COUNTERTRANSFERENCE: A MULTI-RELATIONAL SELF-ANALYSIS

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
Marriage and Family Therapy

By

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Dedication

I would like to dedicate this project to my wonderful family. My husband, Timothy, and my children, Natalie and Cassius, have reluctantly endured many hours of my absence while I immersed myself in the research for this project and explored my affective, cognitive, and behavioral reactions in various relationships. I am deeply grateful to them for their genuine and loving presence, their support, and their endless ability to inform and enrich this process, and my life.
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ABSTRACT

COUNTERTRANSFERENCE: A MULTI-RELATIONAL SELF-ANALYSIS

By

Evelyn G. Ball

Master of Science in Counseling,
Marriage and Family Therapy

Countertransference is ever present in relationships. This is a reality we can neither deny nor avoid. Whereas unconscious countertransference may express itself through toxic behavior, choosing to illuminate and explore countertransference feelings, in professional and personal relationships, offers a tremendous opportunity for growth. The purpose of this self-analysis is to stimulate personal reflection of multi-relational countertransference reactions in all Mental Health Providers and any other interested parties. Once committed to a process of self-examination, Mental Health Professionals and other interested individuals will be better prepared to guide another towards greater self-awareness. In illuminating and examining the countertransference reactions and conflicts that co-exist in my interactions with clients, students, and my own children, I hope to emphasize the universality of countertransference feelings and expose their value as a tool towards greater self-awareness, in-depth understanding of others, emotional maturity, and empathic, therapeutic relating.
CHAPTER I

Introduction

“Something we were withholding made us weak until we found it was ourselves.”

Robert Frost

Countertransference is the psychoanalytic term used to differentiate the transference reactions that emerge in the analyst from those reactions of the patient or client. For the purposes of this paper, only countertransference feelings will be examined. Hayes, Gelso, and Hummel (2011) assert that countertransference examples abound. Additionally, Gabbard (1995) states that therapists and analysts across theoretical perspectives acknowledge the usefulness of countertransference exploration in increasing their understanding of the patient. Orange, Atwood, and Stolorow (2009) describe psychotherapy itself as a process of ongoing “empathic-introspective inquiry” where continuous reflection on the analyst’s subjective organization is required (p. 44). They emphasize that this type of inquiry attempts to recognize the impact of the therapist’s subjective influence as intrinsic to the interplay of subjectivities in the dialogue between therapist and client, and “seeks consistently to analyze it” (p. 44).

Statement of Need/Problem

Hayes et al. (2011) have found that the quality of the therapeutic relationship, and rate of the client’s contentment in the relationship, may be increased as a result of countertransference analysis by the therapist. Small (1990) states that unconscious
material can cause us to respond in a toxic manner. Therapists’ understanding of their internal, affective experience is critical in their work with clients (Gabbard, 1995).

Maroda (2002) has found that what we think seems to take precedence over what we feel. However, Maroda asserts it is not intellectual knowledge that leads to transformation, but rather the affective experience, since it is in the emotional connection that interpretation effects change. In valuing what we think more than our internal, affective reactions, Maroda believes we risk bypassing the most valuable information of all (2002).

Therapists have a responsibility to continuously reflect on their subjective experience, and engage in cognitive and affective analysis (Gabbard, 1995; Maroda, 2002). Gabbard and Maroda believe that countertransference exploration, which includes responsible surrendering to internal, affective reactions, is necessary to develop, strengthen, and mature therapeutic ability (1995; 2002). The Board of Behavioral Sciences (BBS) assesses Marriage and Family Therapists’ knowledge of how to apply and “manage countertransference to maintain integrity of the therapeutic relationship” as well as “knowledge of strategies to manage countertransference issues,” as demonstrated in the BBS report from the Office of Examination Resources (Ferrel, 2002, p. 19). However, Jacobs (1991) and Hedges (1992) highlight that learning to illuminate and explore the therapist’s subjectivity, understood as countertransference, is absent from many therapy models, training programs and workshops.

Therapeutic ability is not only valuable to mental health providers, but also to those in other potentially curative roles. Affective awareness may increase understanding of the intrapersonal and interpersonal dynamics at play in their relationships, and improve
their relational effectiveness. Therefore, there is a need for these individuals, as well as mental health providers, to practice mindful awareness of their countertransference reactions.

**Purpose**

The purpose of this project is to highlight countertransference illumination and exploration as critical components of genuine communication, and of effective, therapeutic practice. The multi-relational self-analysis offers personal illustrations as examples of such a process. Although traditionally explored in psychotherapy relationships, this paper does not confine the examination of countertransference to the clinical setting. It seeks to encourage countertransference illumination and exploration in Mental Health Professionals and other interested parties, such as parents, teachers, doctors, and nurses.

Countertransference exploration increases therapists’ understanding of the subjectivity from which their actions and interventions materialize. Countertransference reactions during a psychotherapy session are limited to a fifty-minute time frame, yet clues relating to therapists’ subjectivity abound in their daily lives. Therefore, this self-analysis seeks to encourage all Mental Health Providers, and any other interested parties, to explore their countertransference reactions in a variety of relationships.

**Significance**

Corey (2009) tells us that therapists will be confronted with personal, unexplored conflicts related to a variety of issues. Small (1990) identifies lack of self-knowledge as
increasing an individual’s limitations in relating therapeutically with clients, patients or children, and increasing the risk of ineffective or harmful relating. Maroda (2002) adds that committing to emotional engagement, and being willing to risk affective involvement in the relationship with a client, is likely to increase one’s therapeutic potential. Willer (2009) states, “countertransference must be attended to carefully, as unexamined feelings on your part will lead the therapy astray” (p. 326).

As a result of this self-analysis, Mental Health Providers and any other interested parties may be encouraged to gain a deeper understanding of their own multi-relational countertransference reactions and conflicts. This self-analysis will increase my therapeutic ability as a therapist with my clients, as a parent with my children, and as a teacher with my students. Additionally, this self-analysis may influence others to submit to a practice of self-exploration and improve their therapeutic potential in their professional and personal relationships.

**Terminology**

The following is an alphabetical list of terminology used

Alliance – In The Dictionary of Psychotherapy, Walrond-Skinner (1986) defines alliance as “The product of an affiliation between two or more members of a family or stranger group which may or may not include the therapist… An alliance is made for the positive purpose of engaging in a mutual task or sharing common interests…” (p. 9).

Attachment – Bowlby (2005) defines three principal attachment patterns as such:
1. Secure attachment: “the individual is confident that his parent (or parent figure) will be available, responsive, and helpful should he encounter adverse or frightening situations. With this assurance, he feels bold in his explorations of the world” (p. 140).

2. Anxious resistant attachment: “the individual is uncertain whether his parent will be available or responsive or helpful when called upon. Because of this uncertainty he is always prone to separation anxiety, tends to be clinging, and is anxious about exploring the world” (p. 140).

3. Anxious avoidant attachment: “the individual has no confidence that, when he seeks care, he will be responded to helpfully but, on the contrary, expects to be rebuffed” (p. 140). Bowlby (2005) states that the individual will then avoid attachments and attempt to be emotionally self-sufficient.

Central Organizing Principles – Orange, Atwood, and Stolorow (2009) explain “These principles, often unconscious, are the emotional conclusions a person has drawn from lifelong experience of the emotional environment, especially the complex mutual connections with early caregivers” (p. 7).

Differentiation of Self – The primary of 8 concepts from Murray Bowen’s Family-Systems Multigenerational Theory. Kerr and Bowen (1988) define it as “The variable degree of emotional separation that people achieve from their families of origin” (p. 97).
Empathy – In The Psychiatric Dictionary, Campbell (1981) defines it as “Putting oneself into the psychological frame of reference of another, so that the other person’s thinking, feeling, and acting are understood and, to some extent, predictable” (p. 215).

(Countertransference) Enactment – Two definitions follow.

1. In The Dictionary of Psychotherapy, Walrond-Skinner (1986) defines it as “The dramatic interpretation of a problem or conflict by the patient, family or members of a group” (p. 114).

2. Maroda (1998) describes enactment as: “An affectively driven repetition of converging emotional scenarios from the patient’s and the analyst’s lives. It is not merely an affectively-driven set of behaviors, it is necessarily a repetition of past events that have been buried in the unconscious due to associated unmanageable or unwanted emotion. Enactment thus involves mutual stimulations of repressed affective experience, ideally with the patient taking the lead” (p. 124).

Enmeshment – Goldenberg and Goldenberg (2008) define it as “A family organization in which boundaries between members are blurred and members are overconcerned and overinvolved in each other’s lives, limiting individual autonomy” (p. 467).

Intersubjective Field – Orange, Atwood, and Stolorow (2009) explain, “The interplay of transference and countertransference, the organizing activity of both patient and analyst within the analytic experience, makes up the intersubjective field of the analysis” (p. 8).
Projective Identification – Melanie Klein coined this term, utilized in psychoanalysis and Object Relations Theory. Two definitions follow.

1. Kernberg (1987) defines it in the following manner:

   Projective Identification is essentially a primitive defense mechanism. The subject projects intolerable intrapsychic experiences onto an object, maintains empathy with what he projects, tries to control the object in a continuing effort to defend against the intolerable experience, and unconsciously, in actual interaction with the object, leads the object to experience what has been projected onto him (p. 796).

2. Goldenberg and Goldenberg (2008) define projective identification in their glossary as “An unconscious defense mechanism whereby certain unwanted aspects of oneself are attributed to another person (e.g., a spouse), who is then induced or incited to behave accordingly to the first person’s projected but split-off feelings” (p. 471).

Splitting – Another term coined by Melanie Klein, and utilized in psychoanalysis and Object Relations Theory. Goldenberg and Goldenberg (2008) define it in their glossary as “…a primitive process by which an infant makes contradictory aspects of a mother or other nurturing figure less threatening by dividing the external person into a good object and a bad object and internalizing the split perception” (p. 472).

Transference – Three definitions encompass the meaning of this term.

1. Freud (1969) explains, “The patient sees in his analyst the return – the reincarnation – of some important figure out of his childhood or past, and
consequently transfers on to him feelings and reactions that undoubtedly applied to this model” (p. 190-191).

2. Willer (2009) defines it in the following manner: “Transference entails transferring feelings, thoughts, and behaviors from a past significant relationship to a current relationship” (p. 319).

3. In The Psychiatric Dictionary, Campbell (1981) identifies transference as a psychoanalytic term and defines it as:

…the phenomenon of projection of feelings, thoughts, and wishes onto the analyst, who has come to represent an object from the patient’s past. The analyst is reacted to as though he were someone from the patient’s past; such reactions, while they may have been appropriate to the conditions that prevailed in the patients’ previous life, are inappropriate and anachronistic when applied to an object (the analyst) in the present (p. 661).

In order to understand countertransference and its role in relational dynamics, it is necessary to review the literature regarding the definitions and perceptions of this phenomenon from its inception in the field of psychotherapy to current day, by analysts, therapists, and others who have attempted to illuminate and utilize it in their professional and personal work. Additionally, it is necessary to review the literature regarding the impact and influence of unresolved and unconscious countertransference conflicts in therapeutic relationships, as well as the benefits when countertransference reactions and triggers are consciously illuminated and unresolved conflicts are explored. It is further necessary to review the literature regarding the ways in which illumination of
countertransference reactions and conflicts may be attained, enhanced, and utilized.

Finally, it is necessary to review the literature regarding the occurrence of countertransference outside the therapy setting. All of the above will be reviewed in the following chapter.
CHAPTER II

Review of Literature

“Countertransference is the best of servants, but the worst of masters.”

Hannah Segal

The purpose of this chapter is to first, define and distinguish between different perceptions of countertransference over time, and identify different types of countertransference. Then, this chapter will examine the impact countertransference can have on therapeutic relationships when therapists’ reactions, triggers and conflicts are unexplored, as well as when they are recognized. Next, this chapter will identify strategies that aid in illuminating and therapeutically utilizing countertransference, presenting case illustrations as examples. Finally, this chapter seeks to explore the presence of countertransference outside the therapist/client dyad in order to provide a bridge to the multi-relational self-analysis that ensues.

Countertransference

Willer (2009) highlights that therapists across theoretical orientations acknowledge that it is normal for therapists to react emotionally to their clients. However, only psychodynamic theories have used the specific term ‘countertransference’ for these types of reactions, beginning with Freud and psychoanalysis (2009). Hayes (2004) also views countertransference as a transtheoretical idea and tells us that all therapists experience countertransference, regardless of whether they define it as such or commit to its
illumination in their clinical work. “Therapists of all theoretical persuasion, by virtue of their humanity, have unresolved personal conflicts; try though we might, no professional credentials or experience shield us from the human condition” (2004, p. 24). However, the term, countertransference, and its understanding, has been evolving since its conception (Marshall and Marshall, 1988).

**Definitions and conceptions over time.** Freud (1969) defines countertransference as that “which arises in the physician as a result of the patient’s influence on his unconscious feelings” (p. 29). Jacobs (1991) defines countertransference as “the emotional and physical responses of the analyst” as the analyst processes and responds to verbal and nonverbal communication from the patient (p. xvii). Hedges (1992) describes countertransference as the various experiences that he goes through while relating with the individuals that come to him for analysis. Alexandris and Vaslamatzis (1992) refer to countertransference as “the processes affecting the therapist’s mind - and, occasionally, his body - during psychoanalytic therapy, and the reasons for which the therapist thinks, feels, and reacts in a particular way” (p. xiii).

Orange (1995) perceives countertransference as a developmental and relational idea, and describes it as the memories and organizing principles within the therapist that become a part of the therapeutic relationship and dialogue. Therapists participate jointly with their patients in creating the experience that transpires between them, and Orange proposes the term “cotransference” to eliminate any inference that the therapist is in any way in opposition to the patient as the term counter-transference may suggest (p. 67). Orange (1995) views the traditional term, countertransference, as describing only those
reactive affective memories of therapists that actually restrict their therapeutic ability, and that decrease their ability to empathize with their patients.

Hirsch (2008) describes countertransference as “pursuits of self-interest,” referring to moments during sessions when analysts attend to their own needs rather than those of their patients, often with conscious awareness (p. 2). Willer (2009) explains countertransference as “therapists’ emotional reactions and relationship patterns in therapy” (p. 317). Orange, Atwood, and Stolorow (2009) refer to countertransference as the areas of unconsciousness in the analyst “that make up the problematic aspects of subjectivity” (p. 8). Reidbord (2010) explains countertransference as the way therapists transfer feelings from meaningful persons in their own past, onto the client.

