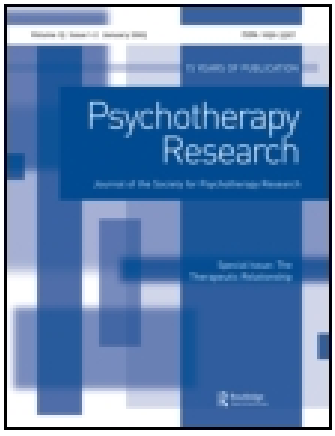

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Types of countertransference dynamics: An exploration of their impact on the client-therapist relationship

Orya Tishby[a] & Hadas Wiseman[b]
[a] Psychology, Hebrew University, Jerusalem, Israel
[b] Counseling and Human Development, University of Haifa, Haifa, Israel
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Types of countertransference dynamics: An exploration of their impact on the client-therapist relationship

ORYA TISHBY[1], & HADAS WISEMAN[2]

[1]*Psychology, Hebrew University, Jerusalem, Israel &* [2]*Counseling and Human Development, University of Haifa, Haifa, Israel*

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Abstract
Objective: The purpose of this study was to develop a typology of countertransference (CT) based on therapists' narratives about their parents and their clients. **Method:** Data are based on interviews conducted in the early, middle and late phases of ongoing psychodynamic psychotherapy with five therapists who treated 12 clients. Narratives were analyzed using the Core Conflictual Relationship Theme Method (CCRT). CT was defined as repetition of CCRT components from therapists' relationship with their parents in their narratives with their clients. **Results:** Raters identified five types of CT in the narratives: Wish from parent transferred to client, Projection of the parent Response from Other (RO) to client, Repetition of the Response of Self (RS), Repeating the negative parent RO, and Repair of the parent RO. **Conclusions:** A preliminary analysis of two psychodynamic therapies, one with good outcome and one with poor outcome, showed that CT types could be reliably rated.

Keywords: alliance; process research; psychoanalytic/psychodynamic therapy

The distinction between "treatment method" and "therapy relationship" is gradually receding, in part because recent studies have pointed to the complex reciprocal relationship between them (Lingiardi, Colli, Gentile, & Tanzilli, 2011; Norcross & Lambert, 2011; Safran & Muran, 2011; Tryon & Winograd, 2011). Whereas in the past the relationship was considered significant mainly in psychodynamic and humanistic-experiential therapies, it is now considered central to the therapeutic process across different types of therapy. One of the conclusions of the second APA task force on evidence-based psychotherapy relationships is that "the therapy relationship acts in concert with treatment methods, client characteristics and practitioner qualities in determining effectiveness" (Norcross & Wampold, 2011). One component of the therapeutic relationship which has been studied extensively is the alliance. A recent meta-analysis has shown that alliance is predictive of outcome regardless of the type of treatment employed (Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012). The same study suggests that therapists' contributions to the quality of the alliance are critical. This finding is in line with one of the recommendations of the APA task force, that researchers employ methodologies that can be used to disentangle therapist and client contributions to the relationship, and ultimately to outcome. One of these therapist contributions is countertransference management, which the APA task force on Empirically Supported Therapy Relationships judged to be a "promising" element in psychotherapy research although there is currently insufficient research to judge its impact on therapy (Norcross & Wampold, 2011).

Countertransference (CT) has gained prominence in the literature on psychotherapy, and is considered central in the client-therapist relational matrix (Gabbard, 2001). Although it originated in psychoanalysis, CT is currently considered a pantheoretical construct, as "therapists of all persuasions have soft spots that can be and are touched upon in their work" (Gelso & Hayes, 2007, p. 49). However,

Correpondece : Orya Tishby, Department of Psychology, Hebrew University, Mt. Scopus, Jerusalem, Israel. Email: orya.tishby@mail.huji.ac.il

research on countertransference has lagged behind, due to difficulties both in defining and operationalizing such a complex construct. Various schools of psychoanalytic psychotherapy have defined countertransference somewhat differently, ranging from the narrow classical view of countertransference as an unconscious, conflict-based response to the client's transference, to the totalistic view that includes *all* of the therapist's feelings, thoughts and behaviors towards the client (for a review of the definitions of CT, see Hayes, 2004; Hayes, Gelso & Hummel, 2011). Gelso and Hayes (2007) proposed an integrative conceptualization of CT, defined as therapists' reactions to clients based on their unresolved conflicts. These reactions may be conscious or unconscious, *triggered by client transference* or other phenomena. This definition retains the classical view of therapists' unresolved conflicts as the source of countertransference. However, it also fits with a modern relational view that defines countertransference as a combination of the therapist's own dynamics invoked by the client and the interaction between client and therapist (Mitchell, 1993). In the present study we used the integrative definition described above (Gelso & Hayes, 2007), which has served as the basis for most of the research in this area (Fauth, 2006).

In terms of operationalizing countertransference, we have found Hayes's (2004) operational model of countertransference to be the most useful in delineating the various aspects of countertransference. Hayes breaks it down into five components: *Origins*—those areas of unresolved conflict in the therapist from which countertransference reactions stem; *Triggers*—therapy-related events that touch on these conflicts, such as client transference, certain content areas discussed by the client, or the phase of therapy (e.g., termination); *Manifestations*—affective, cognitive, behavioral and visceral reactions that therapists experience (e.g., avoidance behaviors, over-involvement with clients); *Effects*—consequences of these reactions on the quality of the therapy process and outcome; and *Management*—the ability to deal with and minimize the negative impact of countertransference (e.g., how therapists deal with their anger, or anxiety and the degree of self-awareness in sessions).

Measuring CT Manifestations and Management

Most research to date has focused on identifying and classifying *manifestations of countertransference* and *countertransference management*, and linking them to client outcome. These manifestations include cognitive, affective, and behavioral responses to client material or to the relationship, and can be measured by self-report or observer ratings, in the lab, or in the field. One of the most well-validated measures of *CT manifestations* is the Avoidance Index (Bandura, Lipsher, & Miller, 1960), which is an observer-rated, trans-theoretical scale. The scale categorizes therapists' responses as approach or avoidance, where avoidance is indicative of countertransference. In a study by Hayes and Gelso (1993), therapists' homophobia was directly related to their avoidance behavior in response to a videotaped vignette of gay clients. Although the scale taps into CT reactions, it has several shortcomings. In particular, reports of scale reliability across different studies have been inconsistent (Fauth, 2006), and the scale categories may not identify a wider variety of countertransference manifestations. For instance, there is no way to rate the approach as CT when there is over-involvement.

