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Countertransference Reactions to Adolescents with Eating Disorders: Relationships to Clinician and Patient Factors

Dana A. Satir, M.A.¹, Heather Thompson-Brenner, Ph.D.¹, Christina L. Boisseau, M.A.¹, and Michele A. Crisafulli, M.A.¹

¹Center for Anxiety and Related Disorders, Department of Psychology, Boston University

Abstract

Objective—Clinical report suggests therapists have strong and sometimes difficult-to-manage reactions to patients with eating disorders (EDs), however, systematic research is largely absent. The purpose of this study was to explore the emotional responses, or countertransference (CT) reactions, clinicians experience when working with patients with EDs, and to identify clinician, patient, and therapy variables associated with these responses.

Method—One hundred twenty clinicians reported on multiple variables related to an adolescent female patient they were treating for an ED.

Results—Six patterns of reactions were identified: Angry/Frustrated, Warm/Competent, Aggressive/Sexual, Failing/Incompetent, Bored/Angry at Parents and Overinvested/Worried feelings. The factors showed meaningful relationships across clinician demographics, patient characteristics, and treatment techniques.

Conclusion—Overall, clinician's reactions were most frequently associated with the clinician's gender, patients' level of functioning and improvement during treatment, and patient personality style. These issues have important implications for training and supervision.

Keywords

Eating disorders; adolescent; psychotherapy; countertransference; clinician attitudes

Widespread public opinion would suggest that clinicians hold negative attitudes and experience numerous challenges when treating individuals with eating disorders (EDs), however, systematic research regarding therapists' actual feelings regarding their patients is limited to a few studies.^{1,2} The perception that clinicians have negative experiences when working with individuals EDs may contribute to a reluctance towards treating EDs in general,³ and may account for the observed dearth of clinicians treating EDs in the community.⁴ Empirical research focusing on clinicians' reactions to working with patients with EDs is needed to address possible misperceptions, as well as understand the reactions that clinicians do have.

Research suggests that therapists' emotional responses, or "countertransference" (CT), influence therapy process and treatment outcome across various forms of psychopathology.⁵ Countertransference has been defined multiple ways since it was first introduced by Freud.⁶ In this study, we define CT as: "all the reactions a clinician has toward a patient, regardless of their source." This comprehensive definition incorporates several possible sources of CT, including patient dimensions (e.g., the patient's psychopathology, history, or personality), therapist dimensions (e.g., the therapist's own history or personality), and dimensions of the therapy itself (e.g., the type of therapy or success of the therapy). It is consistent with those of prior theorists and empirical researchers,^{2,7,8} though some research in CT has focused on reactions due to therapist dimensions alone.⁹ While empirical research on CT reactions to individuals with EDs is limited, a few studies have identified clinician and patient characteristics that may contribute to clinicians' reactions.

Clinician Characteristics and Eating Disorder Treatment

Gender

Research has not indicated that ED treatment outcome is different for male and female therapists, however, research and clinical observation have indicated that gender may play various roles in the treatment process.^{10,11} Research suggests male therapists are more likely than female therapists to express feelings of ineffectiveness when dealing with body image issues,¹² and male clinicians are significantly more likely to express reluctance to treat patients with EDs.³ Clinicians observe that intense discussions around body image and abuse experiences can make male therapists feel intrusive with female clients with EDs,¹³ and research indicates clients with EDs are more likely to indicate preference for female therapists if they report a history of paternal sexual abuse, body image issues, or overprotective mothering.¹⁰

Research and clinical observation indicate that female therapist and patient dyads are also vulnerable to intense feelings and interactions. One study suggests female patients with EDs have stronger feelings about their female clinicians' body shape than other patient groups.¹⁴ A recent survey of members of the Academy for Eating Disorders (an international organization promoting ED research, treatment and prevention) indicated 33.2% of females, but only 2.3% of males, reported a lifetime prevalence of an ED,¹⁵ a factor that may affect clinicians' reactions. Clinicians note potential effects of similarities between female therapists and patients in demographics, education, and culture, especially among early-career female professionals.^{11,16} The potential for identification might benefit the therapeutic alliance, however, there is also a risk for overidentification, which may cause clinicians to avoid conflict, feel competitive, or act overly nurturing towards patients with EDs.¹⁷

Discipline

There is preliminary evidence that the professional discipline of the therapist may have an impact on his/her attitudes and feelings toward his/her patients. One study of medical professionals in contact with patients with EDs in a hospital setting found differences according to group discipline, wherein nurses were more likely to view patients as being

responsible for or causing their illnesses than physicians and psychiatric trainees.¹⁸ Research investigating differences across professional disciplines is needed to determine how and why these attitudes impact the actual treatment of EDs.