Segal (1992) indicates that during Freud’s time, countertransference was seen as an impediment to the analyst’s objective view of the patient; something that the analyst had to conquer and cure in himself. Tansey and Burke (1989) found that in the late 1940’s, however, analysts began to make a critical shift in the conceptualization of countertransference as a useful tool in the interest of helping the patient. Analysts saw countertransference as a way to gain a deeper understanding of the patient through the conscious understanding of their own feelings, highlighting conscious as well as unconscious aspects to analysts’ countertransference. This latter understanding of countertransference took hold with analysts such as Reik, Winnicott, Berman, Heimann, Racker, Kernberg, Segal, and others, although not without each adding their unique perspective to this new conceptualization (1989). Although long accepted as ubiquitous, unavoidable, and even useful in understanding the patient, Berenstein (1995) found that countertransference was often ignored in clinical summaries. He explained:
Perhaps we avoid mentioning it in the literature because doing so gives us the secure, if false, feeling that we, the analysts, are different from our patients. And yet, although in terms of insight and understanding we often are different, in this most human arena we are not – and we must not ever delude ourselves into thinking we are. On this most fundamental level we and our patients are equals; the bond between patient and analyst is based on our common humanity; pain and suffering, loneliness, the human condition are our common glue. If an analyst is perfect, he can be of no use to others. If I do not also know of pain, how can I feel yours, how can I truly understand what you are talking about? (1995, p. 32-33)

Hayes, Gelso, and Hummel (2011) identify the four conceptions of countertransference that have emerged over the last century. Hayes et al. include the source of the countertransference that is attributed to each conceptualization. The first is the classical definition as originated by Freud, where countertransference is seen as an unconscious and detrimental childhood-based reaction to the patient that the therapist must seek to decrease, by resolving those childhood conflicts, through personal analysis (2011).

The second is the totalistic view of countertransference, where countertransference is seen as encompassing all reactions therapists have toward their clients (Hayes et al., 2011). This view places importance on exploring these reactions for their potential to inform the therapist and increase the therapist’s understanding of self as well as the patient (2011). Tansey and Burke (1989) explain that the totalistic approach includes the therapist’s conscious and unconscious responses to the patient, the “‘real’ and neurotically ‘distorted’” (p. 10). Tansey and Burke find that the totalistic view proposes that the
therapist’s perceptions cannot be distinguished between realistic and neurotic because all perceptions are a fusion of past and present dynamics (1989).

The third conception of countertransference identified by Hayes et al. (2011) is known as the *complementary conception*, where countertransference is viewed as being a result of the patient’s relational style. This conception includes the belief that as therapists gain insight about their internal reactions, they can then determine the patient’s conflicts and guide therapy and interventions from that understanding (2011). Eagle (2000) warns that this view represents a new kind of ‘blank screen’ where therapists are seen as void of their own mental processes, strictly transmitting those thoughts and feelings of the patient.

Hayes et al. (2011) identify the *relational perspective* as the final conception. This perspective views countertransference as co-constructed by both, therapist and client, as both their needs and conflicts play a part in the therapist’s affective reactions (2011).

Eagle (2000) agrees that a therapist’s own mental processes and perspectives are always a factor in identification with the client. Hobday (2011) highlights that the current understanding of countertransference is that it is ever present in therapeutic interaction. Hobday believes psychotherapists are wise to be mindfully aware of their true affect as it shifts and wanes throughout the session, in a committed effort to understand their subjective contributions to the therapeutic relationship (2011).

**Types of countertransference.** Winnicott (1949) conceptualized the term, objective countertransference, referring to those reactions or feelings in the therapist that are brought on by the personal traits and style of a particular client. Koch (2005) identified three types of countertransference reactions: those that are the result of the way in which the client behaves with the therapist, those that are rooted in unresolved conflicts from the
therapist’s past, and those that are an interplay of the first two. Similarly, Marshall and Marshall (1988) viewed countertransference on a continuum with two opposing sources, external and internal. If the source of the therapist’s reaction is external it stems from the patient’s presentation, and if the source is internal it stems from the therapist’s previous relationships and experiences. However, they believe that it is impossible to distinguish pure states of either in clinical practice. In session, the therapist experiences a combination of these stimuli as evidenced by a variety of therapist behaviors, feelings, and thoughts (1988).

Kantrowitz (1996) suggests that another way to categorize countertransference is to do so in regards to the different types of countertransference triggers that analysts recognize during therapy, through their awareness of strong, emotional reactions. In a survey study of analysts’ illumination of these triggers, Kantrowitz identified four such categories. One was when there existed a similarity of personal conflicts between analyst and patient, a second was when the analyst admired a quality in the patient that the analyst felt was lacking in himself, a third was when a patient confronted an interpretation of the analyst during therapy, and the fourth was during a countertransference enactment (1996).

Hayes (2004) explored different types of countertransference and identified the integrative conception. This type of countertransference is understood as the reactions or manifestations that exist within the therapist that are strictly due to the therapist’s unresolved past conflicts, conscious or unconscious, in response to a variety of phenomena - including but not limited to, client characteristics or behavior. Hayes infers that even countertransference rooted in the therapist’s past is shaped by client and therapist influences and, therefore, is a co-created occurrence. Hayes (2004) emphasizes
that this understanding “encourages therapists to identify the intrapsychic origins of their reactions, and attempt to understand and manage them” (p. 23).

Hayes (2004) proposes a slight adjustment to the integrative conception, to have it include partially resolved therapist conflicts. He conceptualizes countertransference as those therapist reactions that are rooted in personal conflicts within the therapist, rather than strictly unresolved ones. Hayes believes that countertransference reactions arise from issues that are often partially resolved, as well as those that are unresolved (2004).

It is important to note that Hayes (2004) defines integrative countertransference manifestations as “the affective, behavioral, cognitive, and visceral reactions that therapists experience when their unresolved issues are provoked” (p. 29). He describes countertransference effects as the consequences of a therapist’s reactions on the quality and outcome of therapy. Hayes (2004) explains countertransference management as a therapist’s ability to effectively handle these types of reactions so as to decrease their negative impact and/or increase their benefit on therapy outcome and the therapy process.

Similarly to Koch and Marshall and Marshall, Willer (2009) identifies two main types of countertransference: that which is based on what the client brings to the relationship, and that which stems from therapists’ internal, personal issues. The former describes emotions that any therapist might have toward a particular client. Willer (2009) explains this is due to the way a client presents himself verbally and nonverbally, in regards to expressing his feelings, thoughts, and behavior.

Willer (2009) further identifies three subtypes of countertransference under the first main type, that which is based on the presentation of the client. The first subtype occurs when therapists empathically relate to, and feel, the client’s feelings. The second
subtype is more complex, traditionally described as projective identification, and it refers to situations in which the client is affectively conflicted and projects feelings onto the therapist that he cannot tolerate himself. The therapist identifies with the projected feeling and has the task of identifying this type of countertransference and reflecting the client’s ambivalent feelings back to the client. The third subtype relates to reenacting the client’s relational dynamics and patterns from earlier, primary relationships (2009).

The latter, main type of countertransference, that which is due to the personal issues of the therapist, can be related to the therapist’s current life experience or experiences from the past (Willer, 2009). Research “illustrates that this type of countertransference is normative and universal and cannot be avoided” (p. 329). These types of countertransference reactions highlight the need for self-exploration (2009).

Hirsch (2008) explores different types of internal countertransference, or what he deems as analysts’ conscious and unconscious ‘self-indulgences.’ The first of this type of countertransference is when analysts indulge in momentary lapses of attention and place that attention on their own interests. The second of this type refers to the manner in which psychoanalysts organize the analytic frame and make decisions regarding other, competing, professional responsibilities. The third of this type of countertransference is that which results from analysts’ unique personalities and past occurrences in their lives. Hirsch tell us this latter type can be a transient or continuous element in how analysts shape the relationship with their patients, so that it conforms to a relational pattern the analyst is comfortable with. Hirsch explains:

At some point these interactions inevitably become conscious to the analyst, and the choice presents itself whether to create a disquieting disequilibrium by using
these interactional data to productively address the transference-countertransference theme, or, conversely, whether to coast with the status quo and maintain what might be a mutually comfortable equilibrium between patient and analyst. (2008, p. 3)

**Unconscious vs. Illuminated Countertransference**

“Clinicians must come to believe that there is not only no place to hide, but also no reason to.”

Karen Maroda

Paula Heimann (1949) contends that psychoanalysts who stifle their feelings will make ineffective interpretations. Corey (2009) explains that therapists cannot help clients in areas that they themselves have not personally explored: “If we are not committed personally to the value of examining life we will not be able to convince clients of the worth of personal exploration” (p. 21). Reidbord (2010) believes countertransference can interfere with therapeutic treatment if it is “unexamined – or worse, unrecognized” (para. 11).

Norcross and Hill (2005) identified management of countertransference as one of seven most probably effective components in therapy relationships. Norcross and Hill (2005) stated, “the limited research supports the interrelated conclusions that therapist acting out countertransference hinders psychotherapy, whereas effectively managing countertransference aids the process and probably the outcome of therapy” (p. 205).
Research studies. In a classic study, Cutler (1958) demonstrated that unresolved countertransference issues could have damaging effects on psychotherapy outcome. For his study, Cutler selected two male therapists. Each therapist’s countertransference conflicts were identified through the use of a rating measure that rated 16 personality traits and was completed by the therapist as well as several individuals who knew him well. The ratings were then compared, and those traits that showed a discrepancy between the self-rating and the judges’ ratings, were labeled as countertransference conflicts (1958).

The first therapist in Cutler’s study had substantial training in a graduate program for clinical psychology, moderate experience as a therapist, and had completed personal psychoanalysis (Cutler, 1958). This therapist recorded a total of nine therapy sessions with three different clients. The second therapist had just begun his graduate training, had little experience as a therapist, and had not undergone any psychotherapy. This therapist recorded a total of eight therapy sessions with two different clients (1958).

Both therapists also wrote up a report after each session, giving an account of their perception of what had emerged during the hour and what their own, and their client’s, behavior had been during therapy (Cutler, 1958). The recordings and written accounts were evaluated by judges, in regards to whether each therapist over or under-reported behavior during conflictual and non-conflictual communications with clients – as evidence of countertransference impacting therapeutic effectiveness (1958).

Cutler (1958) had hypothesized that unresolved countertransference issues would influence the therapist and be demonstrated in the therapist’s needs taking precedence over their client’s. Also, that the therapist would be unable to report his and his patient’s behavior objectively and accurately. In fact, he had hypothesized that the therapist would
have “tendencies to omit, distort, or overemphasize certain aspects of the behavior” (p. 350). Additionally, Cutler had predicted that when a conflict was not present, or had been resolved, the therapist would not engage in defensive behavior and, therefore, would be capable of accurately reporting his and his client’s behavior during the session (1958).

In accordance with his predictions, Cutler (1958) found that therapists’ unresolved conflicts resulted in decreased psychotherapy effectiveness. He also found that greater awareness and insight, as that shown by the therapist with more training, experience, and personal therapy, resulted in less defensive behavior toward clients – although not less countertransference reactions or feelings. A total of 27 incidents of over-reporting of behavior were identified. In 25 of these 27, “therapists reported more of the behavior than actually occurred” (p. 355). Cutler wrote:

It seems clear that the appearance in the patient of behavior which is conflict relevant for the therapist prevents the therapist from functioning at maximum efficiency. In addition, there seems to be a definite relationship between the amount of experience and/or self-insight which the therapist has, and his tendency to show task-oriented, rather than ego-oriented behavior. It appears that even though both therapists’ perception of their patients is disturbed by their own conflicts, Therapist 1 is able to make use of his experience to behave in a more appropriate and effective manner in the actual process of psychotherapy. (1958, p. 355)

Robbins and Jolkovski (1987) performed a study assessing the benefits of countertransference awareness. In accordance with Culter, they found that the greater awareness of feeling a therapist had, the greater his engagement in the client’s needs. The
participants were 58 doctoral students in clinical psychology and counseling programs, averaging 29 years of age. The majority of the doctoral students were White, and just over half were male (1987).

The trainees were initially rated on their level of awareness of countertransference feelings (Robbins and Jolkovski, 1987). The trainees had to rate the written statements of an anonymous therapist relating to the usefulness, occurrence, and appropriateness of countertransference reactions. Robbins and Jolkovski also assessed the level of each trainee’s theoretical framework through the use of a three-item self-report. The trainees were then given two audiotapes of “mock” client sessions and assessed on their withdrawal of involvement (a countertransference behavior). They were rated on their choice of response on a written protocol at the conclusion of each of 10 segments per audiotape. The researchers found that “greater awareness of feeling relates to less withdrawal of involvement and that the combination of high awareness of feeling with high theoretical framework provides the least withdrawal of involvement” (1987, p. 276).

In a field study by Gelso, Latts, Gomez, and Fassinger (2002), the researchers investigated the correlation between therapists’ management of countertransference and treatment outcome. There were 32 doctoral therapy students (21 were female) and their 15 supervisors (nine were female) participating in the study. Most of the doctoral students were in their first year of their doctoral program, while the supervisors had an average of 17.8 years of postdoctoral experience as individual therapists and supervisors. A total of 63 clients were receiving therapy with the doctoral students at the University’s counseling center. After the first session, 80% of the clients were rated by their therapist as having slight to moderate dysfunction, while the remaining 20% were rated as having a higher
amount of dysfunction (2002).

To assess countertransference management, Gelso et al. (2002) modified the Countertransference Factors Inventory (CFI) to measure only those factors that specifically related to the process of countertransference management. They ended up with 23 total questions addressing the five subscales of, respectively, self-insight, self-integration, anxiety management, empathy, and conceptualizing skills. To assess counseling outcome, the researchers used the Counseling Outcome Measure (COM). This instrument consisted of four-items in which therapists rated their clients’ improvement or regression of overall self-understanding at the end of therapy, on a scale of 1 to 7 (much worse to much improved). To assess clients’ disturbance level, Gelso et al. used the Client Functioning Level Scale (CFLS). Here, therapists “incorporate intrapsychic factors, interpersonal and social relationships, and situational stressors” to measure initial client functioning on a scale of 0 to 4, functioning better than average to serious dysfunction (2002, p. 864).