Several other measures have been developed that assess feelings, thoughts, and behaviors that arise from countertransference. Betan, Heim, Zittel Conklin, and Westen (2005) devised the Countertransference Questionnaire, a self- report measure that can be used by clinicians from different theoretical orientations. The questionnaire consists of 79 items that assess a range of thoughts, feelings, and behaviors expressed by therapists towards their clients. Some items describe specific feelings, such as: "I get bored in the sessions" or complex feelings, such as "I feel like I've been pulled into things that I didn't realize until after the session was over." Items are grouped into eight factors, such as "feeling disengaged," or "feeling/acting parental and protective," or "feeling sexual." Using this questionnaire the authors identified characteristic CT responses to clients with different personality disorders. Another self-report measure, The Feelings Checklist (Holmqvist, 2001), contains 48 feeling words, which therapists rate on a scale of 0 to 3 following each session. Similar to the results reported by Betan et al. (2005), the Feeling Checklist was shown to correspond to different diagnostic groups, thus indicating that different types of clients evoke typical feelings in their therapists. In a study conducted with nine therapists and 28 clients, Holmqvist (2001) found that, overall, different therapists had distinct feeling patterns that were quite consistent over time and across different clients (i.e., therapist-specific countertransference pattern). However, within each therapist's rather stable and unique emotional universe, different clients, some consistently and some occasionally, evoked different patterns of reactions (i.e., client-specific countertransference). These two measures assess totalistic CT, and do not assess CT as an integrative measure.

One of the limitations of the measures described above is their reliance on therapist self-reports to measure CT. In order to assess CT more objectively, additional measures have been developed that also include the supervisor's perspective on CT. Hayes, Riker, and Ingram (1997) developed the CT Index, a single-item Likert-type scale indicating the degree to which supervisors felt that CT influenced therapists' in-session behavior. However, the fact that this is a single-item scale, and global in nature, limits its usage. A more robust supervisor measure of CT is the Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000). The scale consists of 21 Likert-type items rated from 1 to 5 and contains two subscales that have a positive or negative valence. An example of a positive item is "enmeshed," "overly supportive," or "dependent therapist behavior." Examples of negative items include "punitive," "avoidant," or "aggressive therapist behaviors." The scale has adequate reliability (alpha = .83 for the total score) and has demonstrated concurrent validity with the CT Index and the Countertransference Factors Inventory (described below). The CT Behavior Measure (CBM; Mohr, Gelso, & Hill, 2005) is another measure that contains items reflecting CT behavior that is dominant, hostile or distant. A more recent measure assesses CT as prototypes (Hofsess & Tracy, 2010), and shows good rater agreement on identifying CT behaviors versus non-CT behaviors in the session.

In terms of *CT management*, the most widely used instrument is the Countertransference Factors Inventory (CFI; Van Wagoner, Gelso, Hayes, & Diemer, 1991), and its revised version, CFI-R (Gelso, Latts, Gomez, & Fassinger, 2002). The CFI contains 50 items tapping therapist characteristics theorized to facilitate CT management in general. It contains five subscales reflecting therapist attributes that are important to successful CT management: self-insight, self-integration, anxiety management, empathy, and conceptualizing ability (Fauth, 2006; Hayes et al., 2011). In a recent meta-analysis based on 10 studies, Hayes et al. (2011) reported a strong and significant relationship (r = .56, p = .000) between CT *management* and therapy outcome.

Countertransference and outcome. There is a limited amount of research that links CT to therapy outcome. Rosenberger and Hayes (2002), in an analysis of a single therapy dyad, showed that when the client talked about topics related to the therapist's unresolved conflicts (based on a pre-treatment interview), the therapist was less avoidant and the working alliance was stronger. However, the more frequently clients discussed such issues, the more therapists perceived the sessions as shallow, and themselves as less attractive or less expert. In another study, consisting of 50 therapists and their supervisors, both positive and negative CT appeared to be associated with weaker alliances, (Ligiero & Gelso, 2002). In a study of 20 counseling psychology doctoral students (Hayes et al., 1997), supervisors examined 20 cases of brief therapy, rating each session for CT on the Countertransference Index. In the less successful cases there was a strong negative relationship between CT and outcome, whereas for the successful cases no relationship between CT and outcome was found. Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) interviewed 12 therapists about their experiences with impasses that led to termination. Interviews were analyzed using Consensual Qualitative Research Methodology. Among the variables contributing to impasses were possible therapist mistakes and therapists' personal issues.

Using the CCRT Method to Study the Origins of Countertransference

Our review of the measures of CT points to a lacuna in the study of CT, given that the measures described above pertain to *manifestations* of the conflict, but very little research has been conducted on the *origins* of CT, and how they are triggered in psychotherapy. As Hayes (2004) emphasized within the integrative conceptualization of CT: "to study countertransference meaningfully one needs to be confident that therapist reactions stem from areas of personal conflict" (p. 32). Gelso and Hayes (2007) formulated the countertransference interaction hypothesis, which states that countertransference reflects the interaction between Origins and Triggers: "Each therapist needs to reflect upon what client material or attributes trigger his or her own conflicts and vulnerabilities as a basic step in managing countertransference" (p. 44).

The present study focused on developing a method to identify the origins of CT based on applying the Core Conflictual Relationship Theme Method (CCRT; Luborsky & Crits-Christoph, 1998), which was originally developed to study transference. A person's CCRT consists of three basic components: *Wish* (W), the *Response from Other* (RO), and *the Response of Self* (RS). The Wish component refers to a wish, desire, or intention that the person has towards the other (e.g., to be loved, to be assertive); the RO refers to an actual, anticipated, or fantasized response from the other (e.g., supportive, disapproving); and the RS refers to the person's anticipated or fantasized response of the self in the form of thoughts, emotions, behaviors, or symptoms (e.g., feels accepted, depressed). The three components of the CCRT are derived from relationship episodes (REs), which are

narratives that subjects tell about specific interactions with significant others. In addition to their specific content, the RO and RS can be rated as negative or positive, and the relationship between the three components is rated as complementary or conflictual. The first study to apply the CCRT method to study countertransference was conducted by Tishby and Vered (2011). The method was tested with 12 therapists treating adolescents. They were asked to relate narratives about their parents, and about two of their clients. The interviews were conducted at one time point, approximately in the middle of treatment. The findings showed that all three components of the therapists' CCRTs with their parents (W, RO, and RS) appeared in their narratives about their two clients. However, the parental themes were expressed somewhat differently with each of their clients; namely, different parent ROs appeared with each of the clients, suggesting that countertransference is created both by therapists' personal issues and client triggers. Based on a content analysis of the types of repetition of the CCRT components in the relational episodes with the therapists' parents in the relational episodes with their clients Tishby and Vered (2011) identified four types of countertransference dynamics. These types appeared to link "origins" and "triggers" with countertransference manifestations. The four types were: Identifying with the client RS; Repeating the parent RO; Repairing the parent RO; and Withdrawing.

The Present Study

Based on the encouraging findings of Tishby and Vered (2011), the goal of this study was twofold: (i) To refine and further develop the classification of CT types using the therapist's CCRT with their parents and with their clients in a systematic manner at three different phases of therapy. (ii) To examine in depth the CT types and how they evolve in relation to self-report alliance, session evaluation, and outcome, during one year of psychodynamic psychotherapy. Towards the first goal we studied the countertransference types in 12 cases, in the course of 1 year of psychodynamic psychotherapy (see Method section). To examine CT types therapists were interviewed at the same three time points (early, middle, and late in therapy), rather than at one random point, as was done in the Tishby and Vered (2011) study. Towards the second goal two cases were chosen for in-depth analysis of the types of CT dynamics. Through these cases we will illustrate the CT dynamics over time and their relation to measures of alliance, and post-session measures from client and therapist perspectives and client outcome.

