing a working partnership with a parent in which each party treats the other with respect and consideration, and each clearly understands their respective contributions and obligations, seems critical to case outcome in child therapy.

Table 1 - Rating Scale 1

Percentage of Therapists Agreeing with Statements About Child Patients' Mothers

Statement	Sltly Agree	Mdtly Agree	Strgly Agree	Total
1. Inadequate history	7%	7%	3%	17%
2. Failure to keep child's appointments	3	0	3	7
3. Failure to provide regular information	14	3	3	21
4. Failure to keep own appointments	3	3	3	10
5. Uncooperative re therapist speaking to others	3	0	3	7
6. Resistance to changes in child	21	0	0	21
7. Payment of fee not made	7	3	3	14
8. Failure to express positive feelings about therapy	0	0	3	3
9. Failure to change behavior as suggested by therapist	7	0	3	10
10. Failure to cooperate overall	0	0	3	3

Note: $N = 29$

Table 2 - Rating Scale 2

Percentage of Therapists Agreeing with Statements About Child Patients' Mothers

Statement	Sltly Agree	Mdtly Agree	Strgly Agree	Total
1. Causality of child's problems	7%	52%	31%	90%
2. Struggle with therapist for control	14	7	0	21
3. Dependency on therapist	38	10	14	62
4. Makes therapist feel helpless	21	0	0	21
5. Behaves seductively	17	10	0	28
6. Rival with therapist for affections of child	0	3	0	3
7. Frustrates therapist's attempts to help	14	3	0	17
8. Therapist would be a better parent	14	3	0	17
9. Fails to foster separation	3	34	17	55
10. Therapist wishes could parent this child	24	24	0	38
11. Therapist doesn't like mother	3	0	0	3
12. Mother critical of therapist	7	0	0	7
13. Mother makes therapist feel uncomfortable	7	3	3	14
14. Therapist wants to make up deprivation of child	3	7	0	10

Table 2 (continued)

Statement	Sltly Agree	Mdtly Agree	Strgly Agree	Total
15. Mother doesn't value therapist's efforts	0%	0%	0%	3%
16. Mother physically abusive	3	3	3	10
17. Mother not adaptable	17	17	0	34
18. Mother intrusive re therapy	10	17	0	28
19. Mother emotionally abusive	21	10	7	38

Note: N = 29

Table 3 - Rating Scale 3

Percentage of Therapists Agreeing with Statements About Their Own Mothers' Practical Support

Statement	Sltly Agree	Mdtly Agree	Strgly Agree	Total Agree
1. Failure to provide information	18%	11%	26%	56%
2. Failure to help with problems	18	26	18	63
3. Failure to give honest family information	7	11	33	52
4. Failure to spend adequate time with child	15	15	7	37
5. Failure to help child connect with others	15	11	11	37
6. Failure to support child's changing development	18	15	18	52
7. Failure to provide adequate material resources	7	15	0	22
8. Failure to encourage and praise	4	4	0	7
9. Failure to adapt to child's changing needs	22	7	30	60
10. Overall failure to be sensitive parent	15	22	15	52

Note: N = 27

Table 4 - Rating Scale 4

Percentage of Therapists Agreeing with Statements About Their Own Mothers

Statement	Sltly Agree	Mdtly Agree	Strgly Agree	Total Agree
1. Mother's causal role in child's problems	7%	22%	56%	85%
2. Mother's struggle for control of child's life	26	18	15	60
3. Dependency on child	11	26	33	70
4. Child felt helpless with mother	7	11	4	22
5. Mother seductive with child	22	7	7	37
6. Rivalry with child for others' affection	7	15	7	30
7. Mother's frustration of attempts to achieve	15	15	4	33
8. Therapist feels could be a better parent	30	30	18	78
9. Failure to foster separ.-individuation	15	26	18	60
10. Wish to have had a different mother	15	26	7	48
11. Didn't like mother as a person	15	18	0	33
12. Mother very critical	11	15	0	26
13. Didn't feel relaxed with mother	11	33	18	63

Table 4 (continued)