Doctoral students completed the CFLS for each client after the first therapy session and the COM after termination, as well as two questionnaires (Gelso et al., 2002). Supervisors completed the COM for each client of their supervisees, and the CFI for each of their supervisees. Gelso et al. explained their findings:

The CFI total score was significantly positively correlated with all ratings of client outcome. Therefore, our hypothesis that countertransference management would correlate positively with client outcome was supported. The better therapist-trainees are able to manage their countertransference the more improvement their clients exhibit at the end of brief therapy. It seems especially notable that a
general, traitlike quality in therapists can predict a specific client outcome. (2002, p. 865)

Rosenberger and Hayes (2002) conducted a field study examining a single therapy relationship for a total of 13 videotaped sessions over a period of 18 weeks. The two participants in the study were white and female. The client was 21 years old and the therapist was a 34-year-old licensed psychologist. These researchers wanted to gain insight into the consequences of countertransference when client issues triggered the therapist’s unresolved conflicts, as well as when the therapist’s countertransference was effectively managed (2002).

The therapist’s countertransference blind spots were identified through the use of a self-ratings measure compared to ratings on the same measure by three of her close friends (Rosenberger and Hayes, 2002). The therapist was also interviewed prior to the commencement of treatment to assess unresolved conflicts of which she was already aware. During treatment, raters classified every client communication in regards to whether it related to a therapist conflict. A second team of raters classified every therapist communication in regards to whether it qualified as avoidant. The researchers had hypothesized that unresolved conflicts of the therapist triggered by the client would cause the therapist to engage in avoidant behavior. Additionally, therapist and client completed postsession measures for each session, rating their perception of the working alliance, the therapist’s social influence, and the depth and impact of sessions. Non-verbal behavior was not measured (2002).

Rosenberg and Hayes (2002) identified more than 10 therapist blind spots, ranging from depression to conflicts with aggression. Of the 498 client speaking turns rated by
trained raters, 102 of them were rated as triggering a therapist conflict. Surprisingly, only 10 of those speaking turns were identified as avoidant. “Although the client mentioned issues related to the therapist’s unresolved conflicts an average of more than nine times per session, the therapist displayed very little avoidance behavior” (p. 227). The client continuously rated the therapist as highly competent, attractive, and trustworthy, and both, therapist and client rated their alliance as strong. Both client and therapist rated their sessions high in smoothness and depth, and the therapist indicated that she thought she managed her countertransference well (2002).

Rosenberger and Hayes (2002) found that therapist avoidant communication was inversely related to the client’s discussion of content related to the therapist’s unresolved issues, both for conflicts of which she was aware and unaware. However, the small incidence of avoidant behavior could be due to the therapist’s gender, as the researchers noted that other studies that show therapist avoidant behavior when confronted with conflictual material have had, exclusively, males as therapists. Although the therapist showed little avoidant behavior when confronted with conflictual material, she demonstrated that she was, indeed, adversely affected in these instances. “The more the client talked about issues related to the therapist’s unresolved conflicts, the less attractive, expert, and trustworthy the therapist felt” (p. 228). Additionally, Rosenberger and Hayes concluded that the therapist’s effective management of countertransference promoted session depth and an increase of focus on the client. It is important to note that this study had several limitations, most notably that it was a single-case design (2002).

Hayes, Yeh, and Eisenberg (2007) conducted a field study to examine how therapists’ grief countertransference related to their clients’ perceptions of the therapy
relationship. They examined, specifically, perceptions of therapists’ empathic ability, session depth, therapist credibility, and working alliance. The participants were 69 therapists and 69 current clients who had all experienced the death of a loved one at varying times in their lives. The majority of the therapists and clients were women, and White. The average therapist age was 53.5 years, with an average of 15.8 years of experience, and 29% held a doctorate degree. The therapist participants subscribed to a variety of orientations with just under half of the therapists describing their orientation as eclectic (2007).

According to Hayes et al. (2007), therapists and clients completed a variety of assessment instruments that they subsequently mailed in for analysis. Therapists completed a 13-item inventory to assess their current functioning in regards to the level of grief resolution over the loss of their loved one. Clients completed a total of four instruments each. Therapist empathy was assessed through a client inventory rating a therapist on 10 different items. Similar inventories were used to assess clients’ perception of therapist credibility, session depth, and working alliance (2007).

In examining the data, Hayes et al. (2007) found that clients perceived their therapist as being more or less empathic depending on that therapist’s grief level. Clients perceived therapists who experienced greater grief as less empathic. The researchers wrote:

This finding underscores the importance of therapists’ attending to and working to resolve personal issues that may affect their work with clients… A therapist’s unresolved issues can interfere with critical therapeutic processes such as empathy whereas greater resolution of such issues may serve to deepen the therapist’s
Hayes, Gelso, and Hummel (2011) performed three meta-analyses (some of which have been discussed independently above). One of their meta-analyses examined 10 quantitative studies regarding the relationship between therapists’ countertransference reactions and therapeutic outcome, as well as three qualitative studies on the same issue. Hayes et al. found that countertransference reactions, when unmanaged, negatively affect therapy outcome. Hayes et al. stated that “the acting out of CT [countertransference] is harmful” and that acting out occurred at an increased rate when countertransference was unmanaged (p. 94). Hayes et al. explained management of countertransference as something therapists can do “to, with, or about” their countertransference reactions internally to keep from acting out their conflicts in therapy sessions (2011).

In another meta-analyses, Hayes et al. (2011) examined 10 quantitative and three qualitative studies regarding the correlation between countertransference management and outcome. They found that resolved countertransference conflicts were more likely to be managed and utilized therapeutically by therapists, and that greater management of countertransference played a role in decreasing therapists’ countertransference behaviors. In sum, Hayes et al. found that managing countertransference probably enabled positive therapy outcome by helping therapists control countertransference manifestations during therapy (2011).

Hayes et al. (2011) also examined 11 quantitative studies regarding the relationship between countertransference awareness and the occurrence of countertransference reactions. The researchers found that illuminating and managing countertransference did not play a significant role in decreasing countertransference
reactions, or the emotional triggering of earlier conflicts. Countertransference conflicts continued to be triggered in all therapists, even those able to manage countertransference reactions (2011).

**Clinical observations.** Marshall and Marshall (1988) believe that, at its most unconscious, countertransference can dominate the therapist. The therapist, in turn, may emotionally dominate the client/therapist relationship. Therapists may be unaware of the interpersonal exchanges between their clients and themselves, and therapists’ responses and reactions can produce damaging feedback to the client in the form of anti-therapeutic interventions, while preventing therapeutic relating and positive treatment outcomes (1988).

As noted in the preceding research studies, Marshall and Marshall (1988) have observed that when patients arouse affective states in their therapists that are not yet in the therapists’ command, this may create an obstacle to effective treatment. These authors state: “In actuality, the clinician is subject to defending against thoughts, feelings, and memories which ultimately have roots in the therapists’ experience and his cognitive, perceptual-affective systems” (p. 63). Marshall and Marshall emphasize that therapists who function without conscious awareness will organize the therapy according to their needs rather than their clients’ needs. These authors add that therapists may keep from treating a variety of individuals, may have little control over their therapist activities, may lecture patients, may please their clients by giving in to their clients’ desires, and may be destructive to their clients and their treatment in a variety of other ways. Marshall and Marshall (1988) denote that medical therapists who lack self-awareness may freely prescribe medication upon patients’ request.
Jacobs (1991) describes similar observations, finding that unconscious countertransference reactions are communicated to the patient nonverbally. What occurs in the analysis, in the form of therapist interventions and responses, may be largely influenced by the unconscious countertransference. Jacobs (1991) adds: “Because they are often effectively defended against, however, such responses may, without self-scrutiny, go undetected” (p. 122).

Bollas (1987) and Hedges (1992) agree that one of the great benefits of countertransference illumination and exploration is that it often informs the analyst of the patient’s history or of feelings in patients which they cannot yet sustain, enhancing the analyst’s and the patient’s understanding of the patient. Eagle (2000), however, argues that the benefit of countertransference exploration lies in therapists understanding their own reactions and attitudes that could otherwise create a barrier to therapeutic relating:

Do not assume that all feelings and thoughts that emerge in your experience necessarily, and in any simple, uncomplicated way, reflect what is going on in the patient's inner world. A little dose of the classical view of countertransference, defined as a possible barrier to understanding, is, I believe, in order. (2000, p. 36)

Hirsch (2008) proposes that most analysts know, although they don’t publicly admit, that they often attend to their own interests during a therapy session rather than attending to their patients, and that this is an unavoidable reality. However, the author persists that those who are genuinely willing to face themselves truthfully and take the opportunity to explore these lapses in attention will decrease the likelihood and persistence of these incidents. He also believes that they will be better equipped to utilize this type of countertransference therapeutically when it occurs (2008).
Green (2006) finds it of utmost necessity to illuminate and explore negative countertransference reactions during sessions in order to separate his own affective and cognitive states from those of his clients, and to increase his ability to engage therapeutically. Orange (1995) emphasizes the importance of exploring one’s history in order to be capable of therapeutic relating. Orange was the eldest of 10 siblings and her role in her family of origin was one of provider and caretaker. She describes this as one way in which her past influences her as an analyst. Orange claims it is imperative that analysts understand how their personal history and subjective world shapes their experiences with clients (1995). Similarly, Tansey and Burke (1998) see countertransference exploration as having a positive impact on therapists’ ability to implement therapeutic techniques and build on their empathic potential.

Kantrowitz (1996) draws a parallel between patients’ tendency to explore disavowed aspects of themselves through displacement and analysts’ inclination to do the same. In working with patients, analysts have the “opportunity to investigate areas of unresolved or partially resolved conflict or distress that otherwise might be avoided” (p. 53). In exploring disquieting affective reactions, analysts often discover that they share something with their patient that is unacknowledged and has been disowned, and which only through illumination can have the potential to increase the analyst’s empathic understanding of the patient. After surveying and interviewing dozens of analysts, Kantrowitz has found that self-exploration increased their perceived ability to behave genuinely and therapeutically with their patients on a consistent basis (1996).

Maroda (2004) moves beyond the benefits of countertransference awareness and exploration. She emphasizes the benefits of countertransference disclosure, which she
only recommends for therapists who are seasoned at countertransference illumination and analysis. Maroda (2004) writes that psychoanalysts can actively utilize countertransference by expressing a countertransference reaction to a client as an intervention, and that failing to do so can lead to a host of negative outcomes “such as stalemates, premature or forced terminations, and even sexual acting-out” (p. 4).

Maroda (2004) believes that this type of disclosure creates a more mutual relationship and moves the therapist out of the position of expert. The author emphasizes that patients are free to be spontaneous when in a non-authoritarian atmosphere. “The patient who never knows what his therapist really thinks is afraid of disapproval” (p. 15). Additionally, Maroda has found that engaging in an enactment with a client can be valuable to therapy. However, Maroda (2004) highlights that it is crucial for the therapist to change the ending of the client’s old script by behaving differently from the client’s original cast of characters.

Case illustrations. Marshall and Marshall (1988) give an example of a therapist’s interventions with a client while experiencing unrecognized countertransference. This therapist continuously lectured his client about behaving professionally at his job, to the detriment of the therapeutic relationship and the patient. The therapist rationalized to himself that psychotherapy treatment would be at risk if the patient lost his job. However, this toxic intervention turned out to be countertransference-motivated, surfacing out of the therapist’s own needs and desires. This therapist finally discovered, in supervision, that he was reacting out of devastating anger at his deceased father, who had lost a fortune in his business, and who would have left the therapist independently wealthy had he not squandered money away (1988).
Hayes, Gelso, and Hummel (2011) present a case study of a female doctoral trainee with unrecognized countertransference reactions in relating with an angry male client who presented with borderline behaviors. The researchers indicate that the trainee experienced irritation toward this hostile client, causing her to behave in a muted and controlled manner. This client triggered several of her countertransference conflicts, including anxieties about being inadequate and unable to sufficiently care for others. He consistently rejected her efforts in session. As the doctoral trainee began to illuminate and acknowledge her countertransference conflicts, and to understand how they impacted her relationship with this client, her irritation decreased. She was subsequently able to empathically attune to her client and to his core emotional experience (2011).

Hirsch (2008) writes of an unconscious fear that impacted his ability to engage therapeutically with clients during the period after the September 11, 2001 tragedy. Hirsch became emotionally numb to the New York City trauma, colluding with male patients who were insensitive and in denial about their anxiety. He also began to superficially reassure those patients who were attempting to discuss their fears, denying them the opportunity to fully express their reactions. In hindsight, Hirsch recognizes that he was especially vulnerable yet emotionally disconnected. He was reluctant to face the intense fear he felt for his adult children’s safety due to their potential risk in the New York City subway system (2008).

Marshall and Marshall (1988) illustrate a contrasting case of a female therapist who was aware of her countertransference reaction with a particularly difficult female patient. This therapist was also cognizant of her patient’s affective communication, and was able to utilize the countertransference to effect therapeutic change. Her patient had
previously elicited a feeling of revulsion in other therapists, as was the case with this therapist. However, this therapist understood the communication inherent in the patient’s physical presentation. She took a genuine interest in the patient and soon began to see the patient’s positive qualities. The patient simultaneously began to own her feeling of disgust. Therapeutic movement ensued. The therapist in this illustration was able to make a dramatic change through her ability to “experience the objective countertransference, understand the emotional message, and then develop a therapeutic strategy” (1988, p. 91).

Berenstein (1995) illustrates the benefits of exploring and utilizing countertransference reactions while working through psychoanalysis with a patient from a highly dysfunctional family. Berenstein refers to his patient as, ‘The Snow Leopard,’ a young boy named Peter whom he treated for several years. Berenstein describes the many hours Peter spent in analysis in a fantasy world in which he believed he was a snow leopard in the Himalayas. Peter would retreat into this fantasy world in order to express his agony and avoid having to address his pain directly. Peter’s mother had abandoned him at a young age. In his fantasy world, it was natural and accepted that Peter was full of fury and danger. Peter would behaviorally transform into a snow leopard every time a therapy session began to address Peter’s underlying childhood trauma. These transformations at times became physically dangerous for Peter and Berenstein (1995).

