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Pepperdine University  
Graduate School of Education and Psychology

THE NATURE AND FREQUENCY OF COUNTERTRANSFERENCE REACTIONS IN  
PSYCHOANALYSTS

A dissertation submitted in partial satisfaction  
of the requirements for the degree of  
Doctor of Psychology

by

Michelle Walker

January, 2015

Edward P. Shafranske, Ph.D., ABPP - Dissertation Chairperson

This clinical dissertation, written by

Michelle Walker

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Edward P. Shafranske, Ph.D., ABPP, Chairperson

Louis J. Cozolino, Ph.D.

Susan Spiegel, Ph.D.

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## DEDICATION

For Grandma Lynn who lit up my childhood. Thank you for introducing me to the best things in life like unconditional love, contagious laughter, coffee, and NYC. While you departed from this world far too soon, your vibrant memory lives on in my heart.



## ACKNOWLEDGEMENTS

First I'd like to thank my Dissertation Committee - Dr. Ed Shafranske, Dr. Lou Cozolino, & Dr. Susan Spiegel for challenging and encouraging me throughout this process.

To an incredible ensemble of mentors whose wisdom, guidance, patience, and compassion have been integral in helping me to become a grown-up. It would not have been possible to complete my education without their relentless support and faith in me. Especially Linda Martin, Michael Brodsky, Dave Lechuga, Sharon Schwartz, Lorraine Rose, Val Coleman, Astrid Schwartz, Anne Schofield, and Harold Young. Much gratitude goes to Sharon Schwartz for the many years of professional inspiration, but most of all, for being normal. It is impossible to give enough thanks to Dana Kiesel for introducing me to myself. *"A mind that is stretched by a new experience can never go back to its old dimensions."* - Oliver Wendell Holmes, Jr.

I have been fortunate to cross paths with some remarkable people who have left me with precious memories: Sunny Funk, Chris, Kram, Mango Chutney, Mikey, AB, Ave, Gabbs, Gomey, Liss, and Lans. I am beyond grateful for the loving friends who are continual sources of support and inspiration: Amy Kinsey, Rob Hall, The Botsfords, The Loopers, The Dowds, Tom Bottelsen, Katy Jakle, and Nina Grayson. A very special thank you goes to Shana Spangler for her relentless devotion, patience, love, and expertise in APA formatting. And of course, much love to LJC for enriching my life over the past decade. *"No distance of place or lapse of time can lessen the friendship of those who are thoroughly persuaded of each other's worth."* - Robert Southey

Thank you to my family and extended family for their love, support, and frequent nudging. To Gram, Phil, Jan, The Goodriches, The Fields, The Deffenbaughs, The Heiligers,

and all of the Kinseys for their endless enthusiasm and encouragement. Special thanks go to Craig for being the wise and protective big Brother that I always wished for. Thank you to my little Brother Bradley for his wit, strength, and authenticity. I am ingratiated to my parents for having shaped me and for honoring the ways in which adulthood has re-shaped me. Thank you Mom for your infinite supply of patience, nurturance, acceptance, and empathy. Thank you Dad for instilling in me a strong sense of independence, perfection, dedication, and sensitivity - I love and respect you both very much. *“How bold one gets when one is sure of being loved.”* - Sigmund Freud

To my little love bugs: Mikenna, Tanner, Luca, Kitty, Jackie, & Puss - Thank you for bringing so much light and joy into my world and I adore watching you grow. Thank you Eric Carlton Kinsey for being the biggest blessing in my life. You are a constant source of sanity, levity, logic, encouragement, patience, partnership, and love. Everyday you inspire me to be the best version of myself. Thank you God for all of these blessings. *“And above all, watch with glittering eyes the whole world around you because the greatest secrets are always hidden in the most unlikely places. Those who don't believe in magic will never find it.”* - Roald Dahl

## VITA

### EDUCATION

#### **Doctorate in Clinical Psychology**

Pepperdine University, Los Angeles, CA

Doctoral Dissertation, Preliminaries, Spring 2012

Doctoral Dissertation, Defense, Spring 2014

Dissertation Title: The Nature and Frequency of Countertransference Reactions in Psychoanalysts

Dissertation Chair: Edward Shafranske, Ph.D.

Graduated Summer 2014

#### **Master Certificate in Human Resources**

Cornell University, Online Format

Completed Winter 2012

#### **Master's of Arts in Psychology**

Pepperdine University, Los Angeles, CA

Graduated Spring 2005

#### **Bachelor's of Arts in Political Science**

University of California at San Diego, La Jolla, CA

Graduated Summer 2001

### CLINICAL EXPERIENCE

#### **Psychological Assistantship**

##### **Doctoral Internship**

Dr. Sharon Schwartz Psychotherapy

Tarzana, CA

2012 - Present

On-Site Supervisor: Sharon Schwartz, Ph.D.

- Provide long-term individual and conjoint psychotherapy to adults, adolescents, and children
- Assess patient symptomology, conduct weekly psychotherapy sessions, establish a therapeutic alliance, and administer treatment interventions in accordance with psychodynamic principles
- Review relevant case material, develop clinical interventions, and formulate treatment plans under the guidance of supervisor Dr. Sharon Schwartz

#### **Psychological Assistantship**

##### **Pre-doctoral Internship**

The Maple Counseling Center

Beverly Hills, CA

2007 - 2012

On-Site Supervisors: Sharon Schwartz, Ph.D., Lorraine Rose, Ph.D., Kevin Wittenberg, Ph.D.

Off-Site Supervisors: Peter Wolson, Ph.D., Loren Weiner, Ph.D., Faith Szalay, Psy.D.

- Provided psychodynamic psychotherapy to adults, children, couples, and families coping with mood, anxiety, relational, occupational, and personality disorders
- Participate in individual and group supervisions including the presentation of case material, consideration of diagnostic considerations, development of clinical interventions, and formulation of treatment plans
- Completed year long rotations in the Family Therapy, Couples' Counseling, and Intake/Assessment tracks involving the conduction of psychodiagnostic interviews, assessments, preparation of formal reports, and participation in weekly trainings and supervision
- Completed a 10-week training with the Crisis Response Team which services the needs of those in the community sustaining immediate trauma

**Doctoral Practicum**

The Neurobehavioral Clinic

Lake Forest, CA

2006 - 2007

Supervisor: David Lechuga, Ph.D.

- Administered, scored, and interpreted neuropsychological assessments to child, adolescent, and adult patients with traumatic brain injury, learning disorders, and sports related concussions utilizing instruments including: D-KEFS, CVLT-II, RVLIT, BVMT-R, WMS-III, Trails, Stroop Test, Rey-Osterrieth Complex Figure Test, Grooved Pegboard, Reitan-Klove, Hand Dynamometer, and Finger-Tapping Test
- Administered, scored, and interpreted cognitive assessments to child, adolescent, and adult patients with traumatic brain injury, learning disorders, and sports related concussions utilizing instruments including: WAIS-III, WISC-IV, WRAT-III, Woodcock-Johnson (Achievement), and WIAT
- Administered, scored, and interpreted personality assessments to child, adolescent, and adult patients with traumatic brain injury, learning disorders, and sports related concussions utilizing instruments including: MMPI-2, MMPI-A, MCMI-III, MACI, Roberts, TAT, RISB

**Doctoral Practicum**

Pepperdine University's Psychological and Educational Clinic

Los Angeles, CA

2005 - 2008

Supervisors: Aaron Aviera, Ph.D. & Fiona Chalom, Ph.D.

- Conducted intake assessments and provided individual long-term and brief Psychodynamic psychotherapies to clients with mood disorders, anxiety disorders, personality disorders, and general relational problems in order to increase their environmental adaptability and foster a greater quality of life
- Developed and implemented treatment plans designed to mitigate client symptoms and increase coping mechanisms
- Participated in weekly case conference in order to develop conceptualizations, differentially diagnose, and establish treatment protocols from Psychodynamic, Cognitive-Behavioral, Family Systems, Humanistic-Existential, Cross-Cultural, and Psychobiological perspectives

**Marriage and Family Therapist Trainee**

CGI Counseling Center

Westwood, CA

2004 - 2005

Supervisor: Darlene Cohn, Ph.D.

- Conducted intake interviews and completed formal intake reports for clients with clinical presentations consistent with Axis I and Axis II pathologies
- Psychodynamically conceptualized individual clients with mood and anxiety disorders
- Utilized psychodynamic interventions such as the therapeutic alliance, interpretations, transference, and countertransference in order to improve clients' social, occupational, and emotional functioning

**Marriage and Family Therapist Trainee**

Monte Nido - Residential Eating Disorder Treatment Center

Malibu, CA

2003 - 2004

Supervisor: Ali Borden, MFT

- Co-facilitated psychotherapy groups for patients with Anorexia and Bulimia Nervosa, utilizing Family Systems as well as Cognitive-Behavioral interventions designed to manage and explore their thoughts and feelings about food and body image
- Assisted and supported clients in the planning, preparation, and completion of meals in order to model adaptive eating behaviors and increase their comfort levels around food
- Coordinated projects aimed at reducing client anxiety through the promotion of healthy self-regulating behaviors such as art, yoga, and meditation

## RESEARCH EXPERIENCE

### Research Assistant

The Neurobehavioral Clinic  
Lake Forest, CA  
August 2007

Supervisor: David Lechuga, Ph.D.

- Administered the online IMPACT concussion screening exam to several hundred local high school football players in order to establish their baseline functioning
- Provided a verbal protocol for the online IMPACT concussion screening exam
- Clarified demographic items with respondents, as needed, to insure that the appropriate norms be applied to the data

### Research Assistant

Pepperdine University  
Los Angeles, CA  
2004 - 2006

Supervisor: Louis Cozolino, Ph.D.