Statement	Sltly Agree	Mdtly Agree	Strgly Agree	Total
14. Therapist has to make up for own deprivation	22%	7%	11%	41%
15. Mother didn't value child' achievements	4	4	0	7
16. Mother physically abusive	0	4	0	4
17. Mother not adaptable re child's changing needs	15	15	26	56
18. Mother intrusive	22	18	18	60
19. Mother emotionally abusive	7	11	7	26

Note: N = 27

Table 5

Correlations of Demographic Variables with Rating Scales 1 through 4 and Outcome

	Rating Scale 1	Rating Scale 2	Rating Scale 3	Rating Scale 4	Outcome
Therapist Age	r=-.41 p=.1259	r=-.33 p=.0745	r=.27 p=.1681	r=.27 p=.1745	r=.13 p=.5693
Therapist Sex	r=-.18 p=.3479	r=.26 p=.1733	r=.13 p=.4986	r=.05 p=.7785	r=-.07 p=.7573
Therapist SES	r=-.06 p=.7466	r=-.24 p=.2051	r=.11 p=.5884	r=.18 p=.3720	r=.03 p=.8738
Therapist Yrs. Exp.	r=-.54** p=.0027	r=-.54** p=.0030	r=.04 p=.8328	r=.07 p=.7123	r=.24 p=.2913
Therapist Par. Exp.	r=.25 p=.1816	r=.34 p=.-710	r=.02 p=.8691	r=.14 p=.4986	r=-.30 p=.1681
Therapist Yrs. Ther.	r=-.15 p=.4516	r=-.04 p=.8100	r=.26 p=.1803	r=.39* p=.0401	r=-.04 p=.8324
Child Age	r=.13 p=.5041	r=.21 p=.2582	r=.06 p=.7675	r=.03 p=.8501	r=-.08 p=.7118
Child Sex	r=.22 p=.2424	r=.27 p=.1459	r=.23 p=.2527	r=.17 p=.3956	r=-.04 p=.8118
Child Race	r=.54** p=.0028	r=.44* p=.0168	r=-.03 p=.8602	r=-.02 p=.8564	r=-.47* p=.0257
Child SES	r=.54** p=.0030	r=.39* p=.0346	r=.04 p=.8141	r=-.13 p=.5229	r=-.26 p=.2327

Note: * $p \leq .05$
** $p \leq .01$

Table 6

Descriptive Statistics and Reliability - Rating Scales 1 through 4 and Outcome

	Mean	Stnd. Dev.	Range	Spearman Brown Coefficient
Rating Scale 1	22.48	10.90	10-59	.87
Rating Scale 2	56.90	17.46	19-96	.95
Rating Scale 3	37.78	16.23	11-63	.95
Rating Scale 4	71.67	25.40	26-112	.95
Outcome	31.95	7.69	16-47	.79

Note: For Rating Scales 1 and 2, N = 29. For Rating Scales 3 and 4, N = 27. For Outcome, N = 22.

Table 7

Direct and Indirect Effects of Therapist Feelings About Own Mother and Child's Mother on Outcome