Method

Participants

Twelve cases were selected from a sample of 67 clients who took part in a study conducted in a large university counseling center (Wiseman & Tishby, 2011, 2014). The 12 clients were treated by five therapists, each treating more than one client (except one therapist who at the time had only one client in the study). These cases were chosen to represent successful and less successful outcomes (on the OQ-45): seven cases showed clinically significant change, whereas five cases showed little improvement that was not clinically significant.

Clients. RAP interviews of 10 female clients and two male clients were selected for this study. The clients were undergraduate students in a large university, ranging in age from 20 to 26. They were diagnosed with either mild depression and/or anxiety, presented with difficulties in relationships, with their academic studies, or in consolidating their identity as young adults.

Therapists. The five therapists were clinical psychology interns with 2–5 years of experience, with an age range of 29–32 (four women, one man). They all received weekly individual supervision and group supervision in psychodynamic psychotherapy. The therapists who agreed to participate in the study were told that this is a study on interpersonal relationships and process in psychodynamic therapy. The terms "transference" and "countertransference" were not mentioned, and the therapists were blind to our research hypotheses and questions.

Therapy. Clients were seen once a week for 50 minutes, in psychodynamic psychotherapy, based mainly on object relations (Winnicott, 1971) and relational psychotherapy (Aron, 1996; Mitchell, 1993). The therapy in the counseling center is usually a year long, but in some cases it is extended. In all the cases in this study data were collected up to session 32.

Measures

Core Conflictual Relationship Theme (CCRT) method. The Relationship Anecdote Paradigm (RAP) interview (Luborsky & Crits-Christoph, 1998) was employed to assess clients' and therapists' interpersonal patterns. The therapists were interviewed about relationships with significant others in which they were asked to describe meaningful interactions (Relationship Episodes = RE) with each of the following significant others: Parents (four REs,

two for each parent), romantic partner or close friend (three REs). In addition, the therapists were asked to relate relationship episodes (three REs) about their clients who participated in the study, but were interviewed by a different interviewer (Wiseman & Tishby, 2011). The initial RAP interview with the therapists consisted of 10 Relationship episodes (parents, romantic partner and client) and lasted approximately 45 minutes. It was conducted early in the course of therapy (after session 5). In order to assess the relational dynamics from the therapists' perspective over time, the therapists participated in two additional RAP interviews in which in each they were to relate narratives (three REs) about the interactions with their clients in the middle and later points of therapy (after sessions 15 and 28, respectively). All three RAP interviews were audio-recorded and transcribed verbatim. A group of graduate students in clinical psychology, trained by the second author, rated the therapist episodes on the Hebrew version of the CCRT rating form, which has an adequate reliability coefficient (Wiseman, Metzl, & Barber, 2006).

Self-Report Questionnaires

The self-report questionnaires for the present study included the OQ-45, the Working Alliance Inventory completed by clients and therapists (WAI-C and WAI-T), the Session Evaluation Questionnaire (SEQ), and a Post Session Questionnaire completed by clients and therapists.

Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996). This is a 45-item self-report instrument designed for repeated measurement of client changes occurring throughout the course of mental health treatments. Clients are asked to rate their functioning in the past week on a 5-point Likert scale, from 0 (never) to 4 (almost always). The OQ-45 consists of three subscales: Symptom Distress, Interpersonal Problems, and Social Role. Research has indicated that the OQ-45 has adequate test-retest reliability (.84) and high internal consistency (.93). Concurrent validity has been demonstrated with a wide variety of self-report scales (e.g., Beck Depression Inventory, State-Trait Anxiety Inventory). The OQ-45 is widely used in university counseling centers and mental health centers. The total distress score has been found to be sensitive to change in counselling center clients (Vermeersch et al., 2004). The OQ-45 has been translated into several languages, including Hebrew (Gross et al., in press). In the present study, the alpha coefficient of the total OQ-45 was .91. Clients completed the OQ-45 at intake and after sessions 5, 15, 28, and 32.

Working Alliance Inventory: Client and Therapist versions. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is a widely used 36-item self-report questionnaire that was developed based on Bordin's (1979, 1994) conceptualization of the alliance, and consists of three subscales: Bond, Task, and Goal. Each item is rated on a 7-point Likert scale. The psychometric properties of the WAI are well established (Horvath, 1994). A Hebrew version of the scale yielded high alpha coefficients (Wiseman, Markiewitz, & Berman, 2006). In the present study the WAI alpha coefficients were .87 and .92, for clients and therapists respectively.

Session Evaluation Questionnaire (SEQ; Stiles, 1980). This included the Depth and Smoothness scales of the SEQ. The alpha coefficients for the SEQ were .85 and .75 for depth and .78 and .85 for smoothness for clients and therapists respectively.

Client and Therapist Post-session Questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 1991). The PSQ is a self-report questionnaire that is used to assess post-session outcomes. We used the PSQ rupture and repair items, which were translated into Hebrew for the purpose of this study. For two cases, we report the ratings on the following four items: "Did you experience any problems or tensions in your relationship with the therapist/patient during the session?" (PSQ1); "Please rate the highest degree of tension you felt during the session as result of this problem" (PSQ3): "To what extent was this problem addressed in this session?" (PSQ5); and "To what extent do you feel this problem was resolved by the end of the session?" (PSQ6) (Samstag, Batchelder, Muran, Safran, & Winston, 1998, Appendix A).

Procedure for Identifying the CT Types

Two clinical psychologists (the first author, a senior clinical psychologist and supervisor, and a post-doctoral clinical psychologist) worked independently to identify repetition of parent CCRT components in the narratives of therapists about their relationship with their clients. The raters were provided with two kinds of material: (i) RAP interviews of the 12 therapists, which included relationship episodes about their parents (four REs) and about a specific client at three time points (total of nine REs, three for each time point); (ii) the completed CCRT ratings of these relationship episodes (W, RO, and RS for each RE with parents and with the client). These CCRT ratings were done by a different group of independent raters (four graduate clinical

psychology students) at another university. The narratives with romantic partners were not used in this procedure. The process of identification of the CT types consisted of three steps.