Other therapist factors

One of the few studies of predictors of therapist reactions to patients with EDs indicated that experience level negatively predicted negative therapist reactions.² The size of a clinician's case load and quality of supervision may also explain variance in feelings of frustration, manipulation, and helplessness.^{2, 19}

Patient Characteristics

Severity

ED severity may independently predict and interact with process variables to influence clinicians' feelings and attitudes when treating ED patients. Therapist reactions are almost certainly affected by the significant risk of medical complications in severe EDs, with mortality rates for AN the greatest of all psychiatric illnesses at 10–15%.^{10,20} While medical complications are less frequent in bulimia nervosa (BN), life-threatening symptoms can occur and patients often manifest non-lethal medical symptoms, such as nosebleeds, capillary ruptures, fractures, amenorrhea, and polycystic ovaries.^{22,23} Therapists and researchers working with EDs note that outpatient clinicians may be reluctant to treat patients who require hospitalization,¹³ which affects as many as two-thirds of ED patients during the course of their illness.²⁴ Hospital-based psychotherapists may have different reactions to working with those at risk. While research is limited, the severity of patients' symptoms seems to have important implications for the therapeutic alliance. For example, baseline symptom severity appears to predict poor treatment alliance in cognitive behavioral therapy (CBT) for BN.²⁵

Personality pathology

Another patient factor influencing therapists' responses to patients with EDs may be the substantial comorbidity between EDs and personality disorders. Multiple studies have demonstrated that Axis II Cluster B (dramatic) disorders are especially common in patients with BN, while there is an overrepresentation of Cluster C (anxious) comorbidity in patients with AN.^{26,27} Extremely high prevalence rates of personality pathology have also been reported in samples of ED patients treated by individual clinicians in the community,⁴ including personality pathology of both the undercontrolled/dysregulated and overcontrolled/constricted types.²⁸ Research has begun to confirm decades of clinical observation suggesting that therapists' reactions to patients with personality disorders are particularly intense and negative.^{7,26} Clinicians report feeling more overwhelmed, criticized, disengaged, and helpless with patients with Cluster B diagnoses, and more protective of patients with Cluster C diagnoses.⁷ Other studies suggest the severity of interpersonal problems (characteristic of many personality disorders) predicts poor therapeutic alliances in patients receiving interpersonal therapy for BN.²⁵ Additional research is needed to examine the relationship between personality pathology and clinician reactions to patients with EDs.

Given the paucity of research in this area, our study is exploratory in nature. Therefore we incorporated a wide range of possible therapist, patient, and treatment variables with potential to contribute to CT reactions. The goals of this study were to 1) identify patterns of clinicians' reactions; 2) explore how those reactions differ according to patient, clinician, and treatment response variables.

Method

Clinician-Report Method

This study used a practice-research network of randomly selected, experienced clinicians who treat adolescents in the community. Clinician assessment is the only source of data used in this study. There are several advantages and disadvantages to this method, reviewed extensively elsewhere.^{30–32} One main advantage is that clinicians are experienced observers, with skills and a normative basis from which they can make inferences and recognize nuances in different forms of psychopathology. One key objection made to this method is the potential influence of bias in clinical judgment. Though the reliability and validity for the measures included in the study are reported below, generally research supports the reliability and validity of clinicians' observations quantified with the use of psychometric instruments. When clinicians are asked to describe specific patient characteristics that are quantified empirically (as opposed to beliefs or theories), theoretical orientation appears to predict little variance in descriptions of clinical phenomena.³⁰ Furthermore, this study intended to investigate clinician's reactions to their own patients, and in this domain the clinician's own perception of the patient was paramount, as well as his or her self-report of countertransference reactions. The study was approved by the Boston University Institutional Review Board.

Participants

Participants were recruited from a practice-research network of psychiatrists (M.D.s) and psychologists (Ph.D.s), recruited from the registers of the American Psychiatric and American Psychological Associations, with at least five years experience (post-residency or post-licensure). Participants were initially recruited for a National Institute of Mental Health-funded study of adolescent psychopathology.³³ Approximately 3600 individual clinicians were initially contacted, and over one-third agreed to participate, though membership registration was closed after the intended 950 individuals had completed data collection. In 2004, for this study of adolescent EDs, we sent letters briefly describing the current study and patient subject criteria to 850 randomly-selected clinicians (who had indicated a willingness to participate in future research) from this practice-research network. Network data did not indicate whether the clinicians commonly treated EDs or not. Out of the 850 clinicians contacted, 462 responded they were willing to participate, for an overall response rate of 54%. Of these clinicians, 191(22%) indicated they were currently treating a female patient between 15–18 years old with an ED, and were therefore invited to participate; of these, 124 returned the measures complete for a completion rate of 65% of the relevant subjects. Four subjects were excluded due to incorrect subject selection or otherwise unsuitable data. The current study is part of a larger investigation of personality

subtypes in adolescents with EDs.³³ Participating clinicians received a consulting fee of \$200 for a procedure that required 2–3 hours of time.