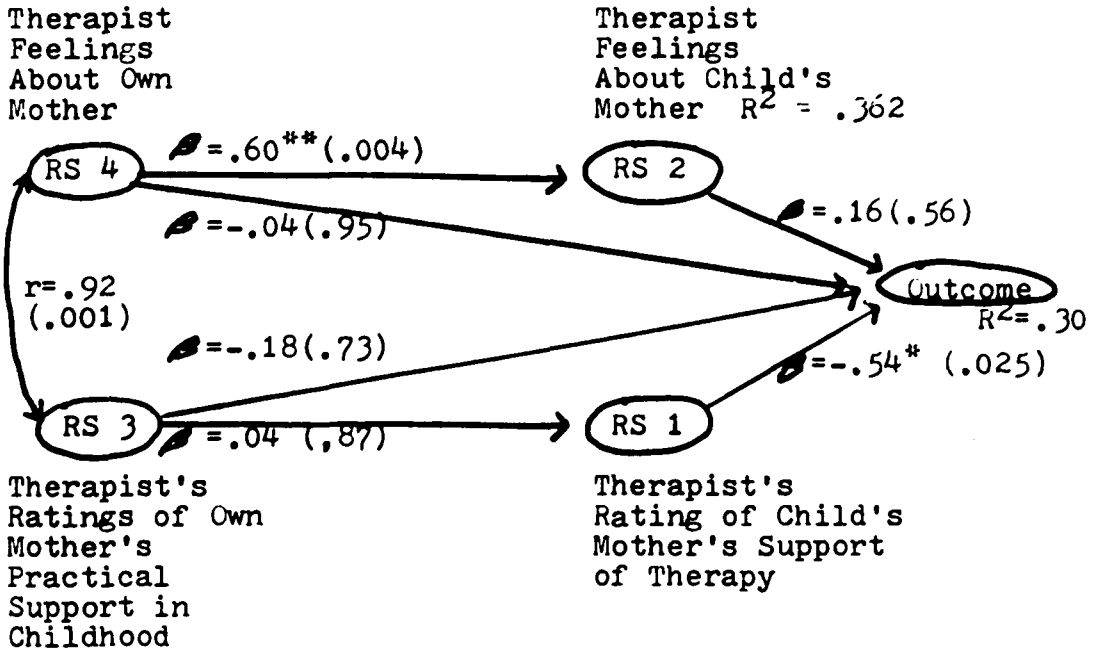
Causal Variables	Dependent Variables	Effects[a] Direct	Indirect Via Therapist's Feelings re Mother of Child	Indirect Via Therapist's Feelings re Child's Mo.'s Practical Support
1. Therapist's Feelings re Own Mother	Therapist Feelings re Mother of Child	.60**	-	-
	Outcome	-.04	.097	-
2. Therapist's Feelings re Own Childhood (Practical)	Therapist Feelings re Child's Mo's Practical Support	.04	-	-
	Outcome	-.18	-	-.02
3. Therapist's Feelings re Mother of Child	Outcome	.16	-	-
4. Therapist's Feelings re Child's Mo's Practical Support	Outcome	-.54*	-	-

[a] For an effect, values are standardized partial regression coefficients

Note: **$p < .05$
*$p < .01$

Diagram 1

Path Analysis of Interrelationships of Rating Scales 1, 2, 3, 4 and Outcome



Note: Therapist's years of experience and child's SES partialled out of input correlation matrix

β refers to standardized partial regression coefficients

*p .05
**p .01

APPENDIX

Appended to this dissertation are copies of Rating Scales 1 through 4, Information Statements 1 and 2, and the instructions accompanying the mailings of these instruments. Rating Scales 5 and 6, as they were identical to Rating Scales 1 and 2, are not appended.

THE CITY COLLEGE
OF
THE CITY UNIVERSITY OF NEW YORK
NEW YORK, N.Y. 10031

THE PSYCHOLOGICAL CENTER
DEPARTMENT OF PSYCHOLOGY

(212) 690-6602, 3, 4

October 29, 1986

Dear Colleague:

Jill Edgar is a student in our clinical program who is doing her dissertation under my mentorship. I believe that she has devised a particularly interesting study, one that is intellectually sound and that at the same time is likely to have useful clinical implications. I would expect that if you agree to take part in her study you will find your participation a useful and stimulating experience. I can also assure you from knowing Jill well that she will handle all information you provide her with sensitivity and with a keen appreciation of the requirements of confidentiality. If you have the time, I would urge you to participate.

Sincerely,

Paul L. Wachtel
Distinguished Professor
Associate Director,
Ph.D. Program in Clinical Psychology

Year-Long Study of the
Relationship Between Children's Therapists and the
Mothers of Children in Treatment

PHASE I

Thank you for your willingness to participate in this study, which will look at the relationship between children's therapists and the mothers of children in treatment. I believe that participation in this study will take approximately one and one half hours of your time or less, spread out over three segments during the year.