- Assisted in the preparation of a book pertaining to the brain as a social organ:  
Cozolino, L. J. (2006). *The Neuroscience of Human Relationships: Attachment and the Developing Social Brain*. NY: WW Norton.
- Researched, reviewed, and archived several hundred research studies in neuroscience
- Selected and coordinated the book's neural imagery in order to facilitate the conceptualization of brain structures, functionality, and circuitry
- Responsible for the creation, formatting, editing, and maintenance of the book's reference section in accordance with APA standards

## TEACHING EXPERIENCE

### Teaching Assistant

Pepperdine University  
Los Angeles, CA  
Fall 2007

Course: Interventions with Children and Adolescents

Supervisor: Carol Falender, Ph.D.

- Researched and collected audio-visual materials relevant to child and adolescent psychopathology and psychotherapy to supplement the doctoral coursework
- Calculated data and produced results of students' self-assessments of their current and aspirational levels of clinical experience with various child and adolescent populations

### Teaching Assistant

Pepperdine University  
Los Angeles, CA  
Fall 2007

Course: Neuropsychological Assessment

Supervisor: David Lechuga, Ph.D.

- Researched and archived audio-visual media samples and electronic publications salient to Neuroscience, Neuroanatomy, and Traumatic Brain Injury to supplement the doctoral coursework

### Teaching Assistant

Pepperdine University  
Los Angeles, CA  
Fall 2006, Spring 2007, Summer 2007, Fall 2007

Course: Comprehensive Review

Supervisor: Sepida Sazgar, Psy.D.

- Developed and maintained a grade database for the students enrolled in the Master's course, Comprehensive Review

- Evaluated students' weekly journal article reviews on topics including: psychopathology, assessment, psychotropic medication, learning theory, and ethics.
- Scored students' clinical vignette essay exams according to DSM-IV-TR criteria

### **Teaching Assistant**

Pepperdine University  
Los Angeles, CA

Summer 2006, Fall 2006, Summer 2007

Courses: Marriage and Family Therapy I & II

Supervisor: Mario de Salvo, M.F.T

- Designed and taught clinical vignettes in order to increase students' proficiency in assessment, conceptualization, and treatment planning from a Family Systems perspective
- Generated and scored course examinations covering Experiential, Transgenerational, Structural, Strategic, Milan Systemic, Post-Modern, and Narrative Psychotherapies
- Assisted with in-class assignments on genogram production, differential diagnostic practice, and clinical role plays

### **Teaching Assistant**

Pepperdine University  
Los Angeles, CA

Spring 2005, Fall 2005, Spring 2006

Courses: Psychoanalytic Developmental Psychology, Physiological Psychology, & Techniques of Psychotherapy

Supervisor: Louis Cozolino, Ph.D.

- Transcribed and translated course lectures presented in the doctoral course, Psychoanalytic Developmental Psychology
- Conducted review sessions on neuroanatomy for master's students enrolled in Physiological Psychology
- Scored exams and maintained a grade database for master's students enrolled in Techniques of Psychotherapy

## **PROFESSIONAL EXPERIENCE**

### **HR Consultant**

Investors Management Company  
Tarzana, CA

September 2011- Present

- Modernize company employment practices and procedures, from pre-employment through termination, in accordance with current state and federal laws
- Responsible for the digital design and formatting of the employee manual and company handbook
- Conduct brief employee trainings on conflict resolution and cultural sensitivity

## **PROFESSIONAL PUBLICATIONS**

Cozolino, L. J., & Walker, M. D. (2008). The social construction of the human brain. In: M. Green's (Ed.), *Risking Human Security: Attachment and Public Life*. London: Karnac.

## **PROFESSIONAL MEMBERSHIP**

- Psychological Assistant, PSB #36833, Board of Psychology, 2012-2014
- Chair, The Maple Counselor and Alumni Association, Beverly Hills, CA, 2009-2010
- Psi Chi, Pepperdine University, Los Angeles, CA, 2003 - present

## **ANCILLARY SKILLS**

- Proficiency in SPSS 22.0, Word, Office, Powerpoint, iPhoto, Aperture, iMovie,

## ABSTRACT

Psychotherapist personal factors, often referred to as countertransference reactions, are widely believed to impact the therapeutic process. While the existence of the countertransference is commonly accepted by contemporary psychotherapists, there is continued debate over its nature, quality and therapeutic utility. Further, there have been relatively few empirical studies on the countertransference reactions of practicing psychologists and other mental health professionals. This study aimed to address this lack by examining the frequency and nature of countertransference experiences as reported by psychoanalysts. Additionally, this study sought to explore the relationship between countertransference reactions and patient symptomology as suggested by recent findings (Betan, Heim, Conklin, & Western, 2005; Brody & Farber, 1996; Rossberg, Karterud, Pedersen, & Friis, 2007, 2008, 2010). Seventy psychoanalysts with memberships to national psychoanalytic organizations completed a brief, web-based survey on countertransference. The results of this study indicated that psychoanalysts report constantly experiencing countertransference reactions and that these reactions are mostly positive in nature, independent of the clinician's background or demographic information. The results also showed that most psychoanalysts defined the CT phenomenon as "all of a therapist's reactions," during the psychotherapy, reflecting the "totalist" perspective of CT. A small but significant association was found between CT definition and reported CT frequency, suggesting the role of theory in shaping clinical experience. While respondents were just as likely to report CT reactions with patients diagnosed with Axis I and Axis II disorders, Cluster B personality disorders were most specified amongst the Axis II endorsements. The findings of this study provide a contemporary outlook on the countertransference phenomenon. This study's limitations relate to its homogenous sample population and abnormal distribution rate.

## **Introduction**

Over the past century the psychotherapy literature has dedicated a good deal of discussion to the role of psychotherapist personal factors on the treatment process, a phenomenon commonly referred to as countertransference. Generally speaking, countertransference refers to a therapist's personal reaction to his or her patient. During the CT experience, "the therapist is a captive to varying degrees on 'four-wheeler' rides over the dunes and beaches of his own private terrain of inner experiences" (Kiesler, 1982, p. 274). These reactions are both unconscious and involuntary, and can be experienced affectively, behaviorally, or cognitively (Gelso & Hayes, 2007).

While psychoanalysis has long underscored the importance of countertransference and its potential negative impacts on treatment, contemporary psychotherapies have embraced CT for its illumination of patients' interpersonal dynamics (Norcross, 2001). In fact, psychoanalytic theory, bolstered by clinical research, has suggested a correlation between countertransference reactions and patient symptomology (Betan et al., 2005; Briggs, 1979; Brody & Farber, 1996; Giovacchini, 1972; Giovacchini & Boyer, 1975; Kernberg, 1965, 1968, 1970; Kohut, 1971; Rossberg et al., 2008, 2010). CT reactions have even been the center of recent civil litigation in which the court found management of CT to be an essential professional competency. Even though clinical experience appears to assist in the management of such reactions, skilled and reputable therapists are often confronted by the countertransference phenomenon (Van Wagoner, Gelso, Hayes, & Diemer, 1991).

Given its clinical relevance and importance, it is striking that there have been relatively few empirical studies that have examined the frequency and nature of CT within psychotherapy practice. Existing studies have measured CT through the deviation of therapist behavior from



that of their normal standard of care (Gelso, Fassinger, Gomez, & Lats, 1995; Hayes et al., 1998; Kiesler, 2001). This study sought to obtain descriptions of the frequency and nature of CT reactions in practicing psychoanalysts, a group that based on training and practice would likely pay particular attention to the phenomenon of countertransference.

## **Background**

Countertransference refers to the internal reactions triggered in a therapist during psychotherapy. According to contemporary analyst Hirsch (1997), “Countertransference is translated into usually subtle actions and these actions may or may not at any given moment, be reflective of a patient’s transference themes” (p. 288). This phenomenon has been present in the psychoanalytic literature since the early 20<sup>th</sup> century. It seems that countertransference theory evolved from the pioneers of psychoanalysis who spoke about the patient-analyst relationship (Mitchell & Black, 1995). Over a century later, extraordinary attention and detail continue to be devoted to its understanding. In fact, the psychotherapy literature contains nearly 5,000 publications that address the construct of countertransference.

**Evolution of the construct of countertransference.** The term countertransference was originally defined by Sigmund (1910/1957) as the analyst’s neurotic reaction brought on by their patient’s transference. This refers to the analyst’s encounter with unconscious experiences triggered by their patient during psychotherapy. The capacity for a therapist or patient to re-experience their unconscious past was addressed in Freud’s earliest writings. In fact it was Freud who developed the theory of repetition compulsion; which refers to the mind’s penchant for repetitive behavior (Freud, 1914/1958). He suggested that events associated with pain would likely be recapitulated, given that “the mental impact of trauma is not as a memory but as an action” (Freud, 1914/1958, p. 150). In other words, unresolved conflict may be re-encountered

until it is properly understood and resolved. As a result, the analyst is apt to “repeat with his own hands the act of murder previously perpetrated against the patient” (Ferenczi, 1932, p. 52).

Mid-century psychoanalytic thought influenced the development of countertransference theory. Analysts speculated about the transmission of affective experience as they addressed one’s capacity to engender feelings in another. Both object-relations and ego-psychology developed theories around infant ego formation and its reliance on projection and introjection. Bion (1957) spoke about the desire to split-off unpleasant internal states ("alpha elements") and the wish for external metabolization ("beta elements"). Fairbairn (1952) discussed the role of infant internalized object relations during times of externally unmet needs. Similarly, projective identification detailed a process of affect regulation involving the evacuation of intolerable emotions (Klein, 1946).