Berenstein (1995) describes his countertransference exploration and how it guided the analysis with Peter. The analyst recounts a period in the analysis when he was overcautious with Peter. He later realized that his countertransference anxiety of hurting Peter, as well as his fear of Peter’s rage, impacted his ability to challenge the boy. Berenstein also explores a parallel, personal conflict with emotional abandonment. He
acknowledges that his own anxiety with this issue often kept him from fully exploring Peter’s abandonment (1995).

Over time, Berenstein (1995) succeeded in helping Peter confront his childhood trauma, and was able to guide Peter out of his periodic delusions. However, he only accomplished this after conscious, relentless, and courageous exploration of his countertransference reactions and conflicts. Berenstein (1995) states that countertransference arises “when the patient’s pain touches our own in a very fundamental place and we cannot bring ourselves to make our patients face this pain, both out of misguided protectiveness and as a way of avoiding facing it ourselves” (p. 33).

In the first of four clinical examples, Ogden (1995) describes his analytic relationship with a woman who suffered from a sense of deadness as a human being. His patient lived almost vicariously through others, and co-created a sense of deadness in him. Ogden actualized this sensation by compulsively checking his pulse through countless hours of painful boredom, and psychological and physical suffering, while listening to this patient tell countless, drawn-out stories of her life. In a heartfelt declaration, Ogden relates his breakthrough discovery that his countertransference behavior was an attempt to ascertain that he was still alive. Ogden’s commitment to his patient is evident when he writes of feeling unexpectedly moved during one of her incessant, random stories. He recounts how he suddenly saw her stories as an unconscious plea to have him make sense of them and use the stories to create a coherent meaning of her life, which she saw as meaningless (1995).

Through the exploration of his countertransference feeling of deadness, Ogden (1995) discovered the tragic meaning of his patient’s stories. He was subsequently able to
empathize with his patient and therapeutically interpret this meaning to her. Ogden’s patient then began to connect with the fantasies that represented this lack of a sense of self. She also began to verbalize a deep fear that she lacked the capacity to create a genuine life of her own. Ogden’s patient continued to stay in touch with this internal, transference-based fear, while gaining the ability to use analogies and symbolism to describe her experiences. Ogden (1995) wrote, “An intersubjective analytic space had begun to be generated in which the deadness could be felt, viewed, experienced and spoken about by the two of us. Deadness had become a feeling as opposed to a fact” (p. 699).

Strategies and Skills to Illuminate and Utilize Countertransference

Hedges (1992) asks, “if there is a special skill involved in tuning into our feelings and making optimal expressive use of them for analytic effectiveness, how do we go about cultivating such a skill?” (p. 4). Racker (1968) writes that the first step in illuminating and utilizing countertransference is to come to terms with the idea itself:

We must begin by revision of our feelings about our own countertransference and try to overcome our own infantile ideals more thoroughly, accepting more fully the fact that we are still children and neurotics even when we are adults and analysts. Only in this way – by better overcoming our rejection of countertransference – can we achieve the same result in candidates. (p. 130)

Research studies. Cutler (1958) examined key factors that enhance countertransference illumination and conflict resolution. In a previously mentioned study in which he analyzed two therapists’ countertransference reactions, each with a different
level of training, experience, and amount of personal therapy, Cutler found that training, personal therapy, and supervision increased therapist self-awareness and psychotherapy effectiveness (1958). Schwartz, Smith, and Chopko (2007), as a result of their research in an empirical test regarding therapists’ countertransference (CT) reactions, also wrote of the importance of supervision. Additionally, they highlighted another important component in exploring one’s countertransference. They concluded:

   Psychotherapists should discuss their reactions with supervisors or colleagues.
   Sharing one's CT reactions can serve many important functions, including venting one's feelings, normalizing the responses, receiving objective information about the reactions from others, and discussing how to respond effectively. We believe that the important aspect of the last two steps is for psychotherapists to determine if CT reactions are primary (i.e., subjective and self-generated) versus client-induced. (2007, p. 389-390)

   Hayes, Gelso, Van Wagoner, and Diemer (1991) conducted a survey to identify therapist qualities pertinent in the illumination and management of countertransference. The researchers designed the Countertransference Factors Inventory (CFI) to assess the importance of several skills and traits in therapists’ ability to manage countertransference, specifically, self-integration, anxiety management, conceptualizing skills, empathy, and self-insight. The participants were 33 expert psychologists, 25 of which were men, all averaging 20.3 years of experience, with an average age of 50 years. All but one of the psychologists identified themselves as psychodynamic therapists (1991).

   The psychologists were sent packages via mail, and asked to rate 50 characteristics, under the five categories above, as to their level of importance in aiding
therapists to manage their countertransference reactions and decrease the occurrence of countertransference behavior (Hayes et al., 1991). All factors were found to be of value in countertransference management, with self-integration and self-insight weighed as most important. The term, self-integration, was used to refer to therapist character/identity stability, and to therapist awareness of self, as well as appropriate level of self-differentiation. In regards to the term, self-insight, Hayes et al. stated:

The greater the clinician's awareness of motivating forces behind his thoughts, feelings, and behaviors, the less prone he will be to misattributing causality for his reactions and hence distorting the therapeutic relationship… Indeed, because countertransference originates in the unconscious, the more the therapist is able to bring into conscious awareness that which was hidden in the unconscious, the less he will find that his patient's material stimulates countertransference reactions.

(1991, p. 142)

Gelso et al. (2002), in their previously mentioned field study with 32 doctoral therapist trainees, identified similar therapist traits and abilities as critical in therapists’ ability to manage countertransference and positively affect therapy outcome. Specifically, self-integration (defined as the ability to maintain appropriate emotional boundaries), anxiety management, and conceptualizing skills (defined as the ability to conceptualize the dynamics of the therapist/client relationship) were found to be of significant value. Gelso et al. found no single element to be more important than another. These abilities or skills appear to be equally important in managing countertransference and facilitating client growth (2002).
In the previously mentioned meta-analysis, Hayes, Gelso, and Hummel (2011) also highlighted the use of self-insight and self-integration as primary to managing countertransference reactions. They explained that self-insight includes the therapist’s commitment to increase self-awareness and psychological health and appears to be crucial in “managing and effectively using one’s internal reactions” (p. 96). Self-integration referred to the resolution of therapists’ major internal conflicts, and related to the importance of personal psychotherapy and clinical supervision. Additionally, they emphasized the need for any approach to be more than purely intellectual. Hayes et al. underscored that an effective approach integrates internal feelings with theoretical knowledge, and is utilized to cognitively and emotionally understand countertransference conflicts and reactions (2011).

Cartwright and Read (2011) designed a 5-step method to aid psychotherapists in managing their countertransference and increasing therapeutic understanding. In order to examine the efficacy of their multi-step method, Cartwright and Read presented a study of a 2-day course in their method, and analyzed the impact their course had on psychologists’ understanding of countertransference. The program’s intention was to help therapists with the following: gain a deeper understanding of the concepts of transference and countertransference as well as a greater ability to apply that understanding in therapy, utilize the learned concepts for reflection on the dynamics that transpire in the therapist/client relationship, and develop strategies for countertransference management (2011).

In Cartwright and Read’s study (2011), of the 28 psychologists who participated in the 2-day course, 26 were female. The majority were European and came from a variety of
therapeutic orientations, though most were trained in theories other than psychodynamic ones. They completed questionnaires responding to clinical vignettes before and after the course. Their responses, pre and post course, were compared and utilized to examine what they learned from the program. Cartwright and Read found that the majority of psychologists in the program gained a greater understanding of countertransference reactions and responses after the completion of the course. The majority also gained a greater understanding of how to manage countertransference (2011).

The program’s five steps proved useful for psychotherapists to utilize as strategies in illuminating, managing, and utilizing their countertransference: In step 1, therapists observe their cognitive, affective, and physical experience in relation to their client (Cartwright & Read, 2011). In step 2, therapists ask themselves if a detected reaction to a client relates to what the client was experiencing or to a relational theme in the client’s past. In step 3, therapists theorize about the relational dynamics occurring between therapist and client. Therapists ask themselves three questions during this step: Am I reacting to my client in a way he expects? Is my affective response similar to that of my client’s in this or a past relationship? Is my affective reaction a result of a personal issue that has been triggered? Less experienced therapists skip this step and complete it as a reflective piece post-session, with the aid of their supervisor (2011).

Cartwright and Read (2011) explained that, in step 4, therapists refrain from engaging in an enactment of their countertransference, either verbally or behaviorally, by managing their reactions. They suggested using breathing, calming, or mindfulness techniques – any technique that will aid the therapist in remaining in an accepting, non-judgmental position. In step 5, therapists consciously coach themselves into shifting out of
their internal countertransference reaction and responding as the therapist, from the adult position. This is done while retaining the initial countertransference reaction for later reflection on its potential meaning and value. Participants in the 2-day training experienced many benefits using these strategies, including an increased ability to illuminate and utilize countertransference therapeutically by the end of the course (2011).

**Clinical observations.** Bollas (1987) examines a unique way to illuminate and utilize countertransference, in which a therapist can “approach himself in a session as the other patient, which he can accomplish by facilitating his own internal mental processes that complement the patient’s free association” (p. 202). Bollas explains that analysts must create a sense of countertransference readiness while accepting that one may not know or understand what is being experienced for quite some time. He recommends that analysts release certain countertransference feelings or intuitions into the communication between analyst and patient for exploration (1987).

Bollas (1987) emphasizes that the ability to sustain uncertainty about the experience will undoubtedly enhance analysts’ ability to lose themselves with their patients, and ultimately find an identity and a meaning together. The analyst, in viewing him/herself as the other patient, needs to be aware that he/she may be analyzing an element of the patient’s parents, or something that the patient cannot bear to feel or recognize in himself. The analyst must explore ideas with the patient and allow the patient to consider if they are of therapeutic use (1987).

Jacobs (1991) feels it is in paying attention to the underlying messages accompanying overt communication, both of the patient and of the analyst, that countertransference can be illuminated and utilized therapeutically. Analysts may
illuminate unconscious feelings, attitudes, and values by paying attention to nonverbal information, such as tone of voice and choice of words, inflection, posture, and so on. Jacobs asserts that this communication may:

…modify, punctuate, emphasize, or contradict the words spoken by each. It often happens that, despite his outward stance of neutrality, what is conveyed by the analyst on the metacommunicational level are subtle judgments concerning the patient’s attitudes and behavior. (1991, p. xxi)

Orange (1995) writes of the subjectivity from which analysts make interpretations and carry out interventions, and suggests strategies to illuminate countertransference. Equally important to the interpretations or interventions being made is the historicity of the analyst making them. This history, which has created the analyst, includes prejudices, or organizing principles. Analysts must explore their prejudices in order to revise them or to develop new organizing principles. “Only then can we enter the playful exchange that broadens and deepens our understanding…we must know and acknowledge our cotransference, our point of view or perspective, if we are to become capable of empathy” (p. 71). Analysts must be prepared to challenge their perspectives when they limit their understanding of others’ experiences (1995).

Kantrowitz (1996) states that, although insights sometimes arise from specific interactions, self understanding is usually acquired over time after continued exploration. Kantrowitz examines the different ways analysts develop self-knowledge, seeing all as solitary endeavors. Some analysts lie on a couch and use free-association, exploring strong affect and the root conflict that provoked a reaction or behavior. Others follow their thoughts in a similar way while involved in an automatic activity, such as walking. During
session, analysts can observe how their affect changes in relation to specific thoughts, be cognizant of thought pattern changes, pay attention to physical sensations, or use visual images as clues that a personal area needs to be explored. Kantrowitz has noticed that after exploration, most analysts feel a need to share their experiences with another, such as a colleague or spouse (1996).

Maroda (2004) has found that the best method for tapping into unconscious countertransference is through the emotional experience created in the dyad. Maroda encourages therapists to listen to their affect states. As she puts it, “our emotions do not lie” (p. 31). Tapping into this experience is achieved by the following: believing that the patient’s affective communication is of primary importance, intellectual understanding gained from education and training, and insight gained from a therapist’s ability to manage difficult feelings, which can be attained through personal psychotherapy (2004).

Maroda (2004) further suggests that therapists be aware of their emotions and comfortable enough with them to express them to their clients. Maroda has experimented with countertransference disclosure and is certain that disclosure is often what leads to dramatic breakthroughs (2004). However, Tansey and Burke (1989) contend that although countertransference disclosure is encouraged by some, it is prohibited by others.

Hedges (1992) agrees that analysts’ disclosure of countertransference feelings is an important part of creating a therapeutic relationship. However, he emphasizes that a common error psychoanalysts can make is assuming that countertransference feelings arise from their personal, earlier conflicts. He warns that this assumption can veer an analysis astray. In disclosing the countertransference, analysts must beware of being ready “to assume personal responsibility for the emerging disruption of untoward feeling,
thereby sidestepping completely the more important interactional component that contains the crucial processes and imagos of the analysis, whose emergence two people are resisting” (p. 25). Hedges identifies several components of utilizing countertransference in exploratory interpretation, including the action of being there with the patient, illuminating the countertransference reaction, and tentatively disclosing it to the patient through exploratory language that infers a request to find meaning together (1992).

Hayes (2004), on the other hand, focuses on internal countertransference. He identifies a framework for therapists to reflect on countertransference reactions and manifestations, that arise from their personal conflicts, in which they work backwards through three categories. First, therapists think about countertransference manifestations that occurred during a session. Then, therapists identify possible triggers for these reactions (2004).

In attempting to identify the triggers of their behavioral, affective, and cognitive reactions to clients, Hayes (2004) suggests therapists reflect on a session’s content and process. Therapists are encouraged to search for similarities between their clients and important people in their lives. Therapists should consider whether any recent structural factors of therapy are of significant value, such as a client missing appointments or termination looming with a particular client. Finally, therapists attempt to find the origins of these reactions and triggers in unresolved, or partially resolved, issues from their past (2004).