All materials should be returned to me in the self-addressed stamped envelopes. Throughout the study, code numbers rather than names will be used on all forms. The list linking code numbers to names will be held by another individual, who will not have access to the information you provide. In other words, I am committed to maintaining my ignorance of which therapist submitted which document.

At this time, I would appreciate it if you would fill out the attached information form and two rating scales regarding your relationship with the mother of a child you are seeing in treatment. For this purpose, the child in question should be:

(a) not older than 12 years 0 months
(b) one whom you have seen individually for at least two months
(c) one whose difficulties do not appear to consist solely of learning delays or disabilities;
(d) one whose mother has been for significant portions of the child's life, and continues to be, his or primary caretaker;
(e) one with whose mother you have some direct, individual relationship, which you intend to maintain during the child's treatment (mother can also be in separate family, group or individual therapy).

Of your child patients who meet these criteria, please choose the one whose treatment began most recently (but not less than two months ago). All further information you provide to me should be about this same mother and child, so please don't forget whom you've chosen.

In approximately six months, I will ask you to fill out two more brief rating scales. These rating scales will relate to your own feelings in a fairly personal way. Of course, it's crucial for the study that you answer as honestly as possible.

Approximately one year from now, I will again ask you to fill out a brief information form and two rating scales. It is irrelevant whether you presently believe that this child will still be in treatment with you in one year's time, but if the treatment terminates during this period, it would be extremely helpful if you would employ some means of preserving your recollection of your feelings about the child and mother at the time of termination and your assessment of treatment outcome for both mother and child.

This first part of the study will take longer than the remaining two portions. Regarding the ratings scales, I know it's often hard to quantify things, but please make the most reasonable choice you can. Don't leave questions unanswered unless the question is totally inapplicable to your case; if this is true, please make a brief explanatory note. I would welcome comments and criticisms of the materials, but please do fill out all the items as best you can.

I believe this study will provide improtant information in an area which has not been significantly explored before. I greatly appreciate your contribution to this effort.

Jill Ramsey Edgar

T#: _____

Information Form #1

TODAY'S DATE: _____

I. Questions about the therapist

1. Your age _____

2. Your sex _____

3. Race _____

4. Your parents' socioeconomic group
upper
upper middle
lower middle
lower

5. Level of graduate education: _____

6. Year of experience as a children's therapist: _____

7. Number of children seen in therapy by you: _____

8. Are you a parent yourself? _____ How long? _____

How many children? _____

9. How many sibling do you have? Older _____
Younger _____

10. How many years of therapy have you had? _____

II. Questions about the child you are seeing in treatment

1. Type of clinical setting in which child is being seen _____

2. Date of first meeting with this child _____

3. Age of child at present _____

4. Sex of child _____

5. Race of child _____

6. Socioeconomic group of child's parents
Upper
Upper middle
Lower middle
Lower

7. Level of education of child _____

T#: _____

8. Diagnosis of child (can be from intake report, if you have not yet formulated one): _____

_____

9. Number of sessions with child to date: _____

10. How many times per week do you plan to see this child?

_____

11. If this child has been in therapy before either in the same setting or elsewhere, please give approximate dates of treatment:

_____

12. Please list your three most important treatment goals for your work with this child:

_____

_____

_____

13. Please rate this child in terms of overall degree of his/her emotional disturbance:

Extr. Severe	Very Severe	Mod. Severe	Moderate	Slight	Very Slight	Almost None

III. Questions about the parents of the child you are seeing.

1. How many times have you seen this child's mother to date? _____ The father? _____

2. Please describe briefly the nature of the relationship (legal, practical and emotional) between this child's parents.

_____

_____

_____

_____

T#: _____

Info. # 1, p. 3

3. How often do you intend to see the mother of this child? _____
The father? _____

4. Please list briefly the three most important treatment goals of your work with the mother of this child:

_____

_____

_____

5. Please describe briefly why you plan to work with the parents or family of this child as you do, and what alternative modalities you rejected:

_____

_____

_____

6. Please rate the mother of this child in terms of overall degree of her emotional disturbance.

Extr. Severe	Very Severe	Mod. Severe	Moderate	Slight	Very Slight	Almost None

7. If the mother of this child has been or is presently in treatment with another therapist, please briefly describe the nature and extent of this treatment, and your relationship, if any, with the mother's therapist:

_____

_____

8. Please provide any significant additional facts about your work with this child and/or his/her family, that your feel are necessary for a basic understanding of the contemplated treatment:

_____

_____

_____

T#: _____

Rating Scale # 1

Scale: Strongly Disagree = 1
Moderately Disagree = 2
Slightly Disagree = 3
Neither Agree nor Disagree = 4
Slightly Agree = 5
Moderately Agree = 6
Strongly Agree = 7

1. The mother of this child provided to me or to the assessment interviewer as complete and accurate a history as possible regarding this child.

   1 2 3 4 5 6 7

2. The mother of this child has helped this child regularly attend appointments with me.

   1 2 3 4 5 6 7

3. The mother of this child has not regularly provided me with information about events in this child's life.

   1 2 3 4 5 6 7

4. The mother of this child has kept her appointments with me whenever possible.

   1 2 3 4 5 6 7

5. The mother of this child has been uncooperative in arranging for me to speak with other important figures in this child's life.

   1 2 3 4 5 6 7

6. The mother of this child has generally resisted changes in the child's behavior brought about by the therapy.

   1 2 3 4 5 6 7

7. The mother of this child has seen to it that the fee for the child's therapy is paid with reasonable promptness.

   1 2 3 4 5 6 7

T#: _____

Rtg. 1, p. 2

8. The mother of this child has expressed positive feelings about my work with this child.

1 2 3 4 5 6 7

9. The mother of this child has failed to change her handling of this child in response to my suggestions.

1 2 3 4 5 6 7

10. The mosther of this child has overall been cooperative in fostering the child's therapy.

1 2 3 4 5 6 7

T#: _____

Rating Scale # 2

TODAY'S DATE: _____

Scale: Strongly Disagree = 1
Moderately Disagree = 2
Slightly Disagree = 3
Neither Agree nor Disagree = 4
Slightly Agree = 5
Moderately Agree = 6
Strongly Agree = 7

1. This mother's attitudes, behavior and pathology have not played a strong causative role in this child's emotional difficulties.

   1 2 3 4 5 6 7

2. This mother is engaged in a struggle with me for control of this child's therapy.

   1 2 3 4 5 6 7

3. This mother is not needy or dependent upon me.

   1 2 3 4 5 6 7

4. I feel helpless in trying to achieve my treatment goals because of the behavior of this mother.

   1 2 3 4 5 6 7

5. This mother does not behave seductively toward me.

   1 2 3 4 5 6 7

6. I feel I am engaged in rivalry with this mother for the affections of her child.

   1 2 3 4 5 6 7

7. This mother frustrates my attempts to help her child.

   1 2 3 4 5 6 7

8. I know I could be a better mother (parent) for this child than his/her own mother.

   1 2 3 4 5 6 7

T#= _____

RS 2, p. 2

9. This mother has fostered the separation and individuation of her child.

1 2 3 4 5 6 7

10. Sometimes I wish I could be the parent of this child.

1 2 3 4 5 6 7

11. I really like this mother as a person.

1 2 3 4 5 6 7

12. I feel that this mother is highly critical of me and my work with this child.

1 2 3 4 5 6 7

13. I feel relaxed and comfortable when dealing with this mother.

1 2 3 4 5 6 7

14. I feel that I can make up to this child through therapy for the emotional deprivation she/he has experienced with her/his mother.

1 2 3 4 5 6 7

15. I feel that this mother values my efforts to help this child.

1 2 3 4 5 6 7

16. This mother is a physically abusive parent.

1 2 3 4 5 6 7

17. This mother is adaptable and flexible in her behavior toward this child.

1 2 3 4 5 6 7

18. This mother is intrusive regarding her child's therapy

1 2 3 4 5 6 7

T#: _____
RS 2, p. 3

19. This mother is an emotionally abusive parent.

1 2 3 4 5 6 7

T#: _____

Long-Term Study of the
Relationship Between Children's Therapists and th
Mothers of Children in Treatment

PHASE II

Thank you very much for your continued willingness to participate in this study. At this time, I would like you to fill out two brief rating scales regarding your relationship with your own mother as you were growing up. I realize it is difficult to make general statements about one's whole childhood and to quantify them, but please answer every question and make the most appropriate and honest choice possible. Please feel free to comment or criticize if you wish at the end.