For the current study, clinicians were directed to describe “a female adolescent patient between the ages of 15–18 with an eating disorder.” To minimize selection biases, clinicians were directed to consult their calendars to select the last patient they saw during the previous week who met study criteria. To test whether clinicians followed these directions, a subsample was recontacted, all of whom confirmed having followed the directions for random patient selection. Additionally, clinicians were asked to consider whether the patient was “someone they felt they knew and understood reasonably well,” which was operationally translated into 6 clinical contact hours but 1 year of treatment. Clinicians were told that patients did not have to meet full criteria for BN or AN, as we were interested in all patients with symptoms of an ED (i.e., including AN, BN, and EDNOS). Patient exclusion criteria were chronic psychosis and mental retardation. Clinicians received a packet containing a cover letter, a consent form, a postage-paid return envelope, and the study measures. Clinicians did not provide identifying information about the patient and were instructed to use only information already available to them from their regular contacts with the patient and their records. With the exception of the Countertransference Questionnaire and the Effectiveness of Treatment Form, clinicians were instructed to describe the patient as she was at the time she began treatment. Each clinician contributed data on one patient only.

Measures

Clinicians completed a thirteen-measure assessment battery.³³ Only the measures used in the following analyses will be detailed here.

Countertransference questionnaire for adolescents (CQ-A).³⁴—The Countertransference Questionnaire, or CQ, was designed to assess CT patterns in psychotherapy for adults. It is written in everyday language, without jargon, to maximize its use across clinicians from different theoretical orientations. The original questionnaire is a 79-item clinician-report instrument. Items measure a wide range of thoughts, feelings, and behaviors expressed by therapists towards their patients, and were derived by reviewing clinical, theoretical, and empirical literature on CT followed by an iterative process of clinical feedback. Initial examination of the factor structure suggested eight conceptually coherent factors accounting for 69% of the variance.⁷ The CT factors demonstrated good predictive and criterion validity, including associations to patient diagnoses and interpersonal characteristics.⁷ To explore the use of the CQ among adolescent patients with EDs in this study, we retained the original 79 questions from this measure and added 7 new items pertaining specifically to the treatment of adolescents. We added items describing unique experiences clinicians may have in working with adolescent patients, generated after a review of the general psychotherapy and psychoanalytic literature on treatment with children/adolescents and CT reactions.^{35,36} A list of three major content areas was identified in the literature: (1) identification with childhood experiences; (2) identification with parental figures and; (3) reactions to specific family members. Specific questions (2–4) for each domain were developed and included the following: identification with childhood (e.g.,

“I find myself thinking about my own childhood after sessions with her”), identification with parental figure (e.g., “I have warm, almost parental feelings toward her”), and reactions to family members (e.g., “I find myself being more critical and blaming of the parents of this patient than other patients’ parents”). These questions were reviewed by a panel of child/adolescent clinicians for their content, thoroughness, and relevance. The expanded 86-item measure is called the Countertransference Questionnaire for Adolescents, or CQ-A. The CQ-A items were rated on a scale from 1 (“Not true”) to 7 (“Very true”).

Clinical data form for adolescents (CDF-A).³⁷—The CDF-A is a clinician-report form that assesses a range of variables relevant to demographics, diagnosis, and etiology. The first section of the CDF-A asks for clinician demographic data, including discipline, orientation and years of practice. The next section assesses aspects of the patient’s adaptive functioning (e.g., school performance, psychiatric hospitalizations). The last section includes a checklist of common Axis I comorbid diagnoses for the patient and first-degree relatives. Previous research has indicated that ratings on the Clinical Data Form are highly reliable and strongly correlate with ratings made by independent reviewers,^{38,39} and other studies using this form with ED samples have shown expected associations with related assessments.³³

Adolescent eating symptom form.³³—Clinicians were asked to rate the presence/absence of diagnostic criteria for AN, BN, and ED not otherwise specified (EDNOS) according to the *Diagnostic and Statistical Manual of Mental Disorders*.⁴⁰ Frequency and duration criteria were also listed. This comprehensive symptom form was used to allow for independent, ED diagnoses by the researchers according to *DSM-IV* criteria. Our research suggests that clinician reports are more reliable when individual ED criteria, rather than full diagnoses, are rated by clinicians.³³ Other assessment research suggests that clinician reports are particularly reliable and valid with regard to adolescent EDs, and that adolescents may underreport some symptoms (e.g., restriction) that require expert observation to assess.⁴¹

Shedler-Westen assessment procedure for adolescents (SWAP-200-A).^{37,39}—The SWAP-200-A is a Q-sort measure designed for use by skilled clinical observers for assessing adolescent personality pathology. The SWAP-II-A includes 200 statements regarding aspects of adolescent personality. Clinician-subjects receive a deck of SWAP-II-A Q-sort cards, instructions for sorting, a return envelope, and a set of eight small envelopes with a pile number marked on each (from 0–7) in which to place the cards once they have sorted them. The SWAP-200-A was adapted from its adult version, the SWAP-200, which has shown evidence of validity, reliability, and utility with adult samples.^{37,39} The SWAP-200-A has demonstrated validity in multiple studies of adolescent personality.^{33,42} Correlations between clinician-rated personality pathology and independent interviews for the SWAP are observed in the range of $r = .70$ to $.80$.³¹ Clinician-reported personality data in adolescents is also predictive of adaptive functioning, attachment patterns, and family/developmental history variables suggestive of validity.^{37,38}