Step 1: Each rater worked independently to identify similar CCRT components (Wishes, Responses of Other, and Responses of Self) in the therapists' relational patterns with their parents and with each of their clients. To be considered as similar, the rated W, RO, and RS with the parent and with the client had to belong to the same CCRT cluster standard category (Edition 3; Barber, Crits-Christoph, & Luborsky, 1998). For example, wishes such as to be loved, to be understood, and to be respected are all part of the cluster "to be loved and understood." The responses from other, which include hurt, dependent, anxious and angry, are all part of the cluster "other is hurt and angry." The responses of self, such as feeling comfortable, feeling loved, and feeling happy, are all part of the cluster "Feeling accepted and respected." In order to identify CT types, raters used the four types in the Tishby and Vered (2011) study as a starting point, examining whether or not these types applied to the data, and looking for additional CT types. On the basis of similarities between the CCRT with parents and clients in the first four cases, the two raters identified the following CT types: Transferring the Wish from parent to client, Projecting the parent RO to the client, repetition of the RS, and repetition of the parent RO. The first three types were new, and stemmed from the data. The fourth was found in data, confirming one of the types in Tishby and Vered. A fifth type was also identified, based on Tishby and Vered: When the therapist's Response of Self to the client was the *opposite* of their own parents' negative RO, raters classified this CT type as "Repair of the parent RO." For instance, if the therapist's parent RO was "misunderstanding" or "distant," the "repair" was the therapist's Response of Self to the client as "understanding" or "close." After rating the first four cases, and identifying five CT types, the raters consulted together with an auditor (the second author), and reviewed and consolidated the CT types and their definitions. The CT type "withdrawal" from Tishby and Vered was re-considered and re-defined as a specific case of repetition of RS (i.e., I withdraw), or of the RO (other withdraws), rather than a separate type of CT. The end product of this process was the definition of each of the five CT types. Compared to the CT types initially suggested by Tishby and Vered (2011) two types were retained (Repeating the negative parent RO and Repair of the parent RO) and three new types were identified.

Step 2: The remaining eight cases were analyzed according to the five CT types. Raters met to discuss differences or uncertainties they had about the rating of specific CT types. After completing the ratings of all 12 cases, the types in these cases were reviewed and discussed with the audit. This led to further refinement of the definitions of each of the five types.

Step 3: The final and third step involved counting the recurrence of each CT type in the 12 cases.

Results

Countertransference Types and their Recurrence

The analysis of the 12 cases following the first two steps described above led to the final list of CT types. Each of the five CT types includes a repetition of CCRT components (W or RO or RS) from the therapist's relationship with his or her parents in the CCRT components with his or her client. Table I presents the definitions for each of the five CT types accompanied by an example that illustrates the repetition that corresponds to the type of CT. The recurrence of each CT type in the 12 cases was identified on the basis of the ratings of CT types in the Relationship Episodes of therapists with their clients at the three time points. In order for a CT type to be counted as a recurrence, it had to be identified at two different time points (out of three), and within each time point to be identified in at least two (out of three) relationship episodes. Table II presents the frequency of the five CT types across the 12 cases for the five therapists in relation to each of the clients who were part of the present study. As can be seen in Table II, the most frequent CT types were Transferring the Wish from Parent to Client (in all 12 cases) and Projection of the Parent RO to the client (in 11 out of 12 cases). The CT type with the lowest frequency was Repair of the Parent RO, which appeared in half of the cases (six cases out of 12). In addition, as can be seen in Table II, there was variability in CT types across cases, showing that there were different patterns of CT for different therapists and clients. For example, Therapist 1 and therapist 4 had all five types across their caseloads, and therapist 2 and therapist 5 had three types out of five, and therapist 3 had four types out of five.

In-Depth Analysis of Two Therapist-Client Dyads: CT Types, Alliance, Post-Session and Outcome

To illustrate the five countertransference types and how they can be related to post-session processes and outcomes, we present two different cases selected from the sample of 12 cases. The cases were selected based on the quantitative data, which showed that one

Table I. Countertransference types

CT type	Definition
1) Wish from parent transferred to client	Therapist's wish from his/her parents is repeated in his/her relationship with his clients.
***Example*:** *The therapist's wish from her parents is **not to hurt them, and to calm their distress**. In an RE about her father, she tells how she called her father every day while she was abroad, so that he would not be anxious. In an RE about the client, she describes the client's concerns about people abandoning her, wondering whether the therapist will also abandon her in a year or two. The therapist says: "I immediately **wanted to calm her** and say that I am not leaving yet …. These are the places that pull me in: **I need to guard her and calm her.**"*	
2) Projection of the parent RO on the client	Therapist perceiving the client's response to him/her in a similar way to his perception of the parent RO.
***Example*:** *Therapist perceives his father as a reticent man with difficulty expressing his feelings or opening up to others. In his RE about a female client he describes a session which takes place on the day that she moved out of her parent's house to her own apartment. She was confused, was not sure what to talk about, and asked the therapist to be more active. The therapist **then perceived her as cold and emotionally distant**, wondering if they were not able to talk anymore.*	
3) Repetition of the RS	The therapist's response to the client (emotional, cognitive or verbal) is similar to his/her characteristic response to his/her parents.
***Example*:** *The therapist feels misunderstood by her parents, and feels that they don't really accept her. Her characteristic RS with her parents is "feeling hurt" and "feeling rejected". When she recounts her initial session with a client, she describes the client as looking surprised to see her, and then saying that she is feeling angry. The therapist felt that these words were directed at her. She **immediately felt terribly hurt**, without taking the time to explore the reasons for the client's anger. She said: It was very strong, and I immediately projected it on myself, that she is angry to see me. I don't really know what was going on, but I was hurt. I took it personally, even though she was talking about more general things in her life."*	
4) Repeating the (negative) parent RO	The therapist's response to the client (RS) is the same as his parents' negative response to him.
***Example*:** *The therapist's father tends to worry a great deal, and the therapist describes how, as a girl, she was overwhelmed by his worries and later learned to sooth his anxieties. In her RE about her client she says: "She told me about some things that she does, **which made me very very very worried**. I told her that **I worried about her**, that is **I disclosed my worry**. I think she knew that what she was doing would make me worried, but she was not really concerned about it. Perhaps she even wanted me to worry, but maybe I am making an inference here…."*	
5) Repair of the (negative) parent RO	The therapist's response to the client (RS) appears to be an attempt to **correct** his own parents' negative response to him.
***Example*:** *The therapist perceived her parents (Parent RO) as controlling and not attuned to her emotional needs. Furthermore, she described them as becoming angry when her emotional needs conflicted with their work schedule. In her RE about the client she described the difficulty in finding a fixed time for therapy sessions with a new client. The client asked to reschedule several times, because she had other activities, and the therapist said: I felt that she needed space in order to enter therapy, and I wanted to give it to her. **I didn't feel angry**, as I might have with other clients.*	

client (dyad A1 in Table I) terminated treatment unilaterally after 28 sessions, with her outcome measures still in the clinical range (see Table III). Throughout her treatment this client's alliance ratings were lower than her therapist's ratings of the alliance (dyad A1 in Table IV). The second client (dyad B2 in Table I) made substantial gains in therapy, and had one of the best outcomes in the study. She maintained a strong and steady alliance throughout therapy, exceeding the sample mean from both client and

Table II. Frequency of countertransference types in 12 cases of psychodynamic psychotherapy

Cases	Wish from Parent transferred to client	Projection of Parent RO to client	Repetition of the RS (parent to client)	Repeating the (negative) parent RO	Repair of the (negative) parent RO	Total CT types per case
A1 Case A	V	V	V	——	V	4
A2	V	V	V	——	V	4
B1	V	V	V	V	——	4
B2 Case B	V	V	V	——	V	4
B3	V	V	V	V	V	5
B4	V	V	V	V	——	4
C1	V	V	V	V	——	4
C2	V	V	——	V	V	4
C3	V	V	V	V	——	4
D1	V	V	——	——	——	2
D2	V	V	V	——	——	3
E1	V	——	——	V	V	3
Sum	12	11	9	7	6	

Table III. OQ-45 scores for two cases over time: Intake, early, middle, and late therapy

	Intake	Time 1	Time 2	Time 3	Time 4	Gain for longest time span
Client A1	89	79	75	75	NA	0.347
Client B2	82	52	62	59	35	−1.13

Note. A negative gain value signifies improvement.

therapist perspectives (dyad B2 in Table IV). Relevant ratings of rupture and repair drawn from the PSQ are incorporated in the presentation of each dyad over time (early, middle, and late therapy sessions). In describing each case we present information about the client, including a brief description of the client's CCRT as identified separately as a context for the therapist-client relationship and dynamics that evolved with the client. After presenting the therapist's CCRT with parents we illustrate the CT types with the client over time in the three phases of therapy.