Psychoanalysts saw a natural application of the projective processes to the therapeutic relationship. Soon projective identification became part of the clinical terminology used to describe an analyst’s embodiment of their patient’s projections (Kernberg, 1965). Just as the primary object must contain their infant’s distress, the analyst must metabolize their patient’s dysregulation. The process of PI implies an unconscious and non-verbal transmission of affective states, whereby the analyst functions as a container for the patient’s dissociated conditions (Ogden, 1979). Despite its somewhat illusive nature, projective identification continues to be a standard part of clinical case conceptualization and continues to maintain its place in the DSM-IV-TR’s *Glossary of Defensive Terminology* (APA, 2002).

Psychoanalytic thought’s paradigmatic shift from a one to two person psychology greatly impacted the notion of countertransference (Stark, 1999). Relational theories have spoken to the impact of fusion between primary objects (Kohut, 1971; Stern, 1977). Similarly,

intersubjectivity theory is based on the premise that human behavior does not exist outside the context of relationship (Atwood & Stolorow, 1984). The spirit of the co-created experience has been applied to psychotherapy and the therapeutic relationship. In fact, terms like Ogden's "analytic third" and Benjamin's "thirdness" have come to describe the powerful 'entity' produced from the patient-therapist interaction (Benjamin, 2004; Ogden, 1994).

**Countertransference theory: Fundamental perspectives.** The prior section outlined the central and historical psychoanalytic substrates of the countertransference phenomenon. A review of the literature reveals three primary positions on CT's definition and utility in psychotherapy. Classicists are neo-Freudians who maintain that CT is strictly an unconscious reaction to the patient's transference and detrimental to the course of treatment. From this perspective, CT distorts the psychotherapist's perceptions of the patient and impedes the analytic process. A second alternative view, (i.e., the totalist perspective) considers CT to be an invaluable part of treatment comprised of both the therapist's unconscious and conscious reactions stimulated by the patient's projections, which provides a window into the patient's psychology (Fromm-Reichman, 1950; Heimann, 1950, 1960; Kernberg, 1965; Little 1951, 1960; Racker, 1957; Winnicott, 1949).

Contemporary psychotherapy has witnessed the emergence of a third perspective born out of both classicist and totalist viewpoints. It defines countertransference as the therapist's personal, albeit distorted reactions to the patient (Blanck & Blanck, 1979; Gelso & Carter, 1985, 1994; Langs, 1974; Watkins, 1985) influenced by the therapist's life history and psychodynamics, which is stimulated by the interaction with the patient. In other words, the internal worlds of both therapist and patient co-create the countertransference experience (Gabbard, 2001), which reflects the "intersubjective" nature of the therapeutic process (Dunn,

1995). This position maintains that countertransference can be both informative and contaminative to the treatment- informative if the CT reactions are properly understood and contaminative if they remain unconscious and continually enacted (Hoyt, 2001; Ligiéro & Gelso, 2002). Despite these varying perspectives, the field is widely in agreement about the existence and importance of countertransference (see an extended list of recommended readings on countertransference theory in the Appendix).

**Importance of countertransference.** Contemporary practice considers the therapeutic interaction to be an intersubjective process in which the subjectivities of both psychotherapist and patient contribute (Renik, 1993; Stern, 2005). Given this perspective, countertransference takes on particular significance. Gabbard (1999) concluded:

Countertransference has moved to the very heart of psychoanalytic and psychotherapeutic theory and technique. It has evolved from a narrow conceptualization of the therapist's transference to the patient into a complex and jointly created phenomenon that is pervasive in the treatment process. (p.21)

While the countertransference phenomenon was born out of psychoanalytic thought, its clinical significance is now emphasized across theoretical orientations (Ellis, 2001; Falender & Shrafranske, 2008; Hayes, 2004; Hoyt, 2001; Kaslow, 2001; Mahrer, 2001; Manning, 2005; Safran & Muran, 2000 ). Whether it's positive or negative, subtle or acute, subjective or objective, countertransference plays a pivotal role in contemporary psychotherapies (Kiesler, 2001). In fact, it has become a standard component of case conceptualization, treatment planning, and clinical training. Perhaps this is because a therapist's experience of a patient helps to shape the therapeutic relationship; which according to recent studies is now considered the

universal curative factor across all modalities of treatment (Geller, Norcross, & Orlinsky, 2005; Lambert & Barley, 2001; Norcross, 2001; Norcross & Lambert, 2011).

Countertransference is also important because it appears to help inform diagnosis. Psychoanalysts have long suspected an association between the countertransference experience and patient symptomology (Briggs, 1979; Giovacchini, 1972; Giovacchini & Boyer, 1975; Kernberg, 1965, 1968, 1970; Kohut, 1971). In fact, recent studies suggest that patients' diagnostic considerations are correlated with the magnitude and nature of the therapist's countertransference reactions (Betan et al., 2005; Brody & Farber, 1996; Rossberg, Karterud, Pedersen, & Friis, 2008; Winnicott, 1949). In other words, certain types of countertransference reactions may be more typical of particular patient groups. In this sense, the countertransference experience provides the therapist with a visceral tool that can be used to better locate and understand the patient's condition.

Countertransference is also valuable in the way that it can act as an agent of alert. Countertransference thoughts, feelings, and images often serve as intense signals to the therapist that adjunctive interventions, consultations, or personal therapy is necessary (Stark, 1999). However, that is not to say that appropriate and adequate treatment interventions would or should prevent the presence of a countertransference encounter. After all, some of the most seasoned clinicians report being challenged by the countertransference experience (Van Wagoner et al., 1991).

**Countertransference: Empirical research.** While theoretical papers on countertransference have been abundant, empirical studies have been limited. This has been attributed to the difficulties of operationalizing a complex and illusive phenomenon (Fauth, 1998; Gelso et al., 1995; Gelso & Hayes, 1998; Hayes et al., 1998; McClure & Hodge, 1987). In

other words, countertransference's subjective and/or intersubjective properties have challenged its capacity to be measured and standardized. As a result, most of the empirical data on countertransference has been gathered using qualitative methods. This includes case studies and phenomenological research with limited sampling.

Most of the quantitative research has indirectly examined countertransference. In other words, these studies have addressed countertransference through the measurement of its affective and behavioral manifestations (Hayes et al., 1998). Most of this data appears to have been collected in analogue versus naturalistic settings. According to McClure & Hodge (1987), perceptual and reporting biases have also been demonstrated in major countertransference studies (Cutler, 1958; Fiedler, 1951; Snyder & Snyder, 1961). These methodological procedures may have compromised the reliability and general applicability of the empirical findings (Singer & Luborsky, 1977).

This limited quantitative data on the countertransference experience coupled with its strong impact on the field of psychotherapy, suggests a need for further exploration of the phenomenon. After all, countertransference has been discussed in the psychotherapy literature for over a decade. Undoubtedly it would be helpful to have more information about the nature of this phenomenon.

### **Purpose of the Study**

The concept of countertransference is pivotal in psychotherapy as it informs the therapeutic relationship, treatment interventions, and clinical training. However, there has been little systematic research that describes the countertransference phenomenon in clinical practice. This study attempted to provide a contemporary perspective on the phenomenon by capturing a broad range of clinicians and their experiences with countertransference during psychotherapy.

Specifically this study proposed to obtain descriptions of the frequency and nature of countertransference reactions in practicing psychoanalysts. It also aimed to shed light on the types of patients and therapists involved in specific types of countertransference reactions.

**Research questions.** (1) How frequent are countertransference reactions in psychoanalysis and psychodynamic psychotherapy (as reported by psychoanalysts)? (2) What types of countertransference reactions do clinicians report? (3) Does client diagnosis influence the frequency and type of countertransference reactions?

## **Method**

### **Research Approach**

This study opted to use a non-experimental survey approach. This method was selected to provide the means to answer the research questions. It entailed carefully designed survey questions, numerically coded responses, and a thorough data analysis using descriptive statistics. This study performed univariate, bivariate, and multivariate analyses on the variables that related to the frequency, classification, and diagnostic correlation of countertransference experiences as reported by psychoanalysts. Descriptive statistics were also to examine distribution and compute participant demographic data.

The survey approach has its advantages as well as disadvantages. Surveys are known to be cost and time effective, but often result in lower response rates. While general self-reports are less susceptible to experimenter biases (Birnbaum, 2004; Edmunds, 1999; Reips, 2002; Rezabek, 2000), they can lead to social desirability biases (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). Many of these challenges can be combatted by using a web-based format (Cobanoglu & Cobanoglu, 2003; Lyons, Cude, Lawrence, & Gutter, 2005).

Empirical studies on countertransference have struggled due to difficulties with operationalizing such a highly complex and subjective concept (Fauth, 1998; Gelso et al., 1995; Gelso & Hayes, 1998; Hayes et al., 1998; McClure & Hodge, 1987). As a result, most of the existing studies are qualitative or case studies. This has resulted in a relative lack of systematic empirical research performed on the topic of countertransference. This study sought to augment the quantitative data on CT by investigating the frequency and nature of countertransference experiences of psychoanalysts.



## **Participants**

Study participants were members of the American Psychoanalytic Association (APsaA). APsaA members are comprised of Psychoanalytic Candidates as well as Certified Psychoanalysts who have completed 4-years of analytic training from an accredited institute. As required by APsaA, these clinicians are experienced mental health providers who are licensed as physicians (psychiatrists), research psychoanalysts, psychologists, marriage, family and child therapists, licensed professional counselors, or social workers.

Participants were members of the National Psychological Association for Psychoanalysis (NPAP). NPAP is comprised of certified psychoanalysts, emerging from all fields of study, who have completed their analytic training at the NPAP training institute. NPAP memberships have also been extended to exceptionally qualified psychoanalysts who have completed their analytic training at outside institutes.