In a prior study, we used Q-factor analysis to identify potential *personality subtypes* with personality pathology representative of adolescents with EDs.³³ Q-factor analysis is

computationally identical to factor analysis, except that the data matrix is transposed, so that patients rather than items are factored, producing subtypes rather than traits. The technique identifies groups of patients who are similar to one another and dissimilar to patients in other groups. For Q-analysis, we followed standard factor-analytic procedure starting with a Principal Components Analysis, scree plot, percentage of variance explained by the model, and parallel analysis to determine the number of factors to rotate.⁴³ We identified four factors accounting for 40.7% of the variance. Ninety-nine of 117 patients in our sample (~85%) loaded above .35 on one of the four factors.

The three common subtypes are identifiable as *high-functioning/perfectionistic* (characterized by significant strengths); *dysregulated* (characterized by borderline and other Cluster B pathology); *depressed/inadequate* (characterized by general Cluster C pathology, including severe self-criticism and social avoidance; and *constricted/obsessional* (characterized by obsessive compulsive personality characteristics such as rigidity and emotional constriction).³³ These three subtype scores allow us to examine the influence of a limited, highly relevant number of personality pathology variables to the CT reactions of clinicians working with adolescents with EDs.

Psychotherapy effectiveness form (PEF)—The PEF asks clinicians to check off whether the patient received psychotherapy and the major classes of psychotropic medications. For each modality of treatment, clinicians are asked to rate efficacy using a 5-point scale. In order to maximize reliability, we created aggregate improvement scores based on the following variables: (1) clinician ratings of patient's pre-treatment GAF scores; (2) clinician ratings of patient's current GAF scores; and (3) clinician ratings of effectiveness of treatment with respect to ED symptomatology and general improvement. These raw score ratings were transformed into *z*-scores which were later averaged to create an aggregate improvement variable.

Data Analysis

Statistical analyses were performed using SPSS (version 12.0 for Windows). We factor-analyzed the CT measure to produce coherent scales reflecting dimensions of CT using principal axis factoring (PAF) with Varimax rotation. To compare CT scores across demographic groups (clinician sex and discipline) we used independent-sample *t* tests. To obtain estimates of the relationships between CT scores and patient variables (personality pathology, functioning level, and improvement in psychotherapy) we used Pearson product-moment correlations and ANOVAs. Finally, for exploratory analyses of the relative influence of multiple intercorrelated patient and clinician variables on clinician CT, we used backwards multiple regression equations.

Results

Clinician Descriptive Statistics

The sample consisted of 120 clinicians, each of whom described the treatment of one adolescent female patient with an ED. Approximately two-thirds of respondents were psychologists ($N = 82$) and the remaining were psychiatrists ($N = 38$). Of the clinician

sample, 50.8% ($N = 61$) was female. With respect to theoretical orientation, 45.8% ($N = 55$) of clinicians identified themselves as primarily cognitive-behavioral, and 35.0% ($N = 42$) identified themselves as primarily psychodynamic; 8.3% ($N = 10$) and 6% ($N = 7$) identified with a primarily biological orientation and family systems approach, respectively. The remaining $N = 6$ indicated 'other' orientation. However, more than 40% identified themselves as "eclectic" or "integrative" in some regard. Clinicians average 21.7 years ($SD = 8.5$) of experience post-internship/post-residency. A specialty in EDs was endorsed by 17.5% ($N = 21$) of the sample.

Patient Descriptive Statistics

Patients averaged 16.5 years of age ($SD = 1.2$; range 15–18). Fifteen percent of the sample was diagnosable by the researchers with AN ($N = 18$); 36.7% with BN ($N = 44$); and 47.5% with EDNOS ($N = 57$); one patient was excluded from further analyses because there was not enough information provided to make a valid diagnosis. Half of those with AN ($N = 9$) were diagnosable with binge-purge AN, and the same number diagnosable with restricting AN. Most clinicians reported their patient was middle class (42.5%) or upper-middle class (40.0%), with an additional 8.3% described as upper class, 7.5% working class, and 1.7% "poor." The patients were predominantly Caucasian (90.8%), with limited minority representation (5.0% Hispanic, 1.7% African American, 0.8% Asian, and 1.7% other).

Patients showed substantial variation in adaptive functioning. The mean pre-treatment GAF score was 51.3 ($SD = 8.6$). Pre-treatment GAF scores varied significantly by ED diagnosis ($F[2,118] = 4.41$; $p = .005$). Patients with AN had the lowest scores ($M = 46.6$, $SD = 13.3$), while those with BN had the highest ($M = 54.0$, $SD = 10.2$). Although 92.5% of patients ($N = 111$) were currently in outpatient treatment, 22.5% had a history of psychiatric hospitalization for their ED, and 19.2% had a history of psychiatric hospitalization for other reasons.