Case Example of a Therapist-Client Dyad with a Weaker Alliance and Outcome

Client (case A1). A 29-year-old female graduate student, whose presenting problems, included a general sense of anxiety and feeling insecure and difficulty forming intimate relationships. Her OQ-45 score at intake was 89 (see A1 in Table III). The client's CCRT with her parents was the following: She wished to have her needs and feelings recognized and validated (W), perceived her parents as rational, not supportive, and at times blaming (RO), and her response of self was feeling angry, hurt and alone (RS).

Therapist A. A 32-year-old married female with 3 years of clinical experience. The analysis of her CCRT with her parents showed that her primary wishes were to be close, not to be abandoned. However, she also wished to oppose the other (let her voice be heard) and at the same time not to hurt the other (W). She perceived her parents as misunderstanding her, angry and controlling and also anxious and helpless (RO). Her response of self with them was to feel helpless, angry, guilty or disappointed (RS). These themes are manifested in the following relationship episode:

> I was 5 years old, and my parents dressed me up as Peter Pan for a costume party in kindergarten. I really didn't want to wear that costume. I objected and I cried. My father took me to preschool with the costume, and he sort of pushed me in forcefully … and I continued to object. He was probably stressed about getting to work on time. It was unpleasant. He wanted to get it over with, wanted me to stop crying and go inside. I felt angry and helpless. You can't really decide anything when you are 5 years old.

Table IV. Working alliance scores for the two cases over time: Early, middle, and late

Therapist/client	Time 1	Time 2	Time 3	Gain T1–T3
Client A1	4.67	4.78	4.03	−1.96
Therapist A1	5.47	5.22	4.81	−1.08
Client B2	5.81	6.47	6.08	0.32
Therapist B2	4.89	5.53	5.43	0.36

Note. A negative gain value signifies deterioration.

CT Types During Psychotherapy (dyad A1)

Early therapy (session 5). The CT types were: Transfer of the wish from the parent, repetition of the parent RO, and particularly repair of the parent RO, which appeared in all three relationship episodes. *Transfer of Wish*: The wish to be close was predominant in all three REs. The therapist emphasizes this wish to be close to her client over and over again throughout her RAP interview. *Repetition of the Parent RO*: She perceives the client as anxious and vulnerable, similar to the way she perceived her mother. The therapist relates to her client's experiences as extremely painful, even when these events seem no more than ordinary frustrating events. For example, the client tells about her disappointment when she received a grade of 92 on a paper that she worked very hard on. The therapist described the patient as being in acute distress, repeating over and over again how hard this situation was. *Repair of the Parent RO*: The therapist perceived her parents as not supportive and not attuned to her emotional needs. In all three episodes about the client the therapist seems to try and "repair" this pattern, by making great efforts to be attuned and not controlling with the client. For example, the client complained about the inconvenient session time, even though the therapist tried to be flexible and change the hour to suit the client's needs. The therapist said: "I felt that I cannot push her … It's not easy getting into therapy and she must have had mixed feelings about it. I had to give her some space, leave it open and I did *not* tell her: 'look, this is your hour and you have to make it work.' I felt that she needed the space and I could give it to her, and I wanted to give it to her. I mean, it didn't annoy me." This episode "echoes" the episode with her father described above, where she was pushed into kindergarten and

her father was annoyed with her. At this time point the therapist's CT seems to respond to the client's needs to be supported, and the therapist is certainly not blaming, unlike the client's parents.

WAI, PSQ and OQ at session 5. At the end of five sessions, there was a 10-point decrease from the intake in her OQ-45 scores (Table III). The therapist's rating of the WAI was higher than the client's rating (Table IV), which is the reverse pattern of what is usually found (i.e., therapists rate the alliance lower than clients). Both client and therapist rated the session as deep and quite smooth; however, the therapist's ratings of depth were higher (Table V). Neither therapist nor the client indicated any tension in the alliance on the rupture and repair items.

Mid therapy (following session 15). The CT types in this phase were: Transfer of the Wish from parent to client, and Repair of the Parent RO. The transfer of the *wish to be close and connected* continued to appear in all three REs; for example, "I can feel her pain—it's good to be so close," or "she read out loud some poems she had written in adolescence and I was really impressed. There was a moment there—an intimate connection." *Repair of the Parent RO* was apparent, as the therapist repeatedly emphasized her need to "be there" for the client, in ways that her own parents had not been able to "be there" for her. For example, the client related her difficulties with one of her professors, and the therapist, in her RE, said: "She needs an adult who will help her understand what is happening, to help her get a grip on herself. At those times I have a gut feeling that she needs someone to be there, to help her, to guide her how to talk, or how to say what she wants." The therapist is somewhat aware of her CT as she indicates to the interviewer: "How do I differentiate between her subjective reality and my own feelings?" Another example of repair was as follows: The client recalled how her mother did not want her to read detective stories as a child, and preferred that she read classical children's literature. The therapist tried hard to be a different type of parent: "I was really in touch with her pain: The child who is being told she is nagging, that she should just get a hold on herself … I also remember my own difficulties as a child with reading, and those hard feelings towards my parents." In the RAP interview the therapist described the strong maternal feelings that the client evoked in her. She described herself as easily shifting into giving advice, and being calming and soothing. It should be noted that some therapists in our study referred to countertransference spontaneously in their RAP interviews, but this was not presented as a focus of the study.

WAI, PSQ and OQ at session 15. There was no change in the client's OQ-45 scores (Table III); the working alliance ratings showed the same gap as before, in that the therapist rated the alliance somewhat higher than client (Table IV). Both therapist and client rated sessions as deep and smooth, with no tension in the relationship (Table V).