The participant population was targeted for several reasons. First and foremost, the topic of countertransference is rooted in psychoanalytic thought. As members of psychoanalytic organizations which require analytic training, participants were likely to be informed about the topic and find it relevant to their clinical work. The expansive national membership of these organizations provided an opportunity to access a representative sample. It was proposed that participants' professional credentials and diversity of experience in the field of mental health would contribute to the study's external reliability and generalizability. While this sample definitively included psychoanalysts, it did not include psychoanalysts who were non-affiliated with the American Psychoanalytic Association or the National Psychological Association for Psychoanalysis. Therefore, a possible threat to generalizability to all psychoanalysts was acknowledged.

## **Instrumentation**

The instrument developed for this study was a self-report survey; administered through the Internet (i.e., Web-based survey instrument). The survey consisted of 11 items, with forced-choice and open-ended response formats. The first portion included demographic items related to professional license, theoretical orientations, and number of patients. The next section addressed the countertransference experience within the context of the therapeutic relationship.

A majority of the survey items were designed for this study. The first exception was item #7, which addressed countertransference classification. Respondents were asked to describe the relational dynamic associated with a recent CT experience. The eight response categories were generated from a study about countertransference and personality disorders (Betan et al., 2005). Permission to use this factor structure was granted by Dr. Ephi J. Betan. The second exception was item #8, which asked about specific emotional reactions evoked during a recent CT experience. Permission to include this checklist was provided by Dr. Rolf Holmqvist.

The brief questionnaire's completion time was approximately 10 minutes (see Appendix B). The results of consultation with a small group of psychoanalysts who took and reviewed the survey instrument indicated that the study description, recruitment letter, survey instructions and the survey itself were clear.

## **Procedures**

**Protection of human subjects.** Prior to recruitment, the investigator of the following study received permission from the Pepperdine University Graduate and Professional Schools Institutional Review Board (IRB) to conduct the study. The investigator sought expedited IRB review and Waiver of Documentation of Informed Consent since the study posed no greater than minimal risk to participants.

**Potential risks and benefits.** This study presented minimal risk to participants. Queries about respondents' countertransference experiences may have prompted thoughts or feelings about patients and/or themselves. The personal nature of these professional reflections may have been emotionally stimulating. However, the participants (in light of their professional training and careers as psychoanalysts) have had experience in recognizing and managing the impacts of CT reactions. Should a participant have a distressing reaction resulting from study participation, they were advised in the research instructions to seek consultation with a trusted professional colleague. Participants received no direct benefit; however, participation in the study may have prompted reflection, thereby enhancing self-awareness. Study participation may have also provided satisfaction in having contributed to the empirical research in psychoanalysis. An incentive, described as follows, was also offered.

**Participation incentives.** According to Lyons et al. (2005), one of best methods to enhance responsiveness is to offer incentives for study participation. Therefore, the author of this study pledged that for every completed survey, a \$1 contribution would be made to the National Alliance on Mental Illness (NAMI). NAMI conducts research and advocacy and provides psychoeducation, treatment referrals, outreach, and support at both national and state levels ([www.nami.org](http://www.nami.org)). This information was disclosed in the Recruitment Letter to Participants. On account of the 70 survey responses, a \$70 donation was made to NAMI on May 5, 2014. The participation incentive was consistent with principles outlined in the American Psychological Association Ethics Standards, Code 8.06(a) which states:

Psychologists shall make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation (APA, 2002).

**Recruitment.** The investigator sought permission from the president of the American Psychoanalytic Association (APsaA) and the president of the National Psychological Association for Psychoanalysis (NPAP), to contact organization members about recruitment for this study. Once permission was granted, a recruitment letter was posted to the APsaA listserv and emailed directly to NPAP members requesting their voluntary participation in the study. The recruitment letter clarified the purpose and goal of the study. There was also a section outlining participation incentives. Embedded in the recruitment email was a hyperlink to the study survey. Those who opted to participate were able to click on the link and be directed to a World Wide Web address ([www.surveymonkey.com](http://www.surveymonkey.com)) where the online survey was accessible. Several weeks later, a follow-up recruitment letter was emailed to organization members in order to remind them about study participation.

**Informed Consent.** The investigator applied for a Waiver of Documentation of Informed Consent from the IRB and the following procedure was used to insure informed consent. The invitation for research participation included a statement of informed consent and indicated that survey completion confirmed their consent. Once respondents clicked the link, informed consent was provided, which explained the confidentiality of the on-line transmission of data. Participants were directed to contact the principal investigator if they preferred a traditional informed consent linking their participation to the study. Respondents were reminded that survey completion implied their consent to participate in the study.

### **Data Collection**

The data from this study was collected through a web-based survey generator known as Survey Monkey ([www.surveymonkey.com](http://www.surveymonkey.com)). According to Cook, Heath, Thompson, & Thompson (2001), computerized administration, computation, and analyses of data is automatic

and efficiently. While Podsakoff et al., (2003), indicate that general self-reports can lead to social desirability biases, if they are brief and web-based they are more susceptible to participation (Cobanoglu & Cobanoglu, 2003; Lyons et al., 2005) and less susceptible to experimenter biases (Birnbaum, 2004; Edmunds, 1999; Reips, 2002; Rezabek, 2000). Furthermore, studies have found web-based measures to be at least 10 times less expensive than paper-based (Ladner, Wingenbach, & Raven, 2002). This financial savings allowed the examiner to allocate more funds towards the participant incentive.

Contemporary findings suggest that online data collection is superior to data collection by mail, with respect to overall responsiveness. In order to produce a reliable data set, response quality was critical in this study. Particularly because self-report measures on countertransference are prone to perceptual and reporting biases (Cutler, 1958; Fiedler, 1951; McClure & Hodge, 1987; Snyder & Snyder, 1961). Fortunately, online surveys have been shown to increase the rate of sensitive data, personal disclosures, and honest endorsements, which has been attributed to computer privacy and internet anonymity (Joinson, Paine, Buchanan, & Reips, 2008; Daley, McDermott, McCormack-Brown, & Kittleson, 2003; Kays, Gathercoal, & Buhrow (In Press); Skitka & Sargis, 2006). Moreover, Bachmann, Elfrink, & Vazzana (2000) indicate that use of an on-line format is correlated with both higher and more detailed responses as compared to mail and telephone-based surveys.

Given that a study's validity depends on its sample size, response rate is also a crucial factor in procedures of data collection. According to Schonlau, Fricker, and Elliott (2002), a majority of research indicates that an online format yields response rates that, at the very least, are equivalent to other survey formats. In fact, a recent study on student health found that on-

line surveys produced roughly the same amount and type of data as did paper-based (Lewis, Watson, & White, 2011).

Traditional paper and pencil surveys have been challenged by question effects, which can compromise data validity and reliability. Participants often skip items, fail to endorse items properly, and are subject to respondent biases. However, it has been shown that on-line surveys enhance survey completion rates because the software can reduce confusion and complication, offer guidance and re-routing, prohibit item skipping, and enable question randomising (Bowling, 2005; Ilieva, Baron, & Healer, 2002; Schonlau et al., 2002; Skitka & Sargis, 2006; Stanton, 1998; Yun & Trumbo, 2000).

The data from this study was collected through a web-based survey generator known as Survey Monkey ([www.surveymonkey.com](http://www.surveymonkey.com)). It was used for survey design, survey administration, data collection, and data storage. Survey Monkey was selected given its excellent reputation for its software and security. That is, responses were anonymous, personal information wasn't requested, and IP addresses were not tracked. During the collection phase, data was saved on the investigator's external USB device and securely stored in a locked file cabinet. Three years after study completion, the data will be destroyed.

### **Data Analysis**

Following 1-month of data collection, a dataset was generated by Survey Monkey and downloaded into Excel and CSV files. Given that computerized data analysis has been shown to result in more accurate data entry and coding (Lyons, et. al., 2005; Wright, 2005), SPSS-22.0 was used to code and analyze this dataset. Prior to computation, the dataset was screened for missing cases, accuracy, normality, outliers, and anomalies. Overall the data in this study met criteria for a descriptive statistical analysis. However, there was an unclear response rate.

Because a private list-serve was used to recruit APsaA members, it is impossible to determine the total size of the target population. Data transformations were necessary to convert the raw data or narrative responses into usable categories and variables. In several instances, categorical variables were converted from ordinal to dichotomous nominal variables. There were 70 respondents and any missing data was excluded list-wise.

Initially, univariate data analyses were performed yielding descriptive statistics. Simple descriptive statistics were used to calculate participant demographic data, including: type of license, years licensed, primary theoretical orientation, and average number of patients seen per week. Descriptive statistics were also used to compute the countertransference variables pertaining to definition, classification, frequency, diagnostic group, and profile. Bivariate analyses were also performed using cross-tabulations and correlations. The specific measures of association and coefficients were selected based on variable type and amount of cells. Statistical significance was noted if  $p < .05$ . Finally, a multivariate data analyses was performed on the countertransference reaction variables. A hierarchical cluster analysis using centroid clustering was used to assign the 24-countertransference reactions into meaningful groups. Once clustered, their relationships with other variables could be examined.

## Results

Data from 70 completed self-report measures was obtained and subjected to statistical analyses using SPSS-22.0. The variables computed were those related to the following research questions concerning countertransference: (a) frequency of countertransference reactions in psychoanalysts, (b) nature of psychoanalysts' countertransference reactions, and (c) diagnostic influence on the frequency and nature of psychoanalysts' countertransference reactions. The following section will outline the data findings.

First, the distribution of each variable related to the research questions was assessed. Negative skews were found for both countertransference definition and countertransference frequency, reflecting values that clustered around the upper end of the ranges. This indicates that a majority of participants reported higher frequencies and more liberal beliefs about countertransference. These variables were shown to be leptokurtic, with lower than normal response distributions. Conversely, the variables addressing diagnosis had moderately positive skews. The variable of countertransference category appeared to be platykurtic, with a flatter than normal distribution. This indicates that responses had a greater variance than a normal distribution. As a result of these abnormalities, nonparametric measures of association were used to examine variable relationships. Given the descriptive nature of this study, abnormal distribution rates were considered part of the findings, rather than a qualifying feature.