Countertransference Factors

We first subjected items from the CQ-A to a principal-component analysis (PCA) using Kaiser's criteria (eigenvalues >1). The scree plot and percentage of variance accounted for were both used to determine the number of factors to rotate, indicating a six-factor solution. Factor analyses with a Varimax rotation were then conducted with seven, six, and five factors to compare interpretability. Using maximum likelihood estimates, a six-factor solution was judged to be the most parsimonious. Table 1 presents the factor structure and rotated factor loadings for characteristic items for each of six extracted factors: Angry/Frustrated, Warm/Competent, Aggressive/Sexual, Failing/Incompetent, Bored/Angry at Parents, and Overinvested/Worried. The six-factor solution accounted for 45.1% of the variance. The overall factor structure was very similar to the original report.⁷

The overall level of negative CT reactions among this group of clinicians was not high (means calculated for the top 8 items loading above .35 on each scale). On a scale where a value of 4 reflected a mid-point between "1=not true" and "7=very true," the highest negative reactions reflected feelings of being Bored/Angry at Parents ($M = 2.38$; $SD = 1.04$) and Failure/Incompetence ($M = 2.02$; $SD = 0.90$). Lower still were average levels of CT

reactions reflecting feelings of being Overinvested/Worried ($M = 1.84$; $SD = 0.77$); Angry/Frustrated ($M = 1.80$; $SD = 0.84$); and Aggressive/Sexual ($M = 1.33$; $SD = 0.49$). The only mean CT score close to the mid-point of the scale was the score for Warm/Competent feelings ($M = 3.36$; $SD = 0.95$).

Countertransference and Clinician Variables

To evaluate differences between clinician demographic groups (sex and discipline) in the six CT factor scores, independent samples t tests were conducted. Analyses comparing gender yielded two significant findings: Male clinicians were significantly more likely than female clinicians to endorse Warm/Competent ($t[119] = -2.48$, $p = .015$) and Aggressive/Sexual feelings towards their patients ($t[119] = -2.44$, $p = .016$). Analyses comparing discipline also displayed two significant findings: Psychiatrists reported significantly more Anger/Frustration ($t[119] = 2.42$, $p = .017$) and Aggressive/Sexual reactions ($t[119] = 2.29$, $p = .024$) than psychologists did. Psychiatrists were not significantly more likely to be male, however, than psychologists were. Zero-order correlational analyses of years of clinician experience ($M = 21.7$, $SD = 8.5$) with the six CT factors were all nonsignificant.

Countertransference and Patient Variables

The patient's age was not significantly related to any CT factors in Pearson's correlations. Comparisons of mean CT reactions between ED diagnoses yielded significant differences with respect to Warmth/Competence ($F[2, 118] = 5.65$, $p = .005$) and Failing/Incompetence factors ($F[2, 118] = 3.58$, $p = .031$). With regard to Warmth/Competence, Scheffé's post-hoc tests indicated that clinicians working with patients with AN scored significantly higher than those working with BN or EDNOS, and those whose patients had EDNOS scored significantly higher on Warmth/Competence than BN. With regard to Failing/Incompetence, Scheffé's post-hoc tests indicated that therapists working with EDNOS showed higher scores than those working with AN.

Countertransference and Treatment Variables

Pearson's correlations were used to determine the relationship between CT factors and the following therapy variables: Treatment length (measured in months) and Aggregate Improvement scores. These results are displayed in Table 2. Significant negative associations were observed between both variables and feelings of Failure/Incompetence.

Multivariate Analyses

In order to develop a more coherent picture of the discrete influences on CT, we elected to run regression analyses, using a range of patient, clinician, and therapy variables to predict the six CT scores. Given the large number of potential independent variables, and the high intercorrelations between them, we elected to use stepwise backward regressions to develop a preliminary picture of the independent variance accounted for by the combination of patient, clinician, and therapy variables. We used $p < .05$ as the criterion for significance and $p > .10$ as the criterion for removal. As independent variables, we included Clinician Discipline and Clinical Sex, which had shown some associations with CT factor scores in bivariate analyses. We chose to include all three patient personality pathology factor scores

(Dysregulated, Depressed/Inadequate, and Constricted). We did not include the High-Functioning personality score because it was negatively associated with all three other scores and was less specific than the other three types of pathology. Since ED diagnostic groups showed significant differences in pre-treatment GAF scores, we included both AN and BN diagnostic categories in our regression model, in addition to pre-treatment functioning (GAF). We also included treatment length and improvement in treatment. The final models are presented in Table 3.

Regarding clinician variables, the pattern of findings indicated that male therapists reported feeling significantly more competent when other factors were controlled, but also reported more negative affect reflecting anger toward the patient or her parents. Therapists who were psychologists reported feeling less angry and frustrated than psychiatrists when other factors were controlled. Regarding patient pre-treatment variables, personality pathology reflecting Dysregulation and Constriction were associated with more clinician Anger/Frustration and less Warmth/Competence. Somewhat surprisingly, a diagnosis of BN was associated with less positive reactions and anorexia nervosa less negative reactions. Length of time and improvement in treatment were associated with less feelings of Failing/Incompetence, but improvement in treatment was unexpectedly associated with more feelings that were Aggressive/Sexual.