This portion of the study is the least time-consuming for you, but probably the most intrusive. As I mentioned to you at the outset of this study, I have made every effort to preserve my ignorance of the identity of people filling out particular questionnaires. I no longer have in my posession the list linking names to code numbers; this list is being held by my assistant who does not and will not have access to any of the data. My assistant will handle all addressing of envelopes. You have my personal commitment never to reobtain the list linking names to numbers.

When you have completed the two scales, please return them to me in the stamped envelope provided. The third and final mailing will be sent to you in approximately six months. Again, my profound gratitude for your effort.

Jill Edgar

Rating Scale # 3

TODAY'S DATE: _____

Scale: Strongly Disagree = 1
Moderately Disagree = 2
Slightly Disagree = 3
Neither Agree nor Disagree = 4
Slightly Agree = 5
Moderately Agree = 6
Strongly Agree = 7

1. At each stage of my development, my mother gave me the information about myself and the world that I needed to develop and mature appropriately.

   1 2 3 4 5 6 7

2. My mother reliably and consistently helped me solve problems I was having as I was growing up.

   1 2 3 4 5 6 7

3. My mother failed to tell me honestly about important events in my family life so that I could understand what was going on.

   1 2 3 4 5 6 7

4. My mother reliably and consistently had time to be with me and talk to me as I was growing up.

   1 2 3 4 5 6 7

5. My mother encouraged and assisted me to make helpful and rewarding attachments with others besides herself.

   1 2 3 4 5 6 7

6. My mother failed to encourage and support my changing development at each stage of my childhood.

   1 2 3 4 5 6 7

7. My mother saw to it that I had adequate material resources as I was growing up.

   1 2 3 4 5 6 7

T#: _____

RS 3, p. 2

8. My mother did not praise and encourage me.

1 2 3 4 5 6 7

9. My mother adapted her behavior to my changing needs and behavior over time.

1 2 3 4 5 6 7

10. Overall, my mother was a sensitive, responsive parent.

1 2 3 4 5 6 7

T#: _____

Rating Scale #4

Scale: Strongly Disagree = 1
Moderately Disagree = 2
Slightly Disagree = 3
Neither Agree nor Disagree = 4
Slightly Agree = 5
Moderately Agree = 6
Strongly Agree = 7

1. My mother's attitudes, behavior and pathology have not played a strong causative role in my emotional difficulties.

   1 2 3 4 5 6 7

2. My mother and I were engaged in a struggle over who would control my life.

   1 2 3 4 5 6 7

3. My mother was not needy or dependent on me when I was growing up.

   1 2 3 4 5 6 7

4. My mother often made me feel helpless in trying to develop and achieve.

   1 2 3 4 5 6 7

5. My mother did not behave seductively toward me.

   1 2 3 4 5 6 7

6. My mother was my rival for the affections and esteem of others.

   1 2 3 4 5 6 7

7. My mother frustrated my attempts to grow and achieve.

   1 2 3 4 5 6 7

8. I know I am (or could be) a better parent than my mother was.

   1 2 3 4 5 6 7

T#: _____
RS 4, p. 2

9. My mother fostered my separation and individuation.

1 2 3 4 5 6 7

10. I wish I could have had a different kind of mother.

1 2 3 4 5 6 7

11. I really liked my mother as a person.

1 2 3 4 5 6 7

12. My mother was highly critical of me and my achievements.

1 2 3 4 5 6 7

13. I felt relaxed and comfortable dealing with my mother.

1 2 3 4 5 6 7

14. I feel that I have to make up in my therapy or other relationships for emotional deprivation I experienced from my mother.