### **Countertransference Definition, Frequency, and Classification**

Univariate and secondary data analyses using simple descriptive statistics and cross-tabulations were performed in order to examine general aspects of the countertransference phenomenon. In terms of theoretical understanding, a vast majority of respondents selected a liberal definition of CT ( $n = 57, 81.4\%$ ), defined as: *all of the analyst's unconscious (and*



*potentially conscious*) reactions to the patient. A cross tabulation showed that 82.4% of *traditional* psychoanalysts ( $n = 28$ ) and 79.3% ( $n = 23$ ) of *mid-century* psychoanalysts endorsed this comprehensive understanding of the CT. Only 8.6% of psychoanalysts endorsed a traditional understanding of CT ( $n = 6$ ), defined as: *the analyst's unconscious (and potentially conscious) reactions to the patient's transference*. The most infrequently reported definition of CT was consistent with the theory of projective identification, defined as *the analyst's unconscious (and potentially conscious) experience of the patient's projections* ( $n = 1$ , 1.4%).

Similar results were shown when psychoanalysts reported CT frequency during an average week of seeing patients. A majority of respondents claimed to *often*, if not *always* encounter CT ( $n = 64$ , 91.4%). Only 1 respondent indicated *rarely*, and there were no reports of *never* experiencing CT in a given week. Specific categories of countertransference experiences appeared only slightly more prevalent than others. Psychoanalysts were the most likely to classify a recent CT encounter as *parental/protective* ( $n = 23$ , 32.9%). After combining the *parental/protective* and *special/overinvolved* categories, the findings showed that nearly 40% of respondents selected care-taking categories of countertransference. Classifications such as *positive* ( $n = 7$ , 10%) and *criticized/mistreated* ( $n = 7$ , 10%) were equally as likely. Very few respondents endorsed *sexualized* ( $n = 3$ , 4.3%) or *overwhelmed/disorganized* ( $n = 2$ , 2.9%) instances of countertransference. Demographic characteristics appeared unrelated to respondent perspectives on countertransference definition, frequency, and classification. Please see Table 2 for the complete results.

### **Countertransference Reactions, Clusters, and Profiles**

The 24-countertransference reactions were calculated after being converted to dichotomous binary variables. Missing cases were excluded list-wise. In response to survey

item #8 on countertransference experience, the most frequently reported CT reactions included: open ( $n = 55, 90.2\%$ ), touched ( $n = 53, 81.5\%$ ), warm ( $n = 53, 81.5\%$ ), sober ( $n = 52, 81.3\%$ ), and calm ( $n = 51, 79.7\%$ ). Respondents were equally unlikely to report feeling shameful and bored ( $n = 19, 29.7\%$ ). Respondents were the least likely to report feeling indifferent ( $n = 19, 29.2\%$ ; see Table 3 for complete results).

A hierarchical cluster analysis was then used to examine the relationships between CT reaction variables. This resulted in the formation of two predominant clusters of countertransference reactions. The first cluster included the following 13 variables: *open, touched, warm, sober, calm, energetic, glad, free, relaxed, content, enthusiastic, playful, surprised*. The second cluster included the following 10 variables: *tense, irritated, powerless, nervous, cold, overwhelmed, paralyzed, indifferent, shameful, bored*. The third cluster was limited to the variable *neutral*. Results of this cluster analysis indicated that a majority of psychoanalyst reactions were consistent with a positive CT profile ( $n = 42, 60\%$ ), a third were consistent with a negative CT profile ( $n = 26, 37.1\%$ ), and a few respondents endorsed an equal number of positive and negative reactions ( $n = 2, 2.9\%$ ). A cross-tabulation revealed that traditional psychoanalysts were twice as likely to report negative CT reactions ( $n = 16, 47.1\%$ ) and the least likely to report positive CT reactions ( $n = 17, 50\%$ ) as compared to mid-century or contemporary psychoanalysts (see Tables 3 for complete results).

### **Countertransference Diagnostic Indications**

Participants were asked to provide diagnostic information on a recent case in which they experienced countertransference. The narrative data was coded according to the following criteria: (1) Responses without personality disorder claims; (2) Report of a personality disorder, even if secondary to an Axis I disorder; and (3) Responses such as, "I don't use DSM-IV criteria"

were coded as *other*. Results showed that slightly fewer psychoanalysts reported the presence of a personality disorder ( $n = 30, 44.8\%$ ) as compared to those who did not indicate a personality disorder ( $n = 31, 46.3\%$ ). Amongst those who reported Axis II pathology, a small majority specified Cluster B disorders ( $n = 17, 56.7\%$ ), which include Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder, and Narcissistic Personality Disorder. Generally speaking, personality disorders were shown to be most likely associated with countertransference reactions ( $n = 37, 56.9\%$ ). Diagnostic data did not appear to be associated with participant demographic information or any of the other data related to the psychoanalyst's countertransference experience.

## Discussion

The nature of countertransference and its impact on treatment continues to be a subject of debate in the psychotherapy community. This study sought to contribute to this discussion by clarifying from an empirical perspective the nature and frequency of countertransference reactions. Descriptive data were collected and several interesting findings emerged. The results indicated that countertransference frequently or regularly occurs as reported by psychoanalysts. Also, countertransference experiences were shown to be twice as likely to generate an array of positive affect states in psychoanalysts, such open and warm. By in large, analysts felt that CT is generated by their unconscious and/or conscious reactions to a patient. In fact, nearly half of all respondents endorsed caretaking categories of countertransference. Psychoanalysts' general beliefs about countertransference appeared to be independent of their clinical experience. There were no significant associations or predictors found amongst any of the CT variables.

One significant finding related to the clustering of countertransference reactions. It was shown that the co-existence of countertransference reaction variables was mostly related to the participant's state of emotion and affect. That is, positive reactions like glad, content, and playful co-occurred; while negative states like nervous, powerless, and irritable co-occurred. Interestingly, CT reactions with ambiguous tones such as sober and indifferent were part of the positive cluster, while neutral was categorized in a cluster of its own. The overall trends in clustering were unsurprising given that the 24 reaction variables used in this study were specifically designed and normed for countertransference measures (Holmqvist & Armelius, 2000). However, these findings must be considered in light of their conversion from ordinal to dichotomous binary variables. As a result, the response categories were condensed. The nominal conversion provided an opportunity for a more in-depth examination of the 24 CT

reaction variables, including their associations to one another, using bivariate and multivariate data analyses. Had the ordinal scale been preserved, the frequencies and hierarchical cluster analysis may have produced different results.

The study findings were inclusive regarding a possible association between countertransference diagnosis and patient symptomology. While the recent psychotherapy literature has suggested a relationship between countertransference reactions and characterological disorders (Betan et al., 2005; Brody & Farber, 1996; Rossberg, Karterud, Pedersen, & Friis, S., 2007, 2008, 2010), this study demonstrated mixed results. That is, no significant bivariate correlations were identified amongst the variables countertransference category, countertransference profile, client diagnosis, and personality disorder cluster. In terms of recent countertransference experiences, psychoanalysts were equal in their tendency to diagnosis Axis I disorders as they were Axis II disorders. However, amongst the Axis II endorsements, Cluster B disorders was specified by a majority of respondents. This finding is consistent with recent findings that more negative CT reactions were associated with Cluster A and B personality disorders than Cluster C (Rossberg, Karterud, Pedersen, & Friis, 2008).

It had been anticipated that a correlation between CT reactions and patient diagnosis would be found (given the theoretical literature); however, the data did not demonstrate such a relationship. Also, it was interesting to note the respondents' strong tendency to report positive CT profiles, which, again, appears less frequently in case literature. What might we make of these findings? One possibility may be related to the study sample. Unlike recent trans-theoretical CT studies, this study's respondents were all comprised of psychoanalysts. Albeit the most traditional form of psychotherapy, psychoanalysis remains distinct in its practitioner training, treatment parameters, and diagnostic protocol. In fact, the recent publication of the

Psychodynamic Diagnostic Manual (PDM, 2006) may account for the elevated level of missing cases and responses such as, "*I don't use this instrument*" on survey items that requested DSM-IV-TR diagnoses. It may be that associations were not found because DSM-IV-TR diagnoses are not commonly used resulting in a confound factor which impacted the data analysis. Further investigation is required to test the various factors that influence relationships such as those between patient characteristics, such as diagnosis, psychotherapist characteristics, psychotherapy process, and CT reactions.

### **Implications for Clinical Psychology**

The findings of this study have provided useful information about the frequency and nature of countertransference reactions in contemporary psychotherapy. While once perceived as a treatment-damaging phenomenon generated by difficult patients; countertransference is now considered a more complex aspect of psychotherapy, involving a variety of experiences and potential impacts, experienced across differing theoretical perspectives and allegiances and patient symptomology (Gabbard, 2001; Norcross, 2001; Stark, 1999). Consistent with Van Wagoner et al.'s, findings (1991), practitioners' clinical proficiency is unrelated to the frequency of their countertransference encounters.

This study also suggests that the countertransference experience should not necessarily be perceived as negative, pathologizing, or a detriment to treatment. Results of this study indicated that both positive and negative countertransference reactions are almost always occurring in the therapeutic relationship, independent of the therapist demographic information or patient disorder. The fact that almost half of the analysts reported care-taking roles in their recent CT experience classification was striking, but not surprising. After all, many aspects of

psychotherapy can be likened to parenting or re-parenting. Moreover, many are drawn to helping professions on account of their history as parentified children (Miller, 1981).