Discussion

The purpose of this study was to explore CT reactions clinicians experience when working with adolescents with EDs. Overall, we identified six distinct patterns of CT reactions. These factors were both clinically and theoretically coherent, and corresponded with a broad spectrum of emotional and interpersonal experiences. Five of the six reflected different dimensions of negative affect, and one reflected a broad dimension of positive affect. Scores on the six factors did not differ between groups of clinicians with various theoretical orientations, suggesting that therapists' responses were not an artifact of their theoretical beliefs. The six dimensions of CT reflected Angry/Frustrated, Warm/Competent, Aggressive/Sexual, Failing/Incompetent, Bored/Angry at Parents, and Overinvested/Worried reactions. These dimensions were very similar to those identified in the original factor analysis of the measure.⁷

Clinicians' reactions did not reflect the widespread impression that it is emotionally difficult or aversive to work with patients with EDs.³ Of the five negative CT reactions, three had extremely low means in the sample (Overinvested/Worried, Angry/Frustrated, and Aggressive/Sexual). The highest negative affect dimension—reflecting feelings of failing the patient or being incompetent—was on average rated between a score of 2 and 3, reflecting the lower part of the 1–7 range. The average Warmth/Competence factor score, in contrast, was close to the mid-point of the scale.

It is important to note that these data were collected from clinicians who had at least one adolescent with an ED in their caseload, and therefore ostensibly were not completely biased against working with these patients. It is possible that clinicians who have more negative reactions to psychotherapy with patients with EDs refer these patients elsewhere.⁴ It is also

possible that the experience of treating adolescents with EDs differs in important ways from treating adults with these disorders.

Clinician Gender

Several differences were found between male and female clinicians' reactions to their patients. In multivariate analyses, male clinicians reported significantly more feelings of warmth and competence. These findings run opposite to survey research suggesting male clinicians feel less effective when treating EDs.¹⁰ It is possible that male therapists feel generally competent as psychotherapists to patients with EDs, but only specifically incompetent when dealing with particular aspects of ED symptomatology. Broader sociological phenomena also may help to explain these gender differences. Data support males' greater strength of confidence relative to females' across specific academic domains over and above actual performance.⁴⁴ Additionally, it may be more socially unacceptable for women to endorse feelings of competence, due to discomfort with competition or self-aggrandizement. In this domain, independent observer ratings of clinician competence and confidence may be useful to accurately observe and explain complex reactions.

The data suggested that male therapists also endorsed more feelings that reflected anger and frustration as well. Males may simply experience aggressive reactions more frequently, as noted by some social psychological research.^{45,46} It is also possible that male clinicians were more willing to openly endorse their feelings of aggression when they occurred, consistent with social role theory and cultural expectations around aggression.⁴⁷ Men have been noted to view their aggression as more useful, whereas women are observed to experience greater guilt around aggression, and to perceive it to be a reflection of loss of control.⁴⁸ Other studies of CT with different patient groups have not found gender differences in angry reactions,⁴⁹ so it is possible that this finding may be specific to EDs, adolescents, or our measure.

Clinician Discipline

Significant group differences were also found between psychiatrists and psychologists in the sample, indicating that psychiatrists endorsed higher levels of Anger/Frustration relative to the psychologists in our sample when other factors were controlled. These differences could be related to the settings where psychiatrists are employed and the roles they are asked to play in treatment teams. Research has indicated that the size of a clinician's case load has been shown to be a mediating variable in predicting greater feelings of frustration, manipulation, and helplessness.^{2,19} Caseload size was not measured in this study, but may be higher for psychiatrists given their roles in medication management. Alternatively, psychiatrists may have different expectations for behavior change or therapy effectiveness based on interventions they employ or differences in training.

This study did not find that the number of years of clinical experience held by clinicians predicted lower levels of negative reactions; contrary to some of the strongest findings from one of the few other studies in the field.² We believe that sampling differences may explain this negative finding. Only clinicians with more than 5 years of experience were recruited to the practice-research network, and this group that treated adolescents with EDs was

particularly experienced—with over twenty years experience on average. In contrast, the findings from a previous study that found an effect of experience on therapists' reactions sampled therapists whose mean years of experience was between 8–9 years.² It is distinctly possible that more variance in clinician response—particularly in the significance of feeling like a failure or incompetent, or overinvested and worried—is associated with differences between the early stages of clinical training and experience and later stages, not with variations among clinicians who are all extremely experienced.

Eating Disorder Diagnosis

Eating disorder diagnosis did not explain much variance in CT when other factors were controlled. In those equations where ED diagnosis was significant, the direction of effect was different than expected. Therapists reported feeling less competent with patients who had BN, and less Overinvested/Worried regarding patients with AN. In this study of adolescents, the patients with AN were actually reported to improve more than those with BN or EDNOS, which is actually more characteristic of adolescent treatment outcome than may be widely known.³³ Known differences in the medical risks between the two disorders may be unimportant when functioning level, improvement, and personality style are controlled.