Koch (2005) asserts that therapists should attempt to address their countertransference issues through consultation, supervision, and personal therapy. Liegner (2007) writes of those same strategies to aid in the resolution of
countertransference conflicts when working with narcissistic patients. She identifies
typical, unmet needs of therapists that get triggered in psychotherapy, as well as what is
required for therapists to work towards resolution of their unmet needs. She writes:

The most frequent sources of these resistances are the candidates’ need not to feel hate, the need to be liked, the need to be right, and the need to deny what is actually occurring. These issues require, in addition to a personal analysis, ongoing supervision and consultation that follows the modern psychoanalytic model. (2007, p. 279)

Norcross and Hill, similarly to Gelso et al. in their 2002 field study, identify “self-insight, self-integration, anxiety management, empathy, and conceptualizing ability” as the central skills needed to manage countertransference (2005, p. 5). Hirsch (2008) also identifies anxiety management as a critical component. He suggests that therapists allow themselves to feel discomfort and resist avoiding anxiety, as a means to accessing and acknowledging countertransference reactions (2008). Tansey and Burke (1998) similarly explain that therapists’ capacity to tolerate anxiety aroused in the therapeutic relationship determines their degree of conscious awareness and ability to process the communication in the relationship.

Tansey and Burke (1998) propose a three-phase sequence for illuminating, processing, and utilizing countertransference, or “interactional communications” (p. 67). The first phase, Reception, involves the therapist receiving communication from the patient and being influenced by it. Therapists must be able to attend to the patient, which begins by clearing their minds of any personal preoccupations. They must also be able to
tolerate verbal and non-verbal pressure from patients, and to recognize their affective response as a signal with potentially fundamental significance (1989).

The second phase, Internal Processing, involves the therapist’s inner experience of the patient’s interactional communication as well as the therapist’s analysis of that communication (1989). “The therapist attempts first to tolerate, then to examine, and ultimately to use his internal reaction as a tool for understanding the patient’s experience” (p. 85). The third phase, Communication, involves the therapist’s empathically sensitive response after having processed the mutual interaction. These phases often overlap, with a therapist working in two or all three of the phases simultaneously. Tansey and Burke emphasize therapists’ ability to become aware of, and tolerate, intense feelings that arise from interactional communication. This ability determines effective progression through the three stages described above (1989).

**Case illustrations.** Hedges (1992) illustrated a case study with a female patient he called Dora. He explored his countertransference, his personal interpretation of it, and what he believed to be his error and failure in the analysis. Dora was deeply attracted to Hedges and dependent on him, and often discussed her attraction openly. She pressured Hedges to disclose how he felt about her. He eventually began to comply, yet felt uncomfortable reassuring her. Hedges became aware of feeling self-conscious and anxious about her growing attention, yet was careful not to let it show (1992).

Hedges (1992) had been keenly aware of disliking Dora’s intensity and intrusion, and one day she noticed him averting her gaze. Their relationship took a turn, as Dora suddenly perceived their relationship as a hoax. She felt betrayed and hated. Hedges felt it important to be upfront with her, and acknowledged his long-growing discomfort with her
admiration. He also admitted he was not completely sure of the reason for his discomfort. After an inner search for a previous conflict to connect to his countertransference behavior, Hedges disclosed to Dora that he had previously had a similar experience, and that this incident had, unfortunately, intruded into their work together. Hedges apologized for this intrusion and therapeutic analysis resumed (1992).

More than a year later, in an attempt to summarize their progress, Hedges made a grave error (1992). He told Dora that at the onset of her analysis she had been invested in seeing herself as “weepy, drab, and homely” (p. 13). In disclosing his view of what he believed to be Dora’s self-perception, Hedges made it clear to Dora and to himself that it was he who had seen Dora in this manner. His previous reassurance to Dora more than a year earlier, that his flinching away on that critical day had been due to a personal conflict from his past, was now seen as a lie. Trust was permanently severed (1992).

After Dora terminated the analysis, Hedges understood that his error had been in the content of his disclosure to Dora, as well as in his lack of insight about her past and her reversal of roles in therapy (1992). He had focused on his own past and its connection to the countertransference reaction. He had illuminated his countertransference correctly, and had then disclosed his discomfort to Dora, although without acknowledging the severity of his feelings. So far, these actions had been genuine and acceptable (1992).

Hedges (1992) had then searched for, found, and communicated to Dora that his reaction was not in relation to her actions and her presentation, but rather in relation to his own, previously unresolved issue with unwelcome admiration. In this interpretation, Hedges failed to recognize Dora’s influence. Dora’s admiration stemmed from Dora’s
dysfunctional relationship with her mother. Had Hedges explored this with Dora, it may have led to dramatic change. Hedges explained:

The lie was that I told her I did not dislike her for intruding, that I did not loathe the way she stared at me and spoke of my sexual appeal for her, that I did not hate her for the way she made me be on my guard every moment... Instead, I felt forced to reassure her of what a fine person she was, how much I liked her, and how her intrusions were no bother to me. True, my disclosure hit the mark in telling her the genetic history of why I was uneasy, but it carelessly sidestepped what she needed me to see – *that we had succeeded in our relationship in replicating the traumatic circumstances of her childhood*. I had fallen into the position she always occupied in relation to her fragile, vulnerable, and demanding mother. *(1992, p. 16)*

In this case study, Hedges (1992) pointed out how and where countertransference understanding can take a wrong turn, and he inferred what it takes to illuminate, explore, and therapeutically utilize countertransference phenomena. After the analysis was long over, Hedges explored and illuminated how genuinely strong his negative feelings were at the time. He learned that minimizing and dismissing the intensity of his feelings was a mistake. Most importantly, however, Hedges found great error in his assumption that his reaction was rooted in an internal countertransference conflict *(1992)*.

Hedges *(1992)* suggested that, in exploring the countertransference, therapists are wise to acknowledge the depth of their feelings. He further suggested that analysts may disclose those strong feelings to their patients in a manner that encourages joint exploration, and that illuminates understanding of the patient’s themes and relationships.
Finally, Hedges suggested that analysts consider the possibility that the countertransference involves a role reversal, or a replication of the patient’s past (1992). Bollas (1987) described a similar phenomenon, stating:

Patients may enact fragments of a parent, inviting us unconsciously to learn through experience how it felt to be the child of such a parent and, ironically, they may almost violently exaggerate the child they had been in the transference, tentatively looking to see if we become the mad parent. (p. 200)

Hirsch (2008) writes of disclosure as a critical element in utilizing countertransference. However, Hirsch writes of countertransference reactions that are rooted in the analyst’s personal conflicts. He recommends that therapists become aware of moments of inward attention during a session and acknowledge this lapse in attending to their clients. Hirsch suggests disclosing the self-absorption to clients while it is occurring, as a means to managing this type of countertransference reaction. He believes that addressing it with the patient may increase therapeutic understanding, and decrease the potential for this type of reaction to be acted out in ineffective or toxic interventions (2008).

Hirsch (2008) shares a personal example of ineffective countertransference management during a time when he was consumed with worry over acute back pain and the possibility of back surgery. He recounts his lack of attunement with a female patient who had been in a series of relationships with unavailable men. During this period, his patient was becoming involved in yet another similar affair in which she was pressuring her lover for increased attention. Hirsch’s patient needed him to see this pattern unfolding once again, but his self-absorption at the time obscured this truth from view (2008).
In his effort to give feedback and simultaneously hide his lack of involvement, Hirsch reassured his patient that she was behaving naturally (2008). Hirsch failed to challenge her choices and behavior. He also failed to address the enactment that was transpiring between him and his patient, in which he was the unavailable man in her life and she was desperately pursuing him for increased, meaningful involvement (2008).

In hindsight, Hirsch (2008) sees self-awareness, honesty, risk, countertransference disclosure, and the ability to tolerate anxiety as key elements that would have advanced their relationship. He believes that the therapeutic choice would have been to question his patient about not noticing his unavailability, to admit to her that he was at a loss of how to respond to her because of his recent lack of attunement, and to encourage her to respond to his disclosed information. The anxiety and discomfort created by the disclosed acknowledgement would have opened up a potential for genuine, therapeutic relating (2008).

Lacocque and Loeb (1988) identify three steps necessary to illuminate, manage, and therapeutically utilize countertransference reactions stemming from death anxiety. The authors suggest that there is often this type of countertransference reaction occurring when therapists describe their patients as aversive, meaning those patients that make analysts feel highly inadequate and vulnerable in a manner that is incredibly difficult to manage. They highlight the following:

We have ignored the anxiety about one’s fate that is not solely the reflection of a pathological upbringing. In fact, however, even the happiest of all childhoods cannot, we believe, prepare one for coping with the terror of dying. (1988, p. 100)
Clients’ anxieties are threatening to therapists’ sense of self, and only in dealing with personal issues of mortality can therapists sustain clients’ anxieties and therapeutically impact those relationships (1988).

Lacocque and Loeb (1988) illustrate the case of a 31-year-old woman, Sara, who presents a debilitating threat to her therapist’s emotional equilibrium. In this case, Sara presented with psychotic symptoms, such as auditory hallucinations. In the therapy sessions that ensued, Sara was initially withdrawn, practically catatonic. However, Sara eventually started demonstrating intense rage towards her therapist, who felt vulnerable and helpless in treating her. Her therapist knew it was therapeutic for her to express her anger, yet his empathic attunement and understanding only brought on greater hostility from Sara and he soon began to feel deeply frightened of her. He realized that his experience with Sara was triggering a memory and feeling of an identity crisis he experienced as a young man. He feared disintegration, brought on by Sara’s attacks and pleas for help as well as the rebirth of his earlier identity anxiety (1988).

Lacocque and Loeb (1988) indicate that a shift, then, occurred. His anxiety softened as he began to feel hate for Sara. He deeply resented his “aversive” patient. The anger that ensued was helpful in that it allowed him to project his anxieties outward, and recapture his sense of self. The final shift came as he gradually moved beyond his hate. Once he came to accept his reaction in relation to Sara, he was able to provide therapeutic treatment and to drop the label of “aversive” when referring to this patient (1988).

According to Lacocque and Loeb (1988), the therapist was then able to attend to Sara’s anxieties, without behaving as she did, neither withdrawing nor attacking. Certainly, projective identification was evident in the therapist’s reaction. Yet, it did not
explain the depths of his reaction as completely as did the idea that Sara had stirred in him an existential conflict about being “but a mere finite being with many shortcomings” (p. 102). In empathizing with Sara, the therapist re-experienced a death anxiety that was his own, although it had been triggered by Sara’s presentation. Lacocque and Loeb outline the three steps that assisted this therapist in illuminating and utilizing his countertransference:

The first step toward resolving the psychological impasse was to detect that his aversion for Sara was a self-protective device against his own acute anxieties. The second step was to recognize that two separate though interrelated processes were occurring simultaneously during therapy: her specific anxieties as well as his own. The third step was to sort out for himself the nature of his acute psychological disequilibrium. He had first to learn about its aetiology and meaning, as well as find ways to contain and manage his anxieties before he could attend to Sara’s turmoil. Finally, Sara’s debilitating anxieties, while no doubt also ontological in nature, had to be distinguished from his: in contradistinction to his own, hers were ongoing, pervasive, and more primitive. (1988, p. 103)

Countertransference Outside the Psychotherapy Relationship

“One sees clearly only with the heart. What is essential is invisible to the eye.”

The Little Prince

Small (1990) writes: “Therapeutic relating takes place not only in the counselor’s office or in group therapy sessions. It happens in all aspects of life, whenever the heart is
open and speaking its truth” (p. 9). In his lecture on psychoanalysis, Neville Symington (2009) emphasizes that tools, such as countertransference, are not the goal of analysis for they do not inspire anyone. Symington identifies the goal of psychoanalysis as seeing and penetrating into the experience of the participants in the dyad. Like Small, he believes this can take place anywhere, anytime, and between any two individuals. Symington considers his *informal* analysis his “true analysis.” The analyst believes any significant other can keep this type of analysis thriving. A relationship need only be alive in one’s heart for there to be a penetrating encounter that brings about growth (2009).

**Prevalence of countertransference in a variety of relationships.** Willer (2009) asserts that any type of transference, which includes countertransference, is not a phenomenon that only occurs in therapy, but rather one that occurs towards anyone that holds some resemblance to an influential person in an individual’s history. Hayes (2004) emphasizes that suffering from personal conflicts is universal. No one escapes having a history; No one escapes reacting to others from that history and from the personal conflicts that it contains. As previously noted on page 11, Hayes (2004) states: “Therapists of all theoretical persuasion, by virtue of their humanity, have unresolved personal conflicts; try though we might, no professional credentials or experience shield us from the human condition” (p. 24).

Liegner (2007) highlights that countertransference is experienced in many professional roles:

The role of countertransference is also a significant factor for those who work in a non-psychoanalytic mode. Caseworkers, parole officers, drug counselors, teachers, and others who deal with the public are regularly bombarded with induced
feelings. These feelings, if not recognized and dealt with, may lead to acute stress, anxiety, and somatic symptoms. (p. 277)

Paterson and Groening (1996) have analyzed clinical teachers’ subjective reactions to students in the nursing field, both student-induced and teacher-induced. Examples of teacher-induced countertransference are pervasive. These include reactions that stem from a teacher’s need to be idealized, a teacher’s desire to be the sole authority in a subject, a teacher’s conflict with a previous student, and a teacher’s need to feel omnipotent (1996).

Henry (2007) presents a case study that exemplifies the prevalence of unconscious countertransference reactions and behavior in the parent/child relationship. Henry’s patient, a 9 year-old boy, had severe relational difficulties. The boy’s mother was highly critical of the boy, and even caused Henry to feel anxious in her presence. Henry witnessed the boy’s mother’s insecurity about parenting, as well as her hostility toward her son, often demonstrated by physically striking the boy and/or screaming at him (2007).

Henry (2007) observed how the mother’s behavior resulted in his patient’s physically aggressive acts, such as symbolizing his mother with a clay figure and torturing it. It became clear to Henry that the mother was unconsciously reacting this way, and behaving in this abusive manner toward her son, due to “unresolved anger towards her abusive father” (p. 447). Although she was referred to individual therapy, where she could have explored her historicity and countertransference reactions, she did not comply with this recommendation (2007).

Benefits of countertransference exploration outside psychotherapy. Paterson and Groening (1996) write about teacher countertransference. Countertransference reactions that are teacher-induced can provide a meaningful learning experience for
teachers and their students. They emphasize that teacher-induced countertransference (TIC) reactions, left unexplored, can lead to destructive outcomes. “Perhaps the most devastating effect of TIC in clinical teaching is that it interferes with the clinical teacher’s ability to know the student well enough to assist in achieving the student’s learning goals” (1996, p. 1124).

