# Countertransference and Child and Adolescent Psychiatry: Bringing Theory Into Practice

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Countertransference, in its broadest definition, refers to the clinician's emotional response to the patient.[1] These reactions can be positive; however, they can also include negative feelings such as dislike, despair, or even aggression and hate. If negative feelings go unrecognized, they can lead to enactments of the countertransference, where the clinician unknowingly acts out his or her feelings toward the patient in the treatment.

Though countertransference has been extensively addressed in the psychotherapy literature, it has been largely neglected in the child psychiatry literature.[2,3] One theory may be that countertransference is often stronger when working with children, leading clinicians to avoid the topic.[2] For instance, many clinicians have difficulty seeing children suffer, struggle with the overlap between their work and their personal experience with parenting, and find working with families particularly challenging.[3] In addition, the field of psychiatry in general has shifted from a psychoanalytic model to a blended biological paradigm, which lends itself less to the identification of countertransference. This is particularly true in the inpatient setting, where managed care has placed a strong emphasis on significantly shorter lengths of stay. Yet it is specifically on an inpatient unit where transference and countertransference can become most notable, as patients in crisis often struggle with attachment difficulties or emerging personality psychopathology.

For example, one of our patients was a young boy with a history of neglect and abuse, whose severe behavioral outbursts led to frequent physical restraints. Despite the best efforts of the unit team, he seemingly thwarted all attempts to help him control his behavior. Over time, the team began to feel frustration and anger, signifying the development of negative countertransference. The idea of feeling anger toward an ill child, however, is incredibly uncomfortable, and this discomfort can lead clinicians to adopt defense mechanisms that play into the enactment of the countertransference. In this case, some team members inadvertently began avoiding the patient to avoid provoking a behavioral outburst. The result was that he did not receive the intensive attention and limit setting he needed, which led to escalating behaviors that sometimes required physical containment. Another common defense in this case was the displacement of anger onto the patient's father, who represented a more acceptable target. The negative countertransference was further fueled by a sense of impotence that set in when most attempts at helping the patient control his outbursts were ignored or sabotaged. Behavioral plans were torn up, and the patient began escalating in response to even the subtlest triggers. As a sense of futility set in, there was also a strong desire to discharge the patient despite his ongoing challenges. Ultimately, the inpatient psychiatric unit could not provide what this patient desperately needed: long-term, stable attachment. Once that became clear, long-term residential placement was pursued.

Recognizing and understanding the negative countertransference was essential to the patient's treatment while he remained under our care. Such an approach allowed us (the team) to understand his behavior in an interpersonal framework and to address our own contribution to his dysregulation. It also allowed us to be mindful of our own motivations in making treatment decisions in order to avoid harmful enactments of the countertransference.

## From Theory to Practice

Initially, countertransference was viewed as entirely undesirable, a contaminant of the otherwise pure and objective therapeutic relationship.[4] Early clinicians endeavored to avoid countertransference feelings

toward their patients, especially when these feelings were negative. Klein and Bion,[5-8] however, described how negative countertransference is a natural and even desired aspect of treatment, where understanding and tolerance of countertransference, rather than avoidance, could lead to healing. They describe how these strong countertransference feelings, such as hatred or anger, must be contained, metabolized, and returned to the patient, who re-internalizes them and learns how to tolerate them.

Negative countertransference can sometimes be generated through the process of projection and projective identification, in which an individual denies an internal aspect of his or herself and experiences it as coming from the external world.[5] For instance, a patient who is unable to tolerate an internal feeling of anger may experience the clinician as being angry, even if this is at odds with objective reality. The patient may then cause the clinician to experience these feelings himself[6,7]; thus, the clinician may actually come to feel angry. The theorized benefit of this process is that the individual is able to place an unwanted aspect of the self in the external world where it can be controlled and contained.

Of course, not all countertransference feelings are due to projection. Countertransference can also arise secondary to the clinician's own internal biases. Even the most skilled clinicians will sometimes feel very strong positive or negative feelings toward a patient that may stem from their own internal psychological makeup. For example, a clinician who has experienced abuse may develop a strong desire to rescue an abused child, while simultaneously developing strongly negative feelings toward the child's parents. Alternatively, a clinician who has difficulty with dependency may be repelled by a dependent patient. These feelings will be out of proportion to what may be experienced by a different clinician. In these examples, the countertransference stems from the internal world of the clinician, independent of the patient. It is important to distinguish between the two forms of countertransference, between a reaction based on one's own psychology and an emotional state that has been projected onto the clinician by the patient. One clue might be that the emotions triggered through projective identification often feel foreign and unexpected, while those that are secondary to internal factors feel more natural.

On an inpatient unit, many patients, particularly those who have suffered disruptions in early relationships, utilize the defense mechanism of projective identification. These patients may split the unit staff or create chaos around them, effectively projecting their chaotic internal world into the milieu.[8] The chaos may also seep through to the clinician, who might then start to feel anger toward the patient. Systematically identifying these emotions within the clinician, containing them, and presenting them back to the patient can help the patient learn to modulate his or her own emotions.[6] In order to do so, the treatment teams could consider holding regular meetings to discuss clinicians' feelings toward patients. Such meetings can normalize these reactions and bring them into context. Understanding these feelings can also help the team understand the patients' internal world, as some of these feelings may be related to projective identification. By working together to contain these projections, rather than avoiding negative feelings, the team will effectively contain the patients, leading to greater stability and improved distress tolerance.

## Conclusions

In our view, countertransference is as relevant today as ever, especially in the treatment of complex patients on an inpatient unit. It is essential to acknowledge countertransference and the ways in which it can influence treatment. It is also imperative to continue to train the newer generations of psychiatry residents and fellows to recognize and manage countertransference.

Properly dealing with these feelings on an inpatient unit requires patience, introspection, and strong team leadership. Especially when the team is considering an intervention that could represent an enactment, such as early discharge, initiation of a sedating medication, physical or chemical restraint, or other restrictions on the unit, the motivations for these decisions should be closely reviewed. This process requires hard work. If we

are willing to exert ourselves and honestly face our reactions to our young patients, such perseverance will be rewarded when even the most challenging patients can receive effective treatment on an inpatient unit.

### Take Home Summary

Clinicians should always be mindful of countertransference, particularly when working with children and adolescents, regardless of the treatment setting. Identifying negative countertransference can provide insight into the patient's internal state, as they may be projecting their internal world onto their environment. Ultimately, working through countertransference can improve treatment outcomes.

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"Apples and oranges" might be your first reaction to this month's Translations article, Zebrafish: A Translational Model System for Studying Neuropsychiatric Disorders. What could such a distant cousin on our genetic family tree have in common with us? Nevertheless, the zebrafish possesses a central nervous system similar to a mammal's, which allows researchers to observe their neurobiological development by virtue of their fast-growing, transparent embryos, and provides a glimpse of how development is affected by malfunctioning risk genes. Figure 1 features a thorough demonstration of the functional analysis, exhibit A of this fruitful exploration.