The notion of traditional analysts endorsing non-classical views on countertransference seems to reflect a paradigmatic shift. CT is seen by the majority of participants to encompass all therapist reactions as well as effects all therapist reactions. If all therapist reactions are deemed countertransference reactions, then it is even more so the therapist's responsibility to track and manage those reactions and underscores the importance of therapist insight and self-awareness. This is consistent with the finding that the management of CT reactions is beneficial to treatment (Gelso & Hayes, 2007).

### **Limitations and Recommendations for Future Research**

Several methodological issues imposed limits on this study. First and foremost, response rate was undeterminable because the confidential list-serve made it impossible to track the number of APsaA members recruited. While total APsaA membership is approximately 3500, the listserve may, for example, have only been comprised of 200-500 valid email addresses. Additionally, data collection was not linked to NPAP organization membership. As a result, it was impossible to know how many NPAP members participated out of the 200 recruited via email.

With respect to instrument design, it would be useful in future research to have a survey item addressing term of treatment. The item could have simply read: *How long have you been treating the subject of your most recent countertransference experience?* (a) Less than 6 months (b) 6 - 12 months (c) 1 - 3 years (d) 3 - 5 years (e) over 5 years. Additional ordinal/interval data and variables may provide a greater context to the countertransference reactions reported by psychoanalysts. Perhaps length of therapeutic relationship would have been shown to be an

influence on countertransference category or countertransference profile. Likewise, treatment setting (i.e.- inpatient, outpatient, hospital, agency, private practice) would have been a valuable piece of demographic data to have. Particular treatment settings are vulnerable to institutional transference which may contribute to institutional countertransference (Gendel & Reiser, 1981).

While the use of free-choice items offer the advantage of obtaining data using the participants' own language, challenges exist in accurately codifying the data into specific categories. The use of forced-choice format would have eliminated potential errors in classification. Similarly, the open-ended format on diagnostic items may have been a contributing factor in the high number of missing cases and declines to state. Finally, self-report measures are vulnerable to social desirability biases and response sets (Mitchell & Jolley, 2007), which the results may be biased.

Future studies on countertransference reactions may benefit from the development of a countertransference scale using the 24-CT reaction variables. Rather than convert them to dichotomous variables, they would remain as ordinal variables coded as *not at all / rather little / rather much / quite a lot*. Respondents would receive a total score based on the subtotals of their positive endorsements and negative endorsements. Such a scale would certainly provide more detailed information about the nature of countertransference reactions in psychotherapy.

### **Conclusion**

This study examined the nature and frequency of psychoanalyst countertransference reactions. It was discovered that psychoanalysts very frequently experience the countertransference phenomenon. They predominantly defined this phenomenon as being comprised of their patient reactions. Respondents were more likely to report positive countertransference reactions. No significant correlations were found between respondent



background, countertransference experience, and patient diagnosis. These findings provide a contemporary perspective on the countertransference phenomenon.

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## TABLES

Table 1

*Participant Demographics (N = 70)*

Characteristic	<i>n</i>	%
<b>Primary theoretical orientation</b>		
Traditional	34	48.6
Mid-Century	29	41.4
Contemporary	5	7.1
Other	2	2.9
<b>Type of license</b>		
Physician (MD or DO)	26	37.1
Psychology (PhD)	24	34.3
Psychology (PsyD)	3	4.3
LCSW (MSW or PhD)	11	15.7
Licensed Psychoanalyst	5	7.1
Other	1	1.4
<b>Years licensed</b>		
Under 10	5	7.1
10-19	9	12.9
20-29	8	11.4
30-39	30	42.9
40-49	12	17.1
50+	6	8.6
<b>Patients seen per week</b>		
Under 10	8	11.4
10-19	30	42
20-29	18	25.7
30+	11	15.7
Retired	2	2.9
Missing	1	1.4

*Note.* Variable categories were developed following a review of the narrative responses.

Table 2

*Countertransference Definition, Frequency, and Classification*

Variable	<i>n</i>	%
Countertransference definition		
The analyst's unconscious (and potentially conscious) reactions to the patient's transference	6	8.6
The analyst's unconscious (and potentially conscious) experience of the patient's projections, i.e., projective identification	1	1.4
The analyst's unconscious (and potentially conscious) reactions to the patient based on the analyst's unresolved conflicts	3	4.3
All of the analyst's unconscious (and potentially conscious) reactions to the patient	57	81.4
Other	3	4.3
Frequency of countertransference experiences per week		
Never	0	0
Rarely	1	1.4
Sometimes	5	7.1
Often	25	35.7
Always	39	55.7
Classification of countertransference experience		
Parental/protective	23	32.9
Special/overinvolved	4	5.7
Criticized/mistreated	7	10
Overwhelmed/disorganized	2	2.9
Positive	7	10
Sexualized	3	4.3
Helpless/inadequate	4	5.7
Disengaged	6	8.6
Other	10	14.3
All	4	5.7

Table 3

*Countertransference Reactions*

Variable	<i>n</i>	%	<i>Cluster</i>
Open	55	90.2	1
Touched	53	81.5	1
Warm	53	81.5	1
Sober	52	81.3	1
Calm	51	79.7	1
Tense	44	67.7	2
Energetic	44	67.7	1
Powerless	41	64.1	2
Irritated	42	63.6	2
Nervous	40	61.5	2
Glad	39	60.9	1
Relaxed	38	60.3	1
Free	39	60	1
Enthusiastic	36	57.1	1
Content	37	56.9	1
Neutral	33	51.6	3
Playful	32	49.2	1
Overwhelmed	26	41.9	2
Surprised	26	41.3	1
Cold	26	40.6	2
Paralyzed	21	32.8	2
Shameful	19	29.7	2
Bored	19	29.7	2
Indifferent	19	29.2	2
CT profiles			
Positive	42	60	
Negative	26	37.1	
Equivalent	2	2.9	

*Note.* Valid percentiles exclude missing cases. Clusters were generated using a Hierarchical Cluster Analysis. Variable reflects respondents' reports of positive and negative CT reactions.

Table 4

*Countertransference Diagnostic Indications*

Variable	<i>n</i>	%
Client diagnosis		
No personality disorder reported	31	46.3
Personality disorder reported	30	44.8
Other	6	9
General diagnosis		
No personality disorder reported	1	1.5
Personality disorder reported	37	56.9
All diagnoses	15	23.1
Other	12	18.5
PD cluster ( <i>n</i> = 30)		
Cluster A	2	6.7
Cluster B	17	56.7
Cluster C	4	13.3
PD NOS	7	23.3

*Note.* Valid percentiles exclude missing cases. Variable was created after reviewing respondent narratives.



## APPENDIX A

### Literature Review Tables

The background literature used to inform this study is a composite of both theoretical studies and empirical studies. Psychodynamically/psychoanalytically oriented articles relevant to the theoretical conceptualization of countertransference were accessed through the electronic database, Psychoanalytic Electronic Publishing (PEPWeb). Within this archive, the *Most Cited Articles* section was searched, the *Article Title Field* was selected, and the term *Countertransference* was queried. This search produced 259 published papers organized by most frequently cited within Psychoanalytic Electronic Publishing (PEP), in descending order. The top 25 papers cited in the past 5-years were reviewed (<http://www.p-e-p.org>).

Empirical studies on countertransference were researched through the electronic search engine PsycINFO and accessed through the EBSCO publishing database. An advanced search was conducted and the term countertransference was queried in the *Article Title Field*. Several search specifiers were employed: studies utilizing empirical methodologies were included, while dissertation studies were excluded. This search produced 473 papers. Of those, papers cited fewer than 5-times within the database and studies that were diagnostically, culturally, or treatment specific were excluded. This yielded a total of 75 articles organized by citation frequency, in descending order. The top 25 articles were selected for review. The references for these publications are included in the literature table found in the Appendix Section and the major contributions of these papers are discussed in the Background section.

Table 5

*Theoretical Papers on Countertransference*

<i>Author</i>	<i>Source</i>	<i>Cited Last 5 Years</i>
Sandler, J. (1976).	Countertransference and Role-Responsiveness. <i>Int. R. Psycho-Anal.</i> , 3:43-47.	89
Racker, H. (1957).	The Meanings and Uses of Countertransference. <i>Psychoanal Q.</i> , 26:303-357.	41
Davies, J.M. (1994).	Love in the Afternoon: A Relational Reconsideration of Desire and Dread in the Countertransference. <i>Psychoanal. Dial.</i> , 4:153-170.	39
Jacobs, T.J. (1986).	On Countertransference Enactments. <i>J. Amer. Psychoanal. Assn.</i> , 34:289-307.	31
Smith, H.F. (2000).	Countertransference, Conflictual Listening, and the Analytic Object Relationship. <i>J. Amer. Psychoanal. Assn.</i> , 48:95-128.	26
Davies, J.M. (1998).	Between the Disclosure and Foreclosure of Erotic Transference-Countertransference: Can Psychoanalysis Find a Place for Adult Sexuality?. <i>Psychoanal. Dial.</i> , 8:747-766.	25
Gabbard, G.O. (1995).	Countertransference: The Emerging Common Ground. <i>Int. J. Psycho-Anal.</i> , 76:475-485.	22
Davies, J.M., Frawley, M.G. (1992).	Dissociative Processes and Transference-Countertransference Paradigms in the Psychoanalytically Oriented Treatment of Adult Survivors of Childhood Sexual Abuse. <i>Psychoanal. Dial.</i> , 2:5-36.	22
Pick, I.B. (1985).	Working Through in the Countertransference. <i>Int. J. Psycho-Anal.</i> , 66:157-166.	22