Patient Personality Pathology

Analyses suggested that patient personality adds considerably to other factors in explaining therapists' reactions. The Dysregulated and Constricted styles explained independent variance in Anger/Frustration (positive association) and Warmth/Competence (negative association) in multivariate analyses. The Depressed/Inadequate style emerged as particularly significant in multivariate analysis of the Aggressive/Sexual factor, in which it was a negative predictor. Indeed, certain items in this CT factor—for example, “I feel envious of, or competitive with her,” seem logically less characteristic of therapist responses to this group. Furthermore, sexuality may be suppressed among this depressed group. The findings regarding Dysregulation (which is akin to borderline personality) and Constriction are particularly important for training and supervision in the treatment of EDs. Cluster B and Cluster C pathology are extremely common in EDs, but have been noted to inspire negative clinician reactions in non-ED samples.⁵⁰ Treatment manuals for adolescent EDs do not commonly include specialized interventions or therapist/treatment considerations for those with personality pathology.^{51,52}

Functioning Level

Pre-treatment level of functioning, length of time in treatment, and improvement in treatment were associated with a range of CT reactions in the expected directions. Therapists understandably feel less incompetent when they know the patient better and when she has improved in treatment. The one unexpected finding was a positive association between Aggressive/Sexual feelings and the patient's improvement in treatment. It is possible that such feelings (though overall reported very little) are experienced as particularly inappropriate in the treatment of individuals in distress. Furthermore, as underweight clients restore their weights, the accompanying biophysiological changes may excite arousal and longing for physical contact in the patient.⁵³ Patients themselves may express more feelings

of all kinds (including aggressive ones) as they improve, and therapists may feel more tolerant of their own aggressive or sexual feelings as their patients' become more robust.

Limitations

These data have at least four important limitations. First, the method of data collection (self-report) from a single informant is vulnerable to biases that may affect validity.⁷ The subject matter—e.g., clinicians' negative internal experiences, self-ratings of treatment effectiveness—may be particularly sensitive to bias due to self-presentation concerns. Though self-report by clinicians is a centrally important face-valid method of assessing clinician reaction, future studies should also employ independent observation of both clinician reactions (through audio or video taping) and patients' psychopathology to maximize external validation.

The second set of limitations follow from the specificity and size of our sample, and therefore the generalizability of our findings. Most clinicians we contacted were ineligible because they did not have a patient with an ED in their practice, and indeed other research has observed that relatively few clinicians treat patients with EDs.⁴ The select group of clinicians willing to treat EDs may have special reactions that others do not have, however, it is still important to observe the reactions of clinicians in this group. The size and power of the sample was additionally a consideration given the large number of variables we were investigating. As noted earlier, this study was intended to be exploratory given the lack of research in this area. We were not able to make corrections for the number of analyses, and therefore all our findings must be considered highly preliminary and suggestive, and certainly require further investigation, preferably with a larger sample.

Additionally, our definition of CT is one that is commonly used and was most relevant to an exploratory study of this kind. Other studies have used a definition of CT that is narrower in scope.⁹ Future research efforts might try to adopt a consistent definition of this construct to facilitate comparisons between findings, but given the paucity of research in this area it may be more prudent to assess CT with several different instruments.

Finally, multiple variables of potential importance were not measured in this work. Clinicians self-report that supervisory experiences are particularly important to the management of negative reactions,² and we did not measure the supervision or peer support provided to the clinicians in this study. There are many other clinician and setting variables that may be important, e.g., the number of hours in the clinician's caseload, whether the clinician's outcomes are being assessed by third parties, whether the clinician has a history of an ED, and whether the clinician has specialized training in the treatment of EDs. Furthermore, particular patient issues (including some we could not measure by clinician-report, such as readiness to change) may interact with other setting or psychotherapy variables. All of these—and other variables—might usefully be studied in the future.

Additional research in this area is very much needed. Studies with other forms of psychopathology have demonstrated relationships between CT reactions and outcome,⁵ as well as the relationship between higher CT enactments and poorer working alliances.⁵⁴ More research is needed to understand the direct relationship between CT and treatment

response and outcome in the treatment of EDs, and the subtle ways CT may mediate the course of the alliance as well as response.