Paterson and Groening (1996) add that a mentor may be necessary to help a teacher identify and reflect on this type of countertransference. Identifying patterns, such as the teacher’s desire to control, may also be of value. Paterson and Groening highlight that countertransference conflicts can only be resolved if they are, first, made conscious. Teachers can gain countertransference insight by making connections between their conduct and underlying intentions, as well as engaging in reflective exploration about how they engage students. Teachers can reflect on their judgments of student behaviors and explore what that tells them about who they are as teachers (1996).

Green (2006) presents an example of parental countertransference. His emphasis is on exploring internal feelings of “hate,” in order to get some distance from another and gain a differentiated perspective. When hate is present, Green finds that its illumination increases his ability to accept others where and how they are at that moment and, thus, regain the capacity to empathize. After recognizing and accepting this energy, Green is able to implement therapeutic interventions, be it as a parent or therapist. The following is an example of this countertransference phenomenon and of his therapeutic approach in a situation with his young daughter (2006).

Green (2006) explains that his wife was away for a few days and that his daughter was relentlessly rejecting him for not being mom. Green describes feeling angry, initially
directing his anger at his wife for being out of town. He considered requiring that his wife stay home in the future so that this would not happen again. He soon realized, however, that his daughter’s rejection had triggered his sense of inadequacy. Green observed that due to his pain, he had taken on his daughter’s perception of him as inadequate (2006).

Green (2006) denotes that his affect shifted as soon as he negated his daughter’s qualification of him. He was then able to accept her affect and presentation as separate from his knowledge of his competence as a father. He was subsequently able to empathize and proceed with an effective intervention, taking his daughter to the park where the two proceeded to enjoy each other’s company. This negation of his daughter’s label of him is what Green calls “using the energy of hate” in the countertransference (p. 193). Green states that acknowledging his hate helped him break free from an affective enmeshment with his daughter that was leading him to consider toxic interventions (2006).

Orange (1995) compares parents and children to analysts and their patients when writing of countertransference and empathic ability. She tells us that empathy is “emotional knowledge gained by participation in a shared reality,” and that parents who are empathic are able to better attune to their children’s emotional reality (p. 21). Orange adds that people need to feel and receive empathic responses in order to experience themselves as integrated and connected to others, and to safely pursue personal aims. Orange (1995) believes that empathic responses can only come from those who understand themselves, their perspective, and their “personal organized subjectivity” (p. 15).

Unconscious countertransference reactions of parents, teachers, and therapists, are akin to what Miller (2001) calls “emotional blindness” (p. xvi). Miller implores that
anyone interested in decreasing the world’s injustice develop a regular practice of illuminating their affective reactions, and then trace them back to unmet needs and pain suffered in their childhood at the hands of emotionally-blind, significant others. Miller believes life-long, emotional, adult repression is due to anxieties about acknowledging the truth of earlier trauma “…for fear that they might end up blaming their own parents” (p. 23). Miller claims this phenomenon is ubiquitous, and perpetuated across all disciplines: family systems, cultural groups, psychotherapy, psychiatry, religion, education, the penal system, politics, medicine, and mental health (2001).

Miller (2001) finds it imperative that parents, doctors, therapists, teachers, and others interested in a better world examine their childhood trauma and become aware of its impact on their emotional reactions to children. It is only through a process of emotional risk, honesty, and acknowledgement of previous trauma that an adult can transition from being emotionally blind to becoming an “enlightened witness” (p. x). Parents who are able to acknowledge and feel repressed childhood emotions, such as fear and rage, can then bypass the traumatization of their own children, stopping the cycle of emotional blindness. “The process of healing requires both the confrontation with childhood traumas and the uncovering of the numerous defense mechanisms that have been erected to protect the child from unbearable pain and distress” (2001, p. 40).

The literature review of the preceding pages present a comprehensive description of countertransference and its role in relational interactions inside and out of the psychotherapy relationship. It is apparent that countertransference is pervasive in psychotherapy relationships as well as teacher/student and parent/child relationships. It is
further apparent that it is necessary for Mental Health Professionals, as well as other individuals interested in developing therapeutic relationships, to gain greater awareness of countertransference reactions and conflicts, and increase their ability to explore and manage them. In order to achieve these goals, several strategies have been identified that can help individuals develop a practice of ongoing countertransference investigation. The following chapter introduces a self-analysis that serves as an example of this type of exploration.
CHAPTER III

Project Audience and Implementation Factors

Researchers have demonstrated that countertransference is ubiquitous and that different types of countertransference reactions, from a variety of sources, influence emotion, cognition, and behavior. Researchers have also demonstrated that an approach of regular examination of countertransference is necessary to ensure and increase empathic ability and positive psychotherapy outcome. It is crucial that responsible individuals working in psychotherapy, as well as other therapeutic fields, submit to a conscientious exploration of their historicity and subjectivity. Additionally, it is imperative that therapists take responsibility for the many ways in which their emotional and mental processes impact and inform their therapeutic relationships.

This chapter addresses the self-analysis that ensues, which provides an example of countertransference exploration in three different types of relationships. The self-analysis hopes to stimulate the exploration of multi-relational countertransference reactions in Mental Health Providers and others, such as parents, teachers, doctors, and nurses. Included in this chapter are the development of the multi-relational self-analysis, the intended population for the project, and an outline of the self-analysis.

Development of Project

The idea for this project has been percolating since the moment I considered becoming a parent. It was then that I became determined to do things differently than what I witnessed in my family of origin. I became aware of my family members’ automatic,
unempathic reactions to children and understood them as countertransference, without
knowing the term or the theoretical concept. Once I had my first child, I began to notice
my own anxiety, narcissistic desires, and automatic reactions and behaviors. I became
increasingly aware of my emotional limitations and curious as to their origins. Throughout
the last few years, I have become increasingly adept at noticing personal reactions and
behaviors towards my children that are suspiciously reminiscent of relational dynamics in
my family of origin. I now believe those reactions and behaviors are the product of
unconscious organizing principles internalized throughout my childhood. It became my
mission to observe these reactions and unearth the earlier, internal conflicts that fueled
them. This was not in an effort to extinguish them, as Freud may have advised, but rather
to understand and accept them in order to be increasingly able to manage them, while
maintaining an empathic presence.

After beginning my MFT Masters program at California State University
Northridge, I began to understand these reactions as countertransference, and soon became
interested in how countertransference affected my relationship with my clients as a
trainee. Much of the reading I felt passionate about, as well as the conferences I was
attracted to, addressed this concept. Becoming increasingly aware of internal
countertransference conflicts that impacted my relationships with my clients, students, and
my children, I began to explore and analyze these activations for my own personal growth,
and found the exploration tremendously meaningful. My chair, Dr. Rubalcava, suggested I
present a countertransference case study for my project. I expressed a desire to document
countertransference reactions with my children and students, as well, and a multi-
relational self-analysis was conceived.
I immersed myself in research from psychoanalytic theory, reading psychoanalysts such as, Maroda, Hirsch, Racker, Ogden, Winnicott, Ferenszi, and Freud. I began to see a pattern in how countertransference was perceived and conceived throughout the decades since Freud first coined the term. I also continued to illuminate additional countertransference reactions and to understand this phenomenon more fully. I noticed how the affective charge of a countertransference reaction would unravel and dissipate as I delved into its emotional and historical core. It became clear that exploring earlier conflicts would be a critical piece in understanding my countertransference. I listened to podcasts on countertransference, read a variety of books on the subject, and found countless articles demonstrating its prevalence and the benefits of its illumination and management. I then organized my reading and my experiences, and slowly began to piece the end product together.

**Intended Audience**

The target population for the self-analysis is individuals interested in illuminating and gaining insight as to their reactions with clients, patients, students, and/or children. They may be of either gender and any age or race. These individuals may be Mental Health Providers, Medical Professionals, or lay individuals, such as parents, teachers, and others. English language fluency is necessary, as well as a tenth grade reading level or beyond.

**Self-Analysis Outline**

1. Introduction
a. Adopted conceptions
b. Adopted strategies

2. Personal Historicity
   a. Early attachments
   b. Childhood conflicts

3. Personal Case Illustrations
   a. Four case illustrations as a marriage and family therapist trainee
   b. Three case illustrations as a public school teacher
   c. Three case illustrations as a parent
CHAPTER IV

Countertransference: A Multi-Relational Self-Analysis

“He who knows others is wise; he who knows himself is enlightened.”

Lao Tzu

Introduction

In previous chapters, I submitted myself to an informal but true analysis, as Symington describes it in his lecture on what defines psychoanalysis (2009). I began my analysis when I picked up the first book on this subject. At times, I was able to penetrate into a unique experience between a writer and myself, such as in reading Symington, Berenstein, Ogden, Miller, and others I reviewed in Chapter II. Similarly, in the ensuing countertransference analysis, I affectively penetrate into each experience between another and myself.

The documented analysis begins with adopted terms and strategies. It then proceeds with a historicity in an attempt to identify critical conflicts from my past that may be triggered during interactions with clients, students, and my children. Finally, the case illustrations that follow present a process of illuminating and exploring countertransference reactions I have experienced as a therapist trainee, teacher, and parent.

Adopted conceptions. In my self-analysis, I adopt the general understanding of countertransference that conceptualizes it as those cognitive, physical, and affective responses that arise in the therapist as she or he processes and responds to verbal and nonverbal communications with a client – or student, or child (Alexandris & Vaslamatzis,
1992; Hedges, 1992; Jacobs, 1991). This view is often referred to as the totalistic perspective (Hayes et al., 2011).

Specifically, I adopt an eclectic view of countertransference, accepting a variety of conceptions as being more or less relevant depending on the situation between the participants. At times, I adopt the relational perception of countertransference (Hayes et al., 2011; Orange, 1995). This view sees therapist reactions as stemming from, both, earlier memories and central organizing principles of the therapist, as well as those of the client, which integrate to create a co-constructed experience (2011, 1995). At other times, I adopt the classical definition of countertransference, which views countertransference as automatic reactions that stem from the therapist’s unresolved conflicts (2011, 1995). These reactions need to be explored so as to gain greater resolution and management of their root conflicts, and decrease detrimental relationship outcomes. I prefer to modify it, as Hayes does, to include those conflicts of the therapist that are partially resolved (2004). At other times, I adopt the complementary conception, referring to countertransference as reactions of the therapist that are elicited by the needs and communication deficiencies of the client (Bollas, 1987; Hedges, 1992; Gabbard, 1995). As warned by Eagle (2000), I do not intend to indiscriminately apply this conception to all my countertransference reactions.

These four conceptions of countertransference, the totalistic, classical, relational, and complementary, encompass the types of countertransference reactions that many writers describe. These types fall into three main categories: countertransference reactions that stem from another’s presentation and projected communication, reactions that stem from the therapist’s past conflicts, and those that are a combination and that stem from
both sources, co-creating the countertransference. At times, one source may be more prominently experienced than the other. In my countertransference exploration, I examine all three possibilities.

**Adopted strategies.** I adopt a variety of strategies identified in the literature reviewed to help me illuminate, explore, and surrender to affective states. I also utilize several of the aforementioned strategies to help me explore possible themes, correlations, and connections between my subjectivity and mental processes, and those of another. The strategies I utilize depend on the specific interaction, the situation, and the intersubjective field that is co-created between another and myself at that given time. I do not use any formal assessments or inventories. Instead, I begin by accepting the idea itself, as Racker suggests, that countertransference reactions are an integral reality in any dyad (1968). From that starting point, I then adopt the strategies that appear to be the most helpful at that moment and in my exploration of that particular relationship.

The following strategies, helpful in exploring countertransference reactions, are ones I have been utilizing for several years and that are recommended by writers in the preceding literature review: training, personal therapy, supervision, observing my affect states and their depth, increasing self-insight through identifying personal conflicts, exploring subjective beliefs, and surrendering to felt affect as well as connecting that affect to a root conflict from past trauma. This final strategy will be further addressed in the next section entitled, historicity. Additionally, I utilize the following recommended strategies throughout my countertransference exploration: managing internal anxiety, sustaining uncertainty, conceptualizing relational dynamics in the dyad, being present and available, and shifting and responding as the therapist, or with reflective maturity.
Marshall and Marshall (1988) do not believe it is possible to distinguish between pure states of countertransference reactions, nor to identify whether they stem from internal or external sources, viewing all countertransference reactions as a blend. Marshall and Marshall are supported in this view by the relational perspective. However, many writers state or imply that one can explore this internally and/or with the other in the dyad, and determine the most likely or prominent source. Hedges (1992) warns of assuming that the countertransference source is internal, yet Eagle (2000) warns of assuming it is external. Orange (1995) highlights that we must continuously challenge our perspectives, or question our interpretations and perceptions, and this is what I intend to do. In my countertransference illustrations, I attempt to differentiate between these sources, through affective surrendering and exploration, documenting which is more dominating in the intersubjective field, as I experience it.

**Personal Historicity**

Several writers suggest unearthing past trauma, continuously gaining greater insight and self-awareness through further exploration of one’s history. Orange (1995) writes specifically about identifying personal events, childhood conflicts, and repressed affect by exploring and documenting one’s *historicity*. This section attempts to do that by examining significant attachments and conflicts in my past that may create a barrier, and/or provide insight, in my professional and personal relationships explored in the case illustrations. It is important to note that the following historicity is highly subjective and incomplete, as it only includes the most memorable conflicts, beliefs, and defenses that have been brought to my consciousness as of this day. Although flawed, it is an honest
attempt to unearth some of what can be illuminated at this moment, with the understanding that it is a process in progress.

**Early attachments.** Three years before I was born, my parents traveled from Argentina to America with two little girls, due to my father’s four-year fellowship at John Hopkins University. My father worked in research science while my mother raised their daughters. I was born on my family’s last year in America. My maternal grandmother and aunt were visiting my family at that time. My grandmother was attempting to gain some distance and relief from her toxic marriage to my Argentinian grandfather. My mother spoke of my grandfather adoringly, describing his enduring affection, adoration, and religiosity, yet also told of his prolonged absences during her childhood, his infidelity, and manipulative strategies.