1 2 3 4 5 6 7

15. My mother valued my attempts to achieve and succeed.

1 2 3 4 5 6 7

16. My mother was a physically abusive parent.

1 2 3 4 5 6 7

17. My mother was adaptive and flexible in her behavior toward me.

1 2 3 4 5 6 7

18. My mother was not intrusive regarding my privacy.

1 2 3 4 5 6 7

19. My mother was an emotionally abusive parent.

1 2 3 4 5 6 7

T#: _____

Long-Term Study of the
Relationship Between Children's Therapists and the
Mothers of Children in Treatment

PHASE III

Thank you for your continued willingness to participate in this study. This is the final set of forms I will ask you to complete.

At this point, I will ask you to complete two brief rating scales and a questionnaire regarding the treatment of the child and mother about whom you answered questions approximately one year ago. The two rating scales are identical to the ones you filled out one year ago. You should answer them, however, in the light of your past year's experience with the mother of the child in treatment. In otherwords, please do not try to remember what you said last time and make it consistent, as I am interested in change over time, among other things.

Please return the papers to me in the envelope provided. If you would like to receive a summary of my research findings for this study, please so indicate by checking the appropriate space on page 3 of Information Form # 2

Once again, my heartfelt thanks for your ongoing participation.

Jill Edgar

T#:_____

Information Form #2

TODAY"S DATE: _____

1. Are you still seeing this child in treatment? _____
   If yes, answer questions 2 and 3. If no, answer questions 4 through 7.

2. How many times have you seen this child since _____?
   _____

3. How many times have you seen the mother of this child since _____? _____

4. What was the date of termination of this child's therapy? _____

5. How many times did you see this child from _____ until the termination of his/her therapy? _____

6. How many times did you see the mother of this child from _____ until the date of termination of therapy? _____

7. Briefly, for what reason(s) did termination of this child's therapy occur?

   _____

   _____

8. Please complete the following ratings regarding the three primary treatment goals you enumerated for this child and for his/her mother last year. Evaluate the attainment of these goals at the present if you are still seeing this child in treatment, or at the time of termination if therapy with this child has been terminated.

Treatment Goals for Child

1. _____

This goal was				
Not Attained	Slightly Attained	Moderately Attained	Largely Attained	Wholly Attained

2. _____

Not Attained	Slightly Attained	Moderately Attained	Largely Attained	Wholly Attained

T#: _____

Info. 2, p. 2

3. _____

Not Attained | Slightly Attained | Moderately Attained | Largely Attained | Wholly Attained

Treatment Goals Re Mother

1. _____

Not Attained | Slightly Attained | Moderately Attained | Largely Attained | Wholly Attained

2. _____

Not Attained | Slightly Attained | Moderately Attained | Largely Attained | Wholly Attained

3. _____

Not Attained | Slightly Attained | Moderately Attained | Largely Attained | Wholly Attained

9. Briefly describe any major changes in this child's life or his parents' life during the past year.

_____

_____

_____

10. Please rate the child in terms of overall degree of his/her emotional disturbance at this time (or at the time of termination if earlier.)

Extr. Severe | Very Severe | Mod. Severe | Moderate | Slight | Very Slight | Almost None

11. Please rate the mother of this child in terms of overall degree of her emotional disturbance at this time (or at the time of termination if earlier).

Extr. Severe | Very Severe | Mod. Severe | Moderate | Slight | Very Slight | Almost None

12. Regarding your work overall with this child over the past year (or until termination if earlier, do you feel:

Very Dissat. | Moderately Dissat. | Slightly Dissat. | Neither Dissat. nor Sat. | Slightly Satisfd. | Moderately Satisfd. | Very Satsfd.

T#: _____

Info. 2, p.3

13. Regarding your work overall with this child's mother over the past year (or until termination, if earlier) do you feel:

Very Dissat.	Moderately Dissat.	Slightly Dissat.	Neither Dissat. nor Sat.	Slightly Satsfd.	Moderately Satsfd	Very Satsfd.

If you would like to receive a summary of my research findings in connection with this study please check here:

_____

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