Late therapy (following session 28). Four CT types were identified: Transfer of the wish from parent to therapist, repetition of the negative parent RO, repetition of the RS, and Repair of the Parent RO. *Transfer of the Wish* was similar to what was described in the previous sections. *Repetition of the Parent RO*: The therapist talked about an episode in which she perceived the client not only as anxious, but as clearly negative towards her, similar to her perception of her parents: Out of control, doesn't like me, doesn't accept me, and doesn't trust me. However, the description of the interactions was vague and it was not clear what exactly prompted her conclusions about the client's reactions. In the last RE she related how the client announced that she was terminating unilaterally, and the announcement sounded harsh and final. The client was seen as rejecting her and as very controlling, much like her parents. Her Responses of Self at this point repeated the responses in her CCRT with her parents; namely feeling helpless, ambivalent, unloved, and guilty. The therapist talked about feeling cheated, thinking that they had a close bond and discovering that it was not that strong after all. The therapist's narrative about the interaction, concerning the client's

Table V. Session depth and smoothness scores for the two cases over time: Early, middle, and late

	Time 1		Time 2		Time 3		Gain T1-T3	
Therapist/client	Depth	Smooth	Depth	Smooth	Depth	Smooth	Depth	Smooth
Client A1	5.67	4.17	5.17	5.50	3.67	4.00	−1.16	−0.750
Therapist A1	6.67	6.17	5.67	4.83	6.33	3.17	0.995	−1.50
Client B2	6.67	3.33	6.83	5.17	6.50	4.00	1.12	−0.44
Therapist B2	5.17	4.00	6.00	3.83	5.00	4.00	−0.36	−0.20

Note. A negative gain value signifies deterioration.

decision to terminate, shows that she did not recognize or validate the client's wish to terminate (the client's Wish in her CCRT to have her needs recognized and validated). *Repair of the Parent RO*: The therapist described herself as feeling hurt and angry, but also insisting that she liked the client, and saw the termination as a move toward independence. This latter part does not seem very convincing given how hurt she was. It seems as though she was still trying to be the "good parent," accepting the client's unexpected move (while simultaneously feeling very hurt) without exploring the client's reasons for her decision.

WAI, PSQ and OQ at session 28. The client and therapist ratings of the WAI at this point dropped below the sample mean, and the client's OQ-45 score did not change from the previous time point. The client's ratings of session depth dropped whereas the therapist's ratings of depth increased, creating a gap between their ratings. Both client and therapist ratings of session smoothness dropped below the sample mean. In the PSQ, the rupture and repair items both indicated a high level of tension (PSQ3 = 4 on a 5-point scale) and both stated that the tension was addressed (PSQ5 = 5), but only partially resolved (PSQ6 = 3).

Summary of the case with a weaker alliance and outcome. Two CT types seemed to predominate throughout this therapy: The Transfer of the wish for the parents to the client that entailed a wish for closeness and connection, and a strong emphasis on Repair of the Parent RO, which was concretized by giving the client "space," constantly validating her anguish and pain, even when the events described in the RE did not seem to be very dramatic. In none of the REs did the therapist describe interventions aimed at helping the client explore or deepen her understanding of her conflicts and pain. It seemed that over and over again the therapist was making sure they were close and that she was a "better parent" than her own parents. These CT dynamics may have impeded the process by making it difficult to be attuned to the client's changing needs throughout therapy, including her need to be independent and terminate the therapy with the therapist's validation and mutual agreement.

Case Example of a Therapist-Client Dyad with a Strong Alliance and a Successful Outcome

Client (case B2). A 30-year-old graduate student who presented with mild depression and concerns over intimate relationships. Her OQ-45 score at intake was 82 (see B2 in Table III).The client's CCRT with her parents: She wished for them to be attuned to her needs and to "see her" (W). She perceived her mother as very loving and caring (positive RO), but at times she was also quite intrusive (negative RO), which made her feel angry and impatient (RS). Her father was described as very rigid and controlling (RO). However, she also felt that he loved her deeply and wanted to help and support her (positive RO) and for this she felt very grateful (RS).

Therapist B. A 28-year-old male therapist with 3 years of clinical experience. This therapist's CCRT with his parents: The main wish was to have clear, preferably verbal, proof of emotional closeness (W). The father was perceived as caring but with a limited ability for verbal emotional expression (RO). There was some emotional closeness with his mother, but the support she offered was usually associated with pragmatic tasks. She also tended to exaggerate the positive aspects of stressful situations, which he perceived as signs that she was not attuned, and did not understand (RO). His responses of self with his parents were mixed: Feeling good, self-confident, and liking the other (positive RS), or feeling anxious and misunderstood (negative RS). The following relationship episode with his father demonstrates these themes:

> I called my father because my sister-in-law had just delivered a baby. I had a new niece and my father had a new granddaughter. I was very excited and wanted to share the excitement with him. I called and asked him how he was, and he didn't say anything so I mentioned the baby, and he said "yes, that's great." He sounded happy but said very little. I asked him about the baby and the delivery, and he said that I should ask my mother because he didn't know these things. I wanted to talk, to share the feelings but he was pretty quiet, so in the end I said that we would probably meet at my brother's house and the conversation ended.

CT Types During Psychotherapy (Dyad B2)

Early therapy (session 5). The CT types in the first RAP interview were as follows: Transferring the wish from parent to client, projecting the parent RO, repeating the RS, and repeating the (negative) parent RO. *Transferring the wish from the parent*: The therapist relates that the client arrived a few minutes late, which made him very anxious. The client began to criticize one of the paintings in the room, which was the therapist's favorite painting. She also commented on the dry plants, wondering why nobody took

care of them. The therapist felt surprised and uncomfortable. He was expecting something else: A warmer and more positive encounter. The CT dynamic here is of the therapist *transferring the wish for closeness and intimacy* from the relationship with his parents to the client. *Projecting the parent RO*: The therapist described the client as distant and practical, wondering whether she was irritated with him, even though he acknowledged that her tone was not angry. The way in which he perceived her resonated with his mother's RO, which was distant and focused on practicalities. *Repeating the RS*: The therapist described himself as feeling misunderstood and not accepted, as he did with his parents. *Repair of the Parent RO*: The client asked to cancel the session, because she had several papers to write. The therapist accepted her request to skip the session but he had mixed feelings about this. He wanted to make sure that he was attuned to the client's emotional needs: Did she want his "permission" to cancel the session, or did she want to be pursued and offered a session on another day? This type of CT seems like an attempt to repair the parent RO (to be empathic and attuned to her emotional needs and not just to be practical like his own parents). Interestingly in this case, the therapist's dynamic of Repair of the RO also fit the client's main CCRT wish: To be seen and for the other to be attuned to her.

WAI, PSQ and OQ at session 5. The client's OQ-45 score decreased considerably from intake to session 5 (Table III). The working alliance ratings of both therapist and client increased above the sample mean (Table IV). On the SEQ both client and therapist rated session depth as higher than the sample means; however, their ratings of smoothness were lower, indicating that although the sessions were valuable they were not experienced as comfortable (Table V).