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Table 1

Factor Structure of the Countertransference Questionnaire for Adolescents (N = 120)

Factor 1: Angry and Frustrated	Loading
I feel angry at her	.78
At times I dislike her	.67
I dread sessions with her	.67
I feel used or manipulated by her	.65
I think or fantasize about ending treatment	.64
I wish I had never taken her on as a patient	.63
I feel frustrated in sessions with her	.62
Factor 2: Warm and Competent	
I have warm, almost parental feelings toward her	.72
I like her very much	.70
I feel nurturing toward her	.68
She is one of my favorite patients	.65
I feel like I want to protect her	.65
She makes me feel good about myself	.62
If she were not my patient I could imagine being friends with her	.55
Factor 3: Aggressive and Sexual	
I feel like I'm being mean or cruel to her	.73
Her sexual feelings toward me make me anxious or uncomfortable	.65
I feel sexual tension in the room	.65
I feel envious of, or competitive with her	.59
I find myself being flirtatious with her	.54
I tell her I'm angry at her	.51
I regret things I have said to her	.51
Factor 4: Failing and Incompetent	
I feel I am failing to help her or I worry that I won't be able to help her	.70
I feel like my hands have been tied or that I have been put in an impossible bind	.62
I feel incompetent or inadequate working with her	.55
I feel hopeless working with her	.49
I feel anxious working with her	.48
I think she must do better with another therapist or in a different kind of therapy	.45
I feel overwhelmed by her needs	.45
Factor 5: Bored and Angry at Parents	
I feel bored in sessions with her	.66
I don't feeling fully engaged in sessions with her	.64
I feel angry at people in her life	.60

I find myself feeling frustrated with parents of this patient more than other patient's parents	.59
I find myself being more critical and blaming of the patient's parents than others' parents	.53
More than with most patients, I feel pulled into things I didn't realize until after the session	.44
I return her phone call less promptly than I do with my other patients	.41
<hr/>	
Factor 6: Overinvested and worried	
<hr/>	
I do things for her, or go the extra mile for her in ways that I don't for other patients	.66
I end sessions overtime with her more than with my other patients	.57
I worry about her after sessions more than other patients	.55
I disclose my feelings with her more than with other patients	.50
I call her between sessions more than my other patients	.49
I have trouble relating to the feelings she expresses	.37

Note: Table presents the 7 highest-loaded items above .35.

Table 2
Correlations of Countertransference Scores with Patient and Treatment Variables ($N = 120$)

	Countertransference Factors					
	Angry/ Frustrated	Warm/ Competent	Aggressive/ Sexual	Failing/ Incompetent	Bored/Angry at Parents	Overinvested/ Worried
<u>Patient Variables</u>						
High Functioning Personality	-.23**	.29**	.10	-.06	-.11	-.01
Dysregulated Personality	.09	-.19*	-.09	.04	-.09	.00
Depressed/Inadequate Personality	-.04	.17	-.19*	.09	.02	.10
Constricted Personality	.23*	-.16	.08	-.05	.15	-.10
GAF Pre-Tx	-.24**	.11	.02	-.06	-.04	.07
<u>Treatment Variables</u>						
Length of treatment (months)	.05	.01	.07	-.29**	.15	-.02
Aggregate Improvement	-.10	.16	.18	-.37***	-.08	.01

* $p < .05$,

**

$p < .01$,

*** $p < .001$

Table 3Stepwise Backward Regressions Predicting Negative Clinician Reaction Scores ($N = 107$)

	R	R ²	Standardized β	F change (model) or t (β)	(F) or (t) p
Angry/Frustrated Final Model	.41	.17		5.62	<.001***
Clinician Discipline (Ph.D.)			-.19	-2.10	.038*
GAF Pre-Treatment			-.17	-1.84	.068
Dysregulated Personality			.23	2.35	.021*
Constricted Personality			.29	3.00	.003*
Warm/Competent Final Model	.46	.22		7.59	<.001***
Clinician Sex (Male)			.20	2.32	.022*
Bulimia Nervosa			-.24	-2.75	.007**
Dysregulated Personality			-.27	-2.89	.005**
Constricted Personality			-.31	-3.40	.001**
Aggressive/Sexual Final Model	.36	.13		5.57	.001**
Clinician Sex (Male)			.24	2.73	.007**
Depressed/Inadequate Personality			-.24	-2.67	.009**
Improvement in treatment			.19	2.15	.034*
Failing/Incompetent Final Model	.44	.20		9.08	<.001**
Clinician Sex (Male)			-.16	-1.88	.063
Length of time in treatment			-.18	-2.00	.048*
Improvement in treatment			-.32	-3.49	.001**
Bored/Angry at Parents Final Model	.33	.11		3.30	.013*
Clinician Sex (Male)			.24	2.53	.013*
Pre-treatment GAF			.16	1.67	.099
Length of time in treatment			.25	2.48	.015**
Improvement in treatment			-.18	.185	.066

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	R	R ²	Standardized β	F change (model) or t (β)	(F) or (t) p
Overinvested/Worried Final Model	.26	.07		4.02	.021 *
Anorexia Nervosa			-.26	2.64	.010 *
Improvement in treatment			-.19	1.91	.058

p<.001;
**
p<.01;
*
p<.05

Variables entered: Clinician Sex, Clinician Discipline, Global Assessment of Functioning (GAF) Pre-Treatment, Anorexia Nervosa Diagnosis, Bulimia Nervosa Diagnosis, Dysregulated Personality, Depressed/Inadequate Personality, Constricted Personality, Length of time in treatment (months), Improvement in treatment (aggregate score).