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Ogden, T.H. (1995).	Analysing Forms Of Aliveness And Deadness Of The Transference- Countertransference. <i>Int. J. Psycho- Anal.</i> , 76:695-709	18
Grinberg, L. (1962).	On a Specific Aspect of Countertransference Due to the Patient's Projective Identification. <i>Int. J. Psycho-Anal.</i> , 43:436-440.	18
Fosshage, J.L. (1995).	Countertransference as the Analyst's Experience of the Analysand: Influence of Listening Perspectives. <i>Psychoanal. Psychol.</i> , 12:375-391.	16
McLaughlin, J.T. (1981).	Transference, Psychic Reality, and Countertransference. <i>Psychoanal Q.</i> , 50:639-664.	16
Gabbard, G.O. (1994).	Sexual Excitement and Countertransference Love in the Analyst. <i>J. Amer. Psychoanal. Assn.</i> , 42:1083-1106.	14
Grinberg, L. (1979).	Countertransference and Projective Counteridentification. <i>Contemp. Psychoanal.</i> , 15:226-247.	13
Tower, L.E. (1956).	Countertransference. <i>J. Amer. Psychoanal. Assn.</i> , 4:224-255.	11
Hirsch, I. (1994).	Countertransference Love and Theoretical Model. <i>Psychoanal. Dial.</i> , 4:171-192.	10
Loewald, H.W. (1986).	Transference-Countertransference. <i>J. Amer. Psychoanal. Assn.</i> , 34:275-287.	10
Davies, J.M. (1996).	Dissociation, Repression and Reality Testing in the Countertransference: The Controversy Over Memory and False Memory in the Psychoanalytic Treatment of Adult Survivors of Childhood Sexual Abuse. <i>Psychoanal. Dial.</i> , 6:189-218.	9
Kernberg, O. (1965).	Notes on Countertransference. <i>J. Amer. Psychoanal. Assn.</i> , 13:38-56.	9
Ehrenberg, D.B. (1995).	Self-disclosure: Therapeutic Tool Or Indulgence; Countertransference Disclosure. <i>Contemp. Psychoanal.</i> , 31:213.	9

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Schwaber, E.A. (1992).	Countertransference: The Analyst's Retreat from the Patient's Vantage Point. <i>Int. J. Psycho-Anal.</i> , 73:349-361.	8
Jacobs, T.J. (2001).	On Misreading and Misleading Patients: Some Reflections on Communications, Miscommunications and Countertransference Enactments. <i>Int. J. Psycho-Anal.</i> , 82:653-669.	8
Parsons, M. (2007).	Raiding the Inarticulate: The Internal Analytic Setting and Listening Beyond Countertransference. <i>Int. J. Psycho- Anal.</i> , 88:1441-1456.	8

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Table 6

*Empirical Studies*

<i>Author</i>	<i>Source</i>	<i>Cited</i>
Davies, J. (1994).	Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. Psychoanalytic Dialogues, 4(2), 153-170.	92
Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni, P. (1998).	Therapist perspectives on countertransference: Qualitative data in search of a theory. Journal Of Counseling Psychology, 45(4), 468-482.	67
Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M. G. (1995).	Countertransference reactions to lesbian clients: The role of homophobia, counselor gender, and countertransference management. Journal Of Counseling Psychology, 42(3), 356-364.	60
Betan, E., Heim, A., Conklin, C., & Westen, D. (2005).	Countertransference Phenomena and Personality Pathology in Clinical Practice: An Empirical Investigation. The American Journal Of Psychiatry, 162(5), 890-898.	56
Ogden, T. H. (1995).	Analysing forms of aliveness and deadness of the transference-countertransference. The International Journal Of Psychoanalysis, 76(4), 695-709.	55
Robbins, S. B., & Jolkovski, M. P. (1987).	Managing countertransference feelings: An interactional model using awareness of feeling and theoretical framework. Journal Of Counseling Psychology, 34(3), 276-282.	47
Schwaber, E. A. (1992).	Countertransference: The analyst's retreat from the patient's vantage point. The International Journal Of Psychoanalysis, 73(2), 349-361.	45

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Ladany, N., Constantine, M. G., Miller, K., Erickson, C. D., & Muse- Burke, J. L. (2000).	Supervisor countertransference: A qualitative investigation into its identification and description. Journal Of Counseling Psychology, 47(1), 102- 115.	36
Hayes, J. A., Gelso, C. J., Van Wagoner, S. L., & Diemer, R. A. (1991).	Managing countertransference: What the experts think. Psychological Reports, 69(1), 139-148.	34
Hayes, J. A., Riker, J. R., & Ingram, K. M. (1997).	Countertransference behavior and management in brief counseling: A field study. Psychotherapy Research, 7(2), 145-153.	33
Hirsch, I. (1994).	Countertransference love and theoretical model. Psychoanalytic Dialogues, 4(2), 171-192.	32
Mohr, J. J., Gelso, C. J., & Hill, C. E. (2005).	Client and Counselor Trainee Attachment as Predictors of Session Evaluation and Countertransference Behavior in First Counseling Sessions. Journal Of Counseling Psychology, 52(3), 298-309.	31
Rosenberger, E. W., & Hayes, J. A. (2002).	Origins, consequences, and management of countertransference: A case study. Journal Of Counseling Psychology, 49(2), 221- 232.	30
Hayes, J. A., & Gelso, C. J. (1991).	Effects of therapist-trainees' anxiety and empathy on countertransference behavior. Journal Of Clinical Psychology, 47(2), 284-290.	30
Fosshage, J. L. (1995).	Countertransference as the analyst's experience of the analysand: Influence of listening perspectives. Psychoanalytic Psychology, 12(3), 375-391.	28
Nivoli, G., Loretto, L., Nivoli, A., & Nivoli, F. (2010).	La controtraslazione del terapeuta verso il paziente con disturbo mentale e comportamento violento. Rivista Di Psichiatria, 45(1), 49-57.	25

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Friedman, S., & Gelso, C. J. (2000).	The development of the Inventory of Countertransference Behavior. <i>Journal Of Clinical Psychology</i> , 56(9), 1221-1235.	24
Tansey, M. J. (1994).	Sexual attraction and phobic dread in the countertransference. <i>Psychoanalytic Dialogues</i> , 4(2), 139-152.	23
Gelso, C. J., Latts, M. G., Gomez, M. J., & Fassinger, R. E. (2002).	Countertransference management and therapy outcome: An initial evaluation. <i>Journal Of Clinical Psychology</i> , 58(7), 861-867.	22
Lecours, S., Bouchard, M., & Normandin, L. (1995).	Countertransference as the therapist's mental activity: Experience and gender differences among psychoanalytically oriented psychologists. <i>Psychoanalytic Psychology</i> , 12(2), 259-279.	22
Van Wagoner, S. L., Gelso, C. J., Hayes, J. A., & Diemer, R. A. (1991).	Countertransference and the reputedly excellent therapist. <i>Psychotherapy: Theory, Research, Practice, Training</i> , 28(3), 411-421.	21

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## APPENDIX B

### Countertransference Survey

1. Please indicate the primary and secondary schools of psychoanalytic theory that influence your clinical work (e.g., ego psychology, object relations, etc.)

Primary \_\_\_\_\_

Secondary \_\_\_\_\_

2. Please indicate the professional license under which you practice (and associated degree if noted).

- a. Physician (MD or DO)
- b. Psychology (PhD)
- c. Psychology (PsyD)
- d. LMFT (MA)
- e. LCSW (PhD)
- f. LCSW (MSW)
- g. LPC (MA)
- h. Research Psychoanalyst (PhD, JD)
- i. Other \_\_\_\_\_

3. When did you receive licensure?

4. On average, how many individual patients do you see per week in psychoanalysis or psychodynamic psychotherapy?

- a. Under 10
- b. 10-19
- c. 20-29
- d. 30 or more
- e. Retired & no longer seeing patients

5. Which of the following definitions of countertransference is closest to your understanding of the phenomenon:

- a. The analyst's unconscious (and potentially conscious) reactions to the patient's transference
- b. The analyst's unconscious (and potentially conscious) experience of the patient's projections, i.e., projective identification
- c. The analyst's unconscious (and potentially conscious) reactions to the patient based on the analyst's unresolved conflicts
- d. All of the analyst's unconscious (and potentially conscious) reactions to the patient

6. Based on the definition you endorsed above, in an average week of treating patients, you experience countertransference:

- a. Never
- b. Rarely
- c. Sometimes
- d. Often
- e. Always

7. Countertransference reactions are often described as "distinctly unusual, idiosyncratic, or uncharacteristic acts or patterns of therapist experience and/or actions towards clients" (Falender & Shafranske, 2008). Your most recent countertransference experience with a patient could be best classified as:

- a. Parental/Protective
- b. Special/Overinvolved
- c. Criticized/Mistreated
- d. Overwhelmed/Disorganized
- e. Positive
- f. Sexualized
- g. Helpless/Inadequate
- h. Disengaged

8. Your most recent countertransference experience with a patient left you feeling...

(0 = not at all, 1 = rather little, 2 = rather much, 3 = quite a lot)

Playful	0	1	2	3
Indifferent	0	1	2	3
Open	0	1	2	3

Sober	0	1	2	3
Cold	0	1	2	3
Nervous	0	1	2	3
Touched	0	1	2	3
Powerless	0	1	2	3
Neutral	0	1	2	3
Content	0	1	2	3
Shameful	0	1	2	3
Warm	0	1	2	3
Glad	0	1	2	3
Bored	0	1	2	3
Relaxed	0	1	2	3
Overwhelmed	0	1	2	3
Irritated	0	1	2	3
Calm	0	1	2	3
Enthusiastic	0	1	2	3
Tense	0	1	2	3
Surprised	0	1	2	3
Energetic	0	1	2	3
Free	0	1	2	3

9. After session, this countertransference experience prompted the following behaviors (check all that apply):

- a. Personal reflection
- b. Dreams related to the countertransference experience
- c. Discussed with a professional colleague
- d. Discussed in personal psychotherapy/psychoanalysis
- e. Other, please describe

10. In your clinical experience, please indicate how this patient's constellation of symptoms could best be diagnosed, according to DSM-IV-TR criteria:

11. In your clinical experience, please indicate which patient groups, i.e., based on DSM-IV-TR criteria, are most likely to produce countertransference reactions:

## APPENDIX C

### Recruitment Letter to Organization Directors

Dear Organization Director,

I am a clinical psychology doctoral candidate at Pepperdine University conducting a study to meet my dissertation requirements under the supervision of my faculty advisor, Edward Shafranske, Ph.D., ABPP. For my dissertation, I am investigating the nature and frequency of the countertransference experience within the psychoanalytic community. Psychotherapist personal factors, often referred to as countertransference reactions, are an important part of the therapeutic process. However, there have been relatively few empirical studies on the countertransference reactions of practicing psychoanalysts. I am contacting the directors of several national psychoanalytic organizations and requesting their assistance with my study. This study has been approved by the Graduate and Professional Schools Institutional Review Board at Pepperdine University.