Mid therapy (session 15). At this time point, the therapist's Wish from the parents does not appear in any of the narratives about the client. *Projection of the Parent RO* appeared once, when the client arrived a few minutes late with a new, flattering haircut, and immediately left the room to get a drink of water. The therapist described her as distant, and interested mainly in practical issues, such as her haircut or a drink, and and not "caring" enough about the therapy process. This claim echoes his perception of his mother, who focuses on practicalities and not on the emotional process between them. However, the therapist says that he restrained himself, and did not say anything about it until later on in the session when he was able to reflect on her coming late with more empathy. Using his CT reactions as a signal to explore her behavior rather than react to it as directed toward him, he asked her whether arriving late might reflect her feelings that she did not deserve to receive therapy. He said that the client accepted the interpretation, which opened up a fruitful mutual exploration. *Repeating the RS*: In this phase, the RS responses were mostly positive, thus repeating the positive feelings that he had in his relationship with his parents (feeling good about himself and self-confident). *Repair of the parent RO*: This appeared in two episodes. In one episode the client told him that a friend's father died, and then asked him not to discuss this further. The therapist wanted to respect her request, but he also thought that her reluctance to discuss the old man's death was related to her guilt about not visiting him in the hospital. He recognized one of the client's typical conflicts: Caring for others versus caring for herself. He decided to pursue this line of interpretation, despite her request not to discuss the issue. He wanted to be a good therapist and bring up important material, but he also wanted to be sensitive to her needs and her ability to process material. His sensitivity to her needs was a repair of his father's limited ability to open up emotionally or be sensitive to his son's needs.

WAI, PSQ and OQ-45 at session 15. In this phase the client's OQ-45 continued to decrease. The client and therapist working alliance ratings increased above the sample mean and the session depth and smoothness ratings (by client and therapist) increased above the sample mean. Neither therapist nor client reported any tension in the session.

Late therapy (session 28). The CT types were: Wish from parent to client and Repair the negative parent RO. Projection of the negative parent RO appeared in only one episode. The therapist RS was mostly positive, with no Repetition of the negative RS. *Transfer of Wish from parent to client*: The client told him that she had bought a new dress, but she felt uncomfortable wearing it, because it exposed her legs too much. The therapist tried to clarify what she meant, and she burst out crying, and told him that her legs were short and chubby, and that she had always been embarrassed about exposing them. The therapist said he was touched by her expressing such intimate concerns openly with him. *Repair of the Parent RO*: The therapist described a dream that the client told him, about a male friend asking her to lay down beside him. In the dream, the client at first felt comfortable, but then she panicked and ran away. In his narrative about the client, the therapist described how he wanted to quickly connect the dream to her

ambivalence about forming a romantic relationship (and also to the transference). However, he spoke of his awareness of his own pressing need to connect deeply very quickly, as opposed to the client's need to regulate closeness and maintain privacy (see the clients' CCRT above). He told himself to slow down, and as the session progressed he gradually interpreted her fear of intimacy in relationships. Although this was painful for her, she continued collaborating with him on this issue. The therapist felt that he succeeded in being emotionally attuned to her, and was able to put his needs aside (unlike his own parents, as well as the client's parents).

WAI, PSQ and OQ-45 scores following session 28. At this time point there was a decrease in the client's OQ-45 score (Table III). There was an increase in the alliance ratings (Table IV) and both client and therapist rated the sessions as quite deep. The client's rating of session smoothness matched the therapist's ratings, which were slightly below the sample mean, which seems to be a product of the deep work (Table V). Both client and therapist reported some tension in the sessions (PSQ3 = 3), but they both indicated that they were able to discuss it and resolve it (PSQ6 = 5).

Summary in the case with a strong alliance and a successful outcome. This therapist had a strong need for emotional closeness and spontaneity; however, it also appeared that he was attuned and sensitive to his client's needs to be recognized, respected, and cared for. At the beginning of therapy, whenever the client needed some distance and privacy the therapist became tense, perceiving her as distant and reticent, thus projecting his parents' RO of distance on her. Later on in therapy this CT type was not present, indicating that perhaps he was able to overcome his anxiety and not allow his CT to influence his perceptions of the client. The narratives told by therapist B2 reflect his tolerance for frustration and his use of self-awareness and empathy. This therapist actually became more flexible throughout therapy, with less projection of the negative parent RO. The therapist's CT of Repairing the parent RO in this particular case seemed to fit the client's needs. Although there are many factors that operated in this treatment, it is possible that the change in CT types and the therapist's ability to manage his CT contributed to the success of this therapy.

Discussion

In this paper we proposed a new method of studying countertransference using relational narratives that therapists tell about their parents and their clients in the course of psychodynamic psychotherapy. These narratives are told during RAP interviews and then coded according to the CCRT method (Luborsky & Crits-Christoph, 1998). By comparing therapists' conflictual relationship patterns expressed in their narratives about their parents to the interpersonal patterns expressed in their narratives about their clients, we can identify therapists' CT dynamics that are *triggered* in their interaction with their clients. These dynamics stem from the therapists' areas of personal conflict; i.e. the "origins" of CT (Hayes, 2004). According to Gelso and Hayes (2007) researchers have long been looking for client characteristics and behaviors that trigger countertransference. However, this body of work has not proven to be very fruitful. Moreover, they point out that countertransference is a mutual process. The specific client behaviors that trigger CT depend on the particular vulnerabilities of the therapist, and not just on client characteristics. Thus, CT is a product of the interaction between client "triggers" and therapist "origins." The CT types identified in our study capture this interaction by providing a link between the client's behavior or speech (perceived by the therapist as the client RO), and the therapist's unresolved conflicts (W, RO, and RS with the parents). It this interaction between the client's responses as perceived by the therapist and the unresolved conflicts which produces CT dynamics that are *unique* to a therapeutic dyad.

Based on the in-depth analysis of the type of repetition of the CCRT components in therapists' relational narratives about parents and about their clients in the present study we defined five types of CT dynamics. Examining these five CT types in 12 cases of psychodynamic therapy showed that some types were prevalent across all therapies (such as Projecting the parent RO), whereas other types appeared only in some of the cases (e.g., Repairing the parent RO). Thus, the number of CT types and the specific types varied from one dyad to another, which supports the "countertransference interaction hypothesis" presented by Gelso and Hayes (2007). These CT types can be hindering or facilitating depending on the therapist's awareness of his or her CT, ability to use it to the client's benefit, or to manage it, as demonstrated by the intensive analysis of the two cases. This analysis constituted a preliminary attempt to identify the five types of CT in a successful case and a less successful one (assessed on the OQ-45), and to explore them in relation to therapist and client self-reports of the alliance (WAI), session depth and smoothness (SEQ), and rupture and repair (PSQ) over time.

In the less successful case (dyad A1), the CT dynamics revealed in the therapist's narratives in

early and mid-therapy were: *Transfer of the wish from parent to client*, and *Repair of the parent RO*. The therapist was highly motivated to help the client and felt very connected and close to her. The initial alliance scores were around the sample mean, and both client and therapist perceived the sessions as deep and smooth. Thus it seems that at the beginning of therapy these CT types may have facilitated the therapy process. However, from the beginning of therapy the therapist experienced the alliance as much stronger than her client did, which is the opposite of what is usually found in alliance research (Horvath, Del Re, Flückiger, & Symonds, 2011). Thus, the therapist's strong wish for closeness and the wish (conscious or unconscious) to repair her parents' RO may have colored this therapist's perceptions of the alliance, so that she was not attuned to the client's changing needs for autonomy later on in therapy. As therapy progressed, the process measures took a plunge, as both the working alliance and the client-rated session depth decreased. The PSQ items showed a rupture, in that there was tension in the session which was not resolved. In this phase the CT type *Projection of the Parent RO* appeared in all the therapist's narratives, with the therapist perceiving her client more and more like her distant and preoccupied parents. As her wish "to be close" and "not to be abandoned" transferred from her parents to her client, and as the client's RO was perceived as distant, the therapist became less and less attuned to her client's relational needs (to recognize and validate her need for autonomy). What was facilitative at the initial phase of therapy became hindering at this phase. The rupture in the collaboration was evident by the disparity between the therapist's and client's WAI ratings of the alliance, which was apparent throughout therapy. At the later stage of therapy the therapist was motivated by CT that had not been processed and her lack of awareness of it was expressed in that she was surprised and hurt by her client's announcement of termination. This seems to have interfered with the therapist's ability to explore the client's reasons for wanting to end therapy and to process the termination (Joyce, Piper, Ogrodniczuk, & Klein, 2007).