My mother was pregnant with me while caring for her two toddler daughters, as well as her mother and young sister. Within weeks of their arrival, my mother received devastating news of her beloved older brother’s tragic death in the Argentinian Air Force. When I was born, my mother was consumed with personal grief and, I suspect, unable to properly attune to my developmental needs. This inability continued. I developed an anxious resistant attachment to my mother (Bowlby, 2005).

My father was emotionally absent from my infancy and childhood. Many family members have commented that his mother avoided physical contact and was emotionally distant. My father’s mode of relating was to communicate mostly in an effort to teach or impart social, medical and political ideas. Thus, I developed an anxious resistant attachment to my father, as well (Bowlby, 2005).

Although my maternal grandmother was a consistent part of my life through early
adulthood, she directed most of her affection and interest towards my older, middle sister. My two, older sisters were emotionally close throughout childhood. They shared interests, perspectives, and their time. Unfortunately, I developed no secure attachments to members of my extended family. Other significant early attachments have been to boyfriends, friends, parents’ friends, and teachers. Many of these followed the attachment cycle and behavior begun in my infancy and childhood, and any countertransference that relates to them correlates more deeply to the earlier, primary attachments described above.

**Childhood conflicts.** I often recognize a primary anxiety lurking, which appears to dodge resolution: a perceived fear that I will fail to fulfill obligations, lose control, and be identified as incompetent. Within this anxiety lies the organizing principle that any amount of imperfection somehow strips me of personal worth or value – a deep sense of inadequacy and shame is at its core. I have a strong, agentic drive, yet the fear of failure is always just around the corner and impacts my ability to feel proud of my accomplishments for prolonged periods. I often feel simultaneously confident and uncertain. This is a conflict that I will most likely continue to manage through psychotherapy, reflection and self-analysis, but that I may never fully resolve. This conflict may negatively impact my professional and personal relationships when not managed sufficiently and when not mindfully considered in interpretations and intervention decisions. However, this conflict, through its exploration and management, also enhances my ability to empathize with another’s insecurities from childhood trauma.

I attribute this internal anxiety to my insecure childhood attachments, and to the conflicting messages I received from my primary caregivers about my value as an individual. As an infant and child, most of my physical needs were taken care of
diligently, but many developmental and emotional needs went unmet due to repeated, failed attunement. My mother worked long hours at home in Argentina, teaching private English classes, while I was tended to by our nanny/housekeeper who walked daily to our house from fields a couple of blocks away. My father worked as a research scientist in our city’s prestigious University. When home, I often caught him lost in thought for long periods. I was afraid for him. I was viscerally aware of his inability to communicate and express himself affectively, and I sensed his emotional frailty. In contrast to my father, my mother was resilient, strong, and in control. Her expectations were high. My behavior was expected to be obedient and flawless. My personal thoughts and feelings were not known, nor were they considered. Anxiety over what my mother deemed adequate developed and increased over time as I matured in age.

When I was five years old, I began Kindergarten at a Catholic Convent, an all-girl school my sisters attended. On my first day, my mother distracted me on the playground by pushing me several times on a swing, and then exited without saying goodbye or explaining when she would return. I never liked swings as a child after that incident. I internalized the following organizing principles: painful feelings are shameful, and abandonment is imminent. I slowly learned to defend against strong affect through repression and dissociation. Although I utilized this strategy to defend against fear of abandonment and worthlessness for many years, personal exploration and grief work in my early and middle adulthood helped me understand and dissolve this barrier to self-awareness and empathy. Its impact, however, is still felt, and a reminder that I need to stay aware of my proclivity to seek emotional enmeshment and/or distance due to an internal fear of abandonment.
In my middle childhood, I became aware of the anxiety and oppression I felt at home. I played outdoors with friends for hours at a time, learning to hold my bladder for an entire day. Going home meant modifying my natural behavior and having to prove that I was doing something useful with my time. I was placed in a double-bind, understanding that to love my mother I had to disavow myself. This created a powerful conflict that still impacts me greatly today, and for many years kept me from adopting my own values. I also engaged in splitting, experiencing my mother as less threatening by splitting my perception of her into good and bad aspects, attributing the “good” to her and the “bad” to myself.

I developed asthma during this age period. I often awoke unable to breathe comfortably and showed up at my parents’ bedside. Their usual response was to show irritation, arguing that my asthma was psychosomatic. I remember anxiously attempting to quiet my wheezing so as not to disturb them further. I now attribute my asthma to a physical concretization of my repressed affect and oppressed, unique self.

Another concretization was my experience with recurring nightmares involving my family being persecuted. I suffered intense anxiety over these dreams, and often walked fearfully to my parents’ room to check on their safety. I did not dare wake them or share my experience with them. I currently attribute these nightmares to a concretization of feeling insecure in my home and with my family. The interactions described above developed into the following organizing principle: when terrified and in desperate need, I am alone. This childhood conflict may get triggered during interactions in which I feel unsupported or undervalued.

Being the youngest of three girls for ten years placed me in the role of the baby,
and I became accustomed to less responsibility than my sisters. I also perceived myself as less knowledgeable and less connected to the family unit. My brother’s birth, when I was 10 years old, afforded me an opportunity to temporarily take a more equal role in the family unit. Along with my sisters, I enjoyed caring for him. A year and a half after his birth, when I was just shy of 12 years of age, our family immigrated to the United States. Our exit from our Argentinian home, culture, and support network of friends and family was made swiftly and with disregard to its emotional impact. On the flight to America, I remember being void of feelings and perplexed as to the reason for their absence.

My parents failed to engage us in a conversation about the emotional challenges of such a move and of the compromises we would now have to make. We retained little from our culture and our roots. Our family’s acculturation strategy was: discard the old way and adopt the new. This crystallized an intimacy/distance conflict. I was hungry for intimacy and attachment but was terrified of its consequences. At home, I often felt intensely homesick, unable to comprehend why I felt alone in my own house and in the presence of my family. This absence of empathic attunement made immigration and acculturation a highly traumatizing experience. I entered Junior High one month after our arrival, in a predominantly white, middle class school. Feeling overwhelmed and out of place, I developed a deep sense of inadequacy in relation to American children.

I did not know how to process the sense of abandonment I felt. I dissociated to the point of having little memory of my life events in Argentina or the language I spoke the first 12 years of my life. English soon became the only language I could speak, and I worked hard to make sure my classmates saw me as non-Latino. I internalized the lack of nurture I received from my family and my new surroundings, and concluded that it was
due to my own lack of worth. Although there were some bright spots, the absence of empathic, emotional support created a deep sense of pain, loss, anger, and shame.

My parents’ marriage deteriorated in my mid teens, although it did not result in divorce. My mother began to openly assert her independence. I felt extremely angry with her, perhaps in an attempt to increase my level of differentiation. I was becoming aware of her personal flaws and beginning to question the split perception that I had previously internalized. My family and culture, however, had taught me to honor my parents and love them unconditionally. For much of my young adulthood, I shouldered unexpressed fury towards my mother as well as shame for harboring those feelings.

This personal conflict is still partly unresolved today, although I have done much psychological work to increase its resolution. I still struggle with the ability to fully and genuinely express myself in my mother’s presence. My desire to communicate honestly with her is often immobilized by our co-created intersubjective field, in which feelings of shame and inadequacy resurface.

My father’s peripheral parenting left me starving for male attention. In my teens, I began attempting to retrieve that love from older, yet unavailable, men through co-dependent love relationships. This pattern continued well into my thirties. I need to stay aware of signs of co-dependent reactions or behaviors in any close relationship, mindful not to enable others or impose on them my own, unmet needs.

In my quest to mature my empathic ability, I will undoubtedly find myself in challenging interactions due to the emotional repression, lack of autonomy and self-esteem, and sense of abandonment that I experienced in my childhood and early teens. Countertransference reactions are likely to be prominent due to the struggles I have had
with differentiation of self. In reflecting on interactions that trigger the
countertransference conflicts described above, I hope to gain self-awareness rather than
engage in countertransference behaviors.

**Personal Case Illustrations**

“There is no place where we all arrive. The journey is our home!”

Jacqueline Small

Much of the literature on countertransference focuses on illuminating and
exploring reactions to gain insight into another’s mental processes. I heed Miller’s and
Eagle’s recommendation in developing a goal that is threefold: I illuminate, explore, and
analyze my countertransference reactions in order to increase self-awareness so as to
decrease unconscious, ineffective, or toxic conduct; in order to increase my empathic
ability and be better able to capture another’s experience; and in order to more effectively
conceptualize the dynamics occurring between myself and another, so as to enable
therapeutic interventions and outcome.

I created the following template as a loose map to utilize in exploring,
documenting and examining my countertransference reactions and their relational
meaning:

1. Notice strong affective reactions during an interaction
   a. identify broad affect (i.e. anger, frustration)
   b. observe visceral sensation, non-verbal behavior and communication
c. surrender emotionally to illuminate root affect

d. be open to idea of releasing/disclosing feeling to the other in dyad

2. Explore and document experience, and challenge perspectives

   a. document the interaction and experience

   b. explore and document possible correlations to past conflicts and note the resolution level of conflicts

   c. explore and document possible external influence from the other’s subjectivity, and/or correlation to the other’s transference themes or communication (enactment, projective identification)

3. Re-Submit to affective surrender

   a. allow for grieving of unresolved conflict

   b. document any new experience/insight

The following case illustrations portray interactions in which I have become aware of strong affect. These illustrations often describe unconscious, and at times anti-therapeutic, behavior. I have chosen ones that explore a variety of countertransference reactions, conflicts, and behaviors. They demonstrate how my process has shed light on empathic successes, as well as failures.

**Four case illustrations as a marriage and family therapist trainee. Case #1:**

When a countertransference conflict results in enactment. In interactions with a client who cancelled or missed many sessions, a countertransference conflict was triggered and the therapist/client relationship was negatively impacted. I initially interpreted chronic
cancellations and missed appointments as my client's transference reaction from an anxious avoidant attachment with primary caregivers. Additionally, I interpreted the missed sessions as my client’s inability to trust me, and as my client's fear, from organizations of past relational trauma, of personal and emotional commitment. Affectively, however, I felt inadequate. I remember feeling a bit rejected every time a session was cancelled moments before its scheduled time.

I only now realize how much my own countertransference reactions may have impacted the sessions that followed the missed ones. Whenever we actually met, every two or three weeks, my client and I engaged in an increasingly casual relationship. I remember labeling my sessions with this client as “not real therapy” because I did not feel we were delving into core issues. We explored current situations and cognitive processes, mostly investigating the content of events and themes, but not the process of my client’s relationships and fundamental beliefs. We tiptoed around strong affect states without either one of us feeling anything.

I attributed my lack of competency with this client to inconsistent session attendance. I did not spend much time reflecting on how my countertransference reaction of feeling rejected and incompetent impacted the manner in which I approached each session thereafter. In fact, in many ways I had given up on my client the moment I sensed this lack of commitment.

I now see this phase in our relationship as unfortunate. Here was a missed opportunity to communicate my countertransference reaction. My client had never had a meaningful and committed relationship and did not know what commitment felt like. In exploring my countertransference, I realized that an enactment was occurring and that I
had failed to notice it. In coasting through our sessions, I colluded with my client’s experience of significant relationships and, like those other individuals from my client’s past, I disengaged from meaningful communication.

I could have expressed, directly to my client, some of the conflicting thoughts and feelings I was having over the missed sessions. For instance, I could have communicated that I welcomed the missed sessions because it meant I got to go home early; that I was feeling ineffective; that I was feeling a growing distance between us probably similar to the distance experienced in my client’s significant, earlier relationships. I could have communicated this in order to open up a dialogue about the reason for our casual relationship, and in order to challenge the anti-therapeutic coasting that we had both become comfortable with.

Part of the ineffective, intersubjective field we created thrived because of projective identification. My client’s defensive technique was to minimize past trauma, and narrate childhood stories with affective dissociation. I, in turn, colluded with my client and allowed meaningful opportunities, in regards to our present and real relationship, to slip by. This was a defensive technique that was also seen in my family of origin and that I have, no doubt, become accustomed to. Not only was I identifying with my client’s projected minimization of affect, I was also comfortable to stay there with my client – in that detached place. Hirsch would say I was coasting in the countertransference (2008). Tragically, we were enacting my client’s typical experience in relationships, in which communication and self-expression remained superficial and in which my client felt disconnected and undervalued.

In illuminating my countertransference reactions of feeling simultaneously
ineffective and comfortable coasting through sessions, I increased my awareness of a countertransference feeling of inadequacy, and of my childhood conflict with dissociation of painful affect. The analysis of this relationship also helped me gain empathy for my client and myself, and increased my ability to “be” with clients openly, willing to consider exploring and communicating the relational reality that transpires in the dyad.

**Case #2: When a countertransference reaction is co-created.** In a session with a client who was exhibiting resistance, I began to feel increasingly frustrated. My client divulged feeling overwhelmed in a parenting situation, and I was helping my client explore possible actions that might alleviate the problem, to no avail. My client kept returning to a focus on parental strategies used in the past that worked minimally then, but clearly could not be enforced now due to the age of the child in question. I saw my client as ignoring the value of what we were exploring together.

I felt thoroughly irritated with my client for not fully engaging in this exploration with me, and for resisting my input. Soon, I began to feel exasperated and started to emotionally retreat from my client, giving up on the idea of making a positive impact. I felt impotent and angry. It then occurred to me that projective identification might be a factor in my emotional experience. My client was feeling exasperated and ineffective as a parent, yet was not able to grasp or express this, and I was feeling exasperated and ineffective as a therapist.

I had initially assumed that an internal countertransference conflict was being triggered. After all, I was intent on getting my point across – a clue that I was reacting from my desire to be the expert and solve my client’s problem. I remember feeling a strong desire to teach clear parenting techniques and motivate my client into action, all
before clearly understanding or exploring what my client wanted and what message my client was trying to convey. I illuminated this inner struggle during the session and consciously pulled back from giving my client direction and engaging in a countertransference behavior. Instead, I did my best to help my client explore personal feelings and discover what my client needed from the relationship with the child in question. However, a feeling of powerlessness nagged at me, and my desire to surrender into apathy persisted.

In reflecting on the session, I later recognized my countertransference reaction as stemming from my past conflict of feeling undervalued in my family of origin. However, I then also saw the projective identification component in this interplay, or the ‘objective countertransference’ piece. I was feeling and experiencing what my client had experienced as a parent. I was also feeling the impotence that my client was describing. In my attempt to energize my apathetic and resistant client towards effective action as a parent, and in my client’s persistent return to a conversation about the actions that we had already deemed ineffective, we were enacting the scene between parent and child being described. My client was playing the child from her experience and I played my client’s parental role.