I would very much appreciate your permission to send a recruitment letter via email to the members of your organization. Their participation would involve completing a brief online survey about a recent experience of countertransference. Survey completion time is approximately 10 minutes. Demographic information will be collected, however no identifying information will be requested.

The study poses no greater than minimal risk to participants, such as possible discomfort in reflecting on the nature of a recent occurrence of countertransference. In the unlikely event a participant were to experience discomfort in responding to the research questionnaire, I will recommend that participants seek clinical consultation to discuss their reactions.

If you have questions or comments please do not hesitate to contact me at my email address [REDACTED] or my dissertation Chairperson, Dr. Edward Shafranske at [REDACTED] or Dr. Thema Bryant-Davis, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at (310) 568-5600.

Thank you for your support with this study.

Sincerely,

Michelle Walker, M.A.  
Doctoral student, Clinical Psychology  
Pepperdine University

## APPENDIX D

### Recruitment Letter to Participants

Dear Clinician,

I am a clinical psychology doctoral candidate at Pepperdine University conducting a study to meet my dissertation requirements under the supervision of my faculty advisor, Edward Shafranske, Ph.D., ABPP. I am conducting a brief study examining the nature and frequency of analysts' countertransference reactions. Such reactions refer to psychotherapist personal factors, which are widely believed to impact the therapeutic process. I am requesting assistance with my study from analysts affiliated with a national psychoanalytic association.

I would very much appreciate your help in completing an online survey about your experience with countertransference. Demographic information will be collected, however no identifying information will be requested. Survey completion time is approximately 10 minutes. Your participation will result in a donation being made to the National Alliance on Mental Health (NAMI). The study poses no greater than minimal risk to participants, such as possible discomfort in reflecting on recent countertransference reactions. Please note that participation is voluntary. By completing the survey you are acknowledging that you have been informed about the study and are granting your consent to participate. The survey can be accessed through the website SurveyMonkey. A link to the web address of the surveys can be found at the end of this letter.

If you have questions or comments please do not hesitate to contact me at my email address [REDACTED] or my dissertation Chairperson, Dr. Edward Shafranske at [REDACTED] or Dr. Thema Bryant-Davis, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at (310) 568-5600.

Thank you for your support with this study.

Sincerely,

Michelle Walker, M.A.  
Doctoral student, Clinical Psychology  
Pepperdine University

[http://www.surveymonkey.com/s.aspx?PREVIEW\\_MODE=DO\\_NOT\\_USE\\_THIS\\_LINK\\_FOR\\_COLLECTION&sm=aJfeqn%2fiPp9JpcDqqcDvty6x7VOumxw6KKwJbd51r7E%3d](http://www.surveymonkey.com/s.aspx?PREVIEW_MODE=DO_NOT_USE_THIS_LINK_FOR_COLLECTION&sm=aJfeqn%2fiPp9JpcDqqcDvty6x7VOumxw6KKwJbd51r7E%3d)



## APPENDIX E

### Follow-Up Letter to Participants

Dear Clinician,

A few weeks ago, I had contacted you to request your participation in a study on countertransference. I would like to take this opportunity to remind you of my study.

I am a clinical psychology doctoral candidate at Pepperdine University conducting a study to meet my dissertation requirements under the supervision of my faculty advisor, Edward Shafranske, Ph.D., ABPP. I am conducting a brief study examining the nature and frequency of analysts' countertransference reactions. Such reactions refer to psychotherapist personal factors, which are widely believed to impact the therapeutic process. I am requesting assistance with my study from analysts affiliated with a national psychoanalytic association.

I would very much appreciate your help in completing an online survey about your experience with countertransference. Demographic information will be collected, however no identifying information will be requested. Survey completion time is approximately 10 minutes. Your participation will result in a donation being made to the National Alliance on Mental Health (NAMI). The study poses no greater than minimal risk to participants, such as possible discomfort in reflecting on recent countertransference reactions. Please note that participation is voluntary. By completing the survey you are acknowledging that you have been informed about the study and are granting your consent to participate. The survey can be accessed through the website SurveyMonkey. A link to the web address of the surveys can be found at the end of this letter.

If you have questions or comments please do not hesitate to contact me at my email address [REDACTED] or my dissertation Chairperson, Dr. Edward Shafranske at [REDACTED] or Dr. Thema Bryant-Davis, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at (310) 568-5600.

Thank you for your support with this study.

Sincerely,

Michelle Walker, M.A.  
Doctoral student, Clinical Psychology  
Pepperdine University

[http://www.surveymonkey.com/s.aspx?PREVIEW\\_MODE=DO\\_NOT\\_USE\\_THIS\\_LINK\\_FOR\\_COLLECTION&sm=aJfeqn%2fiPp9JpcDqqcDvty6x7VOumxw6KKwJbd51r7E%3d](http://www.surveymonkey.com/s.aspx?PREVIEW_MODE=DO_NOT_USE_THIS_LINK_FOR_COLLECTION&sm=aJfeqn%2fiPp9JpcDqqcDvty6x7VOumxw6KKwJbd51r7E%3d)

## APPENDIX F

### Introduction to the Survey and Consent to Participate

Dear Participants:

My name is Michelle Walker and I am a doctoral candidate studying clinical psychology at Pepperdine University, who is currently in the process of recruiting individuals for my study entitled, “The Nature and Frequency of Countertransference reactions of Psychoanalysts.” The professor supervising my work is Dr. Edward Shafranske. The study is designed to investigate a clinician’s recent experience with countertransference during psychotherapy, therefore I am inviting individuals who perform psychotherapy to participate in my study. Please understand that your participation in my study is strictly voluntary. The following is a description of what your study participation entails, the terms for participating in the study, and a discussion of your rights as a study participant. Please read this information carefully before deciding whether or not you wish to participate.

If you should decide to participate in the study, you will be asked to complete a brief questionnaire comprised of free-response and multiple choice items. It should take approximately 10 minutes to complete the survey.

Although minimal, there are potential risks that you should consider before deciding to participate in this study. These risks include emotional discomfort due to reflecting on my countertransference experiences with patients. In the event you do experience emotional discomfort or negative reactions to the survey, it is recommended that you seek clinical case consultation.

Although there are no direct benefits to all participants in this study, your participation in this study will result in a donation being made to the National Alliance on Mental Illness (NAMI). Other possible benefits may include reflecting on and gaining greater understanding of your countertransference reactions with patients which may improve your ability to manage these reactions. Furthermore, increased knowledge about the nature and frequency of countertransference reactions may contribute to a greater understanding of the countertransference phenomenon for psychoanalytic treatment and the field of professional psychology.

If you should decide to participate and find you are not interested in completing the survey in its entirety, you have the right to discontinue at any point without being questioned about your decision. You also do not have to answer any of the questions on the survey that you prefer not to answer--just leave such items blank. After 2 weeks, a reminder note will be sent to you to complete and return the survey.

If the findings of the study are presented to professional audiences or published, no information that identifies you personally will be released. The data will be kept on a USB drive and secure stored in a locked file cabinet for 3 years following study completion, at which time the data will be destroyed.

If you have any questions regarding the information that I have provided above or would like documentation linking yourself to the research, please do not hesitate to contact me at the address and phone number provided below. If you have further questions or do not feel I have

adequately addressed your concerns, please contact my dissertation Chairperson, Dr. Edward Shafranske at [REDACTED] If you have questions about your rights as a research participant, contact Dr. Thema Bryant-Davis, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at (310) 568-5600.

By completing the on-line survey you are acknowledging that you have read and understand what your study participation entails, and are consenting to participate in the study.

Thank you for taking the time to read this information, and I hope you decide to complete the survey.

Sincerely,

Michelle Walker, M.A.  
Doctoral Student, Clinical Psychology

APPENDIX G

Pepperdine IRB Approval Letter

# PEPPERDINE UNIVERSITY

## Graduate & Professional Schools Institutional Review Board

November 4, 2013

Michelle Walker

Protocol #: P1013D01 Project Title: The Nature and Frequency of Countertransference Reactions of Psychoanalysts

Dear Ms. Walker:

Thank you for submitting your application, The Nature and Frequency of Countertransference Reactions of Psychoanalysts, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Edward Shafranske, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted Full Approval. The IRB approval begins today, 11/4/2013, and terminates on 11/4/2014. In addition, your application to waive documentation of informed consent, as indicated in your Application for Waiver or Alteration of Informed Consent Procedures form has been approved.

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond 11/4/2014, a Continuation or Completion of Review Form must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Michelle Blas, Director of Student Success at [gpsirb@pepperdine.edu](mailto:gpsirb@pepperdine.edu). On behalf of the GPS IRB, I wish you success in this scholarly pursuit.  
Sincerely,

Thema Bryant-Davis, Ph.D. Chair, Graduate and Professional Schools IRB Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives Ms. Alexandra Roosa, Director Research and Sponsored Programs Dr. Edward Shafranske, Faculty Chair