In the successful case (dyad B2) the CT dynamic of *transferring the wish from the parent* was also predominant, as the therapist wished for immediate intimacy with his client. However, this wish was mostly facilitative as it helped build the client-therapist bond and closeness in the sessions. Moreover, based on the therapist's narratives over time there was a gradual shift in his response to this dynamic, indicating his ability to manage his CT (Gelso & Hayes, 2007). At first the therapist expected the client to initiate intimacy, and withdrew when she seemed too cold (similar to the CCRT pattern with parents: Projecting the parent RO and Repeating the RS). In the course of therapy he became more flexible, and suppressed his natural tendency to withdraw. Instead, he invited the client in a sensitive manner to explore her feelings, as seen in the "new dress episode." Thus, the therapist was capable of using the CT in a way that was facilitative to the process, by working collaboratively with the client. The CT type *repairing the parent RO* was prevalent, but not as dominant as in the less successful case. In addition, when this therapist tried to "repair" he was cautious, and careful not to force his needs for closeness on the client and to be attuned to what she needed from him at this time. This therapist, unlike the therapist in dyad A1, was able to contain his CT and to withhold or delay responses based on his CT, until the timing seemed right. As a result, he may actually have been able to "repair" both for himself (being more spontaneous and intimate) and for the client (she was seen and heard). The therapist's growth and change over the course of therapy is an important aspect of the collaborative process (Wiseman, Tishby, & Barber, 2012), and has been described by several writers in the relational analytic literature (Maroda, 1991; Muran, 2002).

Our initial conclusion from the exploration of these five types of CT dynamics and the ways in which they facilitated or hindered processes over the course of psychodynamic psychotherapy suggests that CT types are not hindering or facilitating in and of themselves. The interpersonal context and the therapist's management of the CT dynamics play an important role in the impact of CT on process and outcome. The CT dynamics that constitute repetition of a conflictual negative pattern (*transferring the wish*, *projection of parent RO*, *therapist as parent RO*, and *Repeating the RS*) may have a potential for hindering, if not processed and held in check. However, with careful attention, as was the case for the therapist in the successful outcome, these CT dynamics can also provide important clues about the client's emotional states, and lead to useful interventions. This therapist's sensitivity to ambivalence around issues of closeness in relationships (depicted in his "origins"—projection of the distant parent RO) alerted him to his client's ambivalence and guilt about receiving therapy in the middle phase of her treatment. This type of relational process fits with the modern relational view of enactment in therapy, and the role of the therapist's CT in those enactments (Safran, 2002).

The CT dynamic *Repair of the parent RO*, if it does not predominate, as in the less successful case (dyad A1), can be facilitative to the process. This seems to be

the case especially if the therapist's need to "repair" resonates with the kind of repair that a particular client needs. When "repair" was successful, it seemed to contribute to a "corrective emotional experience" (Castonguay & Hill, 2012) for both participants. Such potentially corrective processes were illustrated in both cases, for example, when therapist A provided "space" for her client at the beginning of psychotherapy (dyad A1), or therapist B's work with his client's dream about intimacy. However, when the "pull" to repair appeared to operate at the expense of attunement to client needs, as in the case of the therapist in dyad A1 during the late phase of therapy, it hindered progress and possibly contributed to the client's initiated termination.

Limitations of the Study and Recommendations for Future Research

The analyses presented in this paper constitute a first step towards developing a typology of CT. Our initial experience in classifying these types seems promising, as they are relatively easy to identify and appear to provide useful clinical information. Because the systematic identification of CT dynamics was based on 12 cases, and complements a previous study of CT with adolescents (Tishby & Vered, 2011), we believe that analyzing additional cases might lead to refining the CT types and perhaps identifying additional types. Our study was a preliminary one, and a larger body of cases needs to be examined to further prove the usefulness of our typology with other client samples.

The next step in this research project is to create a manual for identifying these CT types in CCRT narratives, and to test the reliability of the ratings. In addition to creating the manual, we plan to continue to examine links between CT types, processes, and outcomes in a larger sample of clients and therapists. CT types can then be linked to manifestations, using scales such as CFI or ICB, and other measures of CT. In addition, the relationship between CT dynamics, the alliance, and rupture and repair is a promising direction for future investigation. For example, CT dynamics can be investigated in instances where therapists report strong negative or positive emotions that may indicate over-involvement, and when the client or an outside observer (e.g., supervisor) report a rupture. The CT categorization can be used to study processes in conjunction with the observation of videotaped therapy sessions, so that judges can assess what actually went on in the session. Of course judges will need to have access to therapists' CCRTs or other sources of information on personal conflicts. In addition, interviews with therapists on the extent and nature of their awareness of CT can add important information.

Finally, we note that analyzing therapists' narratives without taking into account the clients' narratives presents a limited perspective on the therapy process. Clients' relational narratives about the therapist are a source of information not only on their transference, but also on therapists' countertransference. We are currently developing guidelines to further study client narratives, and the ways in which to describe dyadic processes. In future studies a combination of therapists' and clients' narratives, along with videotapes of therapy sessions, would provide a rich source of data for studying how the interpersonal process unfolds, and how transference and countertransference dynamics (Safran, 2002) develop in the client-therapist encounter.

Our preliminary conclusions and recommendations are in line with those made by Hill and Knox (2009) on studying the therapeutic relationship. These authors advocate the use of qualitative approaches to study the relationship and recommend combining methods that examine events as they occur overtly by interviewing clients and therapists about their inner experiences in the sessions.

Recommendation for Clinical Practice

Therapists' CCRTs may prove to be a useful tool for supervision. Though it may not be suitable for novice therapists, advanced trainees who are ready to examine and process their CT can use it for their personal and professional growth. The modern relational conceptualization of psychotherapy is "an ongoing cycle of therapeutic enactment, disembedding and understanding, enactment and disembedding" (Safran, 2002, p. 171). Within this framework, identifying one's CT pattern is an important supervisory tool. Monitoring one's countertransference can assist in building a positive alliance. In addition, understanding and managing countertransference can help therapists to repair an alliance rupture, which is central to good process and outcome (Safran & Muran, 2011). Monitoring countertransference also provides therapists with clues as to subtle or unconscious communications from clients about their relational needs. Finally, although countertransference was originally defined in psychoanalytic theory, we believe that it is a useful construct for other orientations as well, since all types of therapy are carried out in the context of a relationship in which there is an encounter between the therapist and client's interpersonal patterns.

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