Had I been able to understand all this during session, I may have decided to disclose my frustration to my client and wondered aloud if it was similar to what my client experienced as a parent or to what my client was experiencing now. This could have given my client an opportunity to own the feeling with new insight, and it may have also strengthened our therapeutic alliance. Although I was not able to fully recognize the external or objective countertransference components of this interaction during session,
identifying it post session was still extremely valuable. I have gained further self-awareness and experiential knowledge in regards to the interplay of external and internal countertransference for the next opportunity with this, or another, client. Illuminating internal countertransference, directly related to my own relational history, has also been valuable. I do not believe I would have identified with my client’s helplessness and frustration so fully had there not been a subjective hook in my pool of relational childhood conflicts.

Regarding the amount of internal versus external countertransference, my reaction described above would not have developed without a substantial extent of it stemming from a subjective, unresolved conflict. I see this case illustration as a clear example of co-transference, a reaction co-created by my client’s projected subjectivity and magnified by my subjective past (Orange, 1995). It could also be called intersubjective countertransference. Having this insight further prepares me for future interactions that present an opportunity to therapeutically utilize the understanding of this dynamic.

**Case #3:** *When a direct request for advice illuminates a countertransference reaction.* I was recently scheduled to accompany one of my clients to a court hearing for a request my client made to the Superior Court. The agency I worked for recommended that therapists help their clients in this manner, and I initially agreed without careful thought about the issues surrounding this appearance, for my client or myself. I felt increasingly anxious as the date drew near. I was nervous about being asked questions that might conflict with confidentiality, as well as about feeling intimidated by the legal environment. The latter reaction relates to an earlier conflict of feeling inadequate in encounters with perceived authority figures.
In the days prior to the hearing, my client had failed to complete a critical document that would likely result in the request being denied or, at best, rescheduled for a future date. I was aware that my client was possibly sabotaging the entire process. My countertransference reaction, described above, became evident the day before the hearing. My client left me a message saying that the idea of attending this hearing was causing undue stress, and asked me to return the call and advise on whether I thought it was okay to miss the appointment. I felt a tinge of hope for a moment, recognizing that if my client did not attend, I did not have to attend, either. However, for several reasons, it was in my client’s best interest to follow through on this request to the court.

I carefully considered how to respond. Although I did not want to give advice, a response was necessary. I was concerned that in not responding, I could be encouraging my client to miss the hearing. It was important for my client to take responsibility for the decision, and reach that decision after consciously examining the repercussions of such a choice.

An urgency sensation also emerged, and was worth exploring. I have often recognized a penetrating need to attempt to control situations in which I have no actual control. This perpetuates a cycle of anxiety. My childhood struggle with a sense of self and with asserting my voice in relationships, and my model of a controlling and ultra-agentic caregiver, plays a role in countertransference reactions and interactions with clients. Internally, doing can inadvertently take priority over being with, and it can be a struggle for me to withstand anxiety and accept situations in which I have no control.

In illuminating my countertransference experience, I was able to call my client and leave a simple message saying that I was available to talk. My message revealed that I had
no judgment and that I was willing to “be” with my client, allowing my client’s decision to slowly show itself without influencing it in either direction. Out of this openness and space grew a personal determination, in my client, to attend the aforementioned hearing. I was also then able to accompany my client without internal hesitation.

**Case #4: When termination triggers a countertransference conflict.** In terminating therapy with clients, as a trainee, I observed a sense of abandonment looming. I had been at my agency for over a year. I had given my clients two months notice, and they had the option of being assigned a new therapist. However, my clients were not ready to end the relationships they had with me, nor interested in doing so. They were grateful and tried to be understanding, yet two of them attempted to extend our sessions beyond the agreed upon time frame, demonstrating resistance.

A countertransference reaction of anxiety and guilt emerged. I felt I was abandoning them. The feeling was almost identical to the one I experienced on the occasions my children cried as I went off to work. Was I having separation anxiety, or was it a narcissistic reaction in which I was resisting the termination of relationships from which I gained confidence and validation? Although there was logic to this, there was also another sensation that was connected to my fear of failure, inadequacy, and low self worth. I was afraid that I was failing my clients. I had not yet helped them find closure or reach personal understanding, except for in minor areas. Now I was just walking away, ending our relationships because of my own needs.

How could I justify leaving my clients who had abandonment, trust, and adjustment issues? Was it responsible? I struggled with these questions and had varying answers on different days. I began to feel myself seeking assurance from my clients that
they were going to be okay. However, I recognized that my clients could not soothe my discomfort, nor should they be asked to do so. It became difficult for me to trust that the relationships we had developed and the work that we had accomplished was enough.

When I sat with this conflict, surrendering emotionally, I was flooded with feelings of abandonment and of profound shame. I illuminated internal doubt about whether I was ethical and good. This reaction appeared to stem from a cultural or religious organizing principle. In the past, I have rarely considered my educational background in a private Catholic school as having added a moral pressure. Now, however, I could acknowledge its impact. I needed to know that in terminating with my clients I was not behaving immorally. I sought validation that I was a good person. It appeared that I was having difficulty accepting myself as imperfect. I was making an imperfect decision in terminating therapy with my clients and this was causing me a good amount of anxiety. I was engaging in a form of splitting, and I wanted to trace this back to its root conflict.

My tendency to engage in splitting, seeing people as all good or bad, felt preverbal, before attending Catholic school. I sensed that I probably learned a black and white perspective from my caregivers, as well. Repression of uncomfortable feelings encourages this limited understanding of humanity, and I knew I had learned how to repress negative affect in my early attachments. The assortment of emotions I was feeling slowly became illuminated, and I began to empathize with my struggle and my willingness to explore the countertransference. I was careful not to inadvertently communicate this struggle to my clients during our last few sessions. I did not want to give them the responsibility of taking care of me. Instead, I explored my clients’ themes surrounding ending relationships, and found further resolution of my conflicts in this type of relational exchange.
I focused on internal countertransference in this exploration because I had an identical reaction with all of my clients during the termination phase. However, this does not signify that projective identification was absent from our experiences. I recognize that I may also have been identifying with some of my clients’ projected feelings of abandonment, since this was a relevant issue in most of my clients’ lives.

**Three case illustrations as a public school teacher.** *Case #1: When a countertransference reaction results in enactment.* Recently I felt at a loss with a resistant student whom I was having a negative impact on. I explored my countertransference reactions in interactions with this student, and I just felt incredibly frustrated. This student was resisting me at every turn, ignoring any and all educational material I was attempting to impart. No matter how I approached subjects and concepts, my student appeared utterly bored, paid no attention, and proceeded to lose all motivation and any interest in learning. I made behavior contracts with this student to try to get some engagement to take place, but all my efforts failed. My contracts consisted of a potential to earn points for every bell-to-bell period in which my student focused on a lesson and completed assignments in a given time. I was thoroughly frustrated by our impasse, and I was uncomfortable with the amount of irritation I felt towards this student.

When I conferenced with my student’s parent and asked about previous school experiences, I learned that they had followed this same pattern for several years. The parent also communicated that my student had much responsibility at home and little say in fun activities, so there was nothing the parent could withhold for this student to earn through a change in behavior at school. I was concerned by what appeared to be a
regimented and luster-free home life, and I theorized that my student had many unmet needs, such as the need for increased autonomy.

I recognized that this student needed someone to help change the emotional and relational cycle that had developed at school. I was determined to modify our intersubjective field and increase the potential for positive interactions. I persevered with the usual behavior charts, which I believed praised engaged behavior and focused on positive effort. For this student, however, it was a weak attempt and an ineffective one.

My countertransference reaction was expected. I felt angry over being ignored, and inadequate over lacking the ability to engage this student. My reaction was probably triggered by a childhood experience of being taken for granted. Unable to engage my student put me in a familiar position, and my anxiety caused a countertransference behavior, masked as behavior management: requiring this student to demonstrate interest in my teaching efforts by behaving as I desired. I continued to reflect on my reactions to this student for several weeks.

While at a training on behavior modification, my relationship with this student suddenly became clear. I theorized that I was enacting my student’s relationship with the parent, and that other teachers in previous years had possibly done the same. My behavior charts sent a message of expected perfection, just as the parent appeared to do at home. The chart that was in front of this student every day asked for attention, focus, and completion of assignments. It did not specify how much, how often, nor for how long. It was left to my student to assume specifics, and the logical assumption my student had made was that I expected absolutes.
I felt wrenching anxiety about what my student must be experiencing, but was not in a position to explore this in the dyad, due to my limited role as teacher. I recognized this as a replication of one of my childhood conflicts. I had to suppress my individual needs, just as my student did. Of course, I also realized I could be mistaken. Perhaps my countertransference reaction was strictly a subjective experience and not co-created. Perhaps, but I decided to follow through on my theory and make some changes.

I immediately revised the behavior chart and, in doing so, changed the focus of my attention. On the revised chart, I specified that I expected engagement in each lesson for half of the minutes the lesson took, and that I expected half of each assignment to be completed in the given time. I spoke with this student the next morning and communicated that I had made a mistake in implementing the previous conduct chart because it required perfection, and that had not been my intention. I explained the new changes I would be making, the new student expectations, and asked if this sounded appropriate and acceptable. I allowed my student to be the judge. I suggested we try this out and modify it as my student saw fit. My student agreed. I demonstrated to this student that I was taking a personal interest, and I began making an extra effort to build rapport outside of the academically confined environment.

This exploration and realization transformed my understanding of this student. It increased my capacity for empathy in our relationship. My changed perception that morning was probably a key factor in what occurred next. My student instantly adopted a motivated stance, focused on lessons, and began completing assignments without further prompting. Not only did my student meet the expectations on the personalized behavior chart, but exceeded them.
From then on, this student was engaged the majority of the time, and appeared to truly enjoy classroom activities. I consciously and consistently acknowledged this student’s efforts, and showed appreciation for the unique contributions this student made to the classroom. Our relationship has been transformed since. A few weeks later, I had a conversation with my student’s parent in which I explained much of this process and how it led me to arrive at this new perspective. My student’s parent was encouraged, and communicated interest in adopting a similar perspective at home. Illuminating my countertransference reaction was crucial in the transformation that occurred. Only through acknowledging my strong, negative feelings and withstanding the anxiety that they created, was I able to continuously reflect on my relationship with this student and allow for a therapeutic change to unfold.

**Case #2: When a student’s compliance is a defensive reaction to the teacher’s countertransference behavior.** A strong countertransference reaction became evident to me in an interaction with a student who was responding to my questions regarding missing assignments by silently nodding, compliantly. This went on for several moments. I could see there was an internal conflict occurring for this student, who perhaps wanted to tell me the truth about the missing work, yet feared my reaction to the disclosure. My student appeared speechless by the predicted consequence of telling the truth or of failing to respond.

As a child, I experienced a sense of dread when challenged by adults. I had felt terrified, antagonized, and frozen, incapacitated due to the lack of understanding with which I was treated. I had actually been furious at the threatening adult, yet simultaneously terrified of letting that fury be known. I had internalized an organizing
principle that children aught to never be angry with adults as this was perceived as disrespectful behavior. The difference between internal, natural feelings and controllable behaviors had never been explained to me nor understood by my significant others. I had also internalized the organizing principle that in order to be loved and accepted I needed to suppress my own thoughts and feelings.

I imagined my student was having a similar feeling, perhaps because of a transference phenomenon or perhaps because of the stance I was taking in the perceived “authority” role. When this childhood conflict of mine was triggered, I was unconsciously swept up by the conflicting affect states. Although I wish I had been able to empathize with my student, this was not the case. Instead, I felt frustrated and angry. I believe that the central organizing principles described above were triggered when I sensed that my student was reacting the way I had as a child. I then took on the role of the threatening adult from my past, and enacted the scene from my childhood.

Perhaps I was, instead, identifying with my student’s projected anger. However, on closer inspection, my reaction was profoundly reminiscent of the described experience from my own childhood. In my exploration of this interaction, I knew I could not identify my reaction as strictly projective identification. My reaction was, in fact, multilayered. I was experiencing internal countertransference, the anger of the ignored adult, and perhaps my student’s projected anxiety.

Through further exploration of this incident, I also illuminated a strong, internal countertransference reaction of feeling threatened. I was not only feeling the threat I experienced as my child self in the childhood conflict, I was also feeling threatened by my student in the current interaction. I realized I perceived my student as an adversary. I was
enacting my childhood scene and angry with my student for making that enactment possible.

Clearly, I had not resolved this particular childhood conflict and this caused a failure in my therapeutic relating as a teacher. I had not acknowledged, explored, nor expressed my anger toward the adults that had treated me in this manner when I was a child. This last element is key, I believe, in transforming my empathic ability in this type of interaction in the future. Additional exploration of this conflict will allow me to grieve the oppression I experienced as a child, empathize with myself, and further resolve this conflict. It will also enable me to empathize with students rather than engaging in any amount of confrontational countertransference behavior.

**Case #3: When reporting child abuse triggers a countertransference conflict.** I had a strong countertransference reaction during the reporting of suspected child abuse. I became flooded with anxiety and feelings of guilt. The primary feeling was fear that perhaps my suspicion was exaggerated and unfounded, and that my action would cause unnecessary trouble for the family, and ultimately hurt the child. After all, I had very limited information in regards to the suspected abuse, and foul play was in no way conclusive. However, I felt I had to act to protect my student, as was my legal and ethical responsibility as a teacher. My fear for this student’s welfare confirmed my decision to make the report. This was an interesting phenomenon. My guilt reaction begged for further exploration.

In further exploring my countertransference reaction, I recognized that this experience triggered a previous “blame and shame” dynamic from my family of origin. Uncomfortable feelings were often followed by a compulsion to blame someone. In this
unfortunate situation, I was also blaming someone, and then felt guilty that maybe I was the one to blame. I was afraid that I was not behaving responsibly. In the current decision to call Child Services, I was blaming parents and having negative, hostile feelings towards them. This triggered my sense of inadequacy.

Often, my sense of inadequacy has risen from a root fear that I may be a “bad person.” When I was a child, I sometimes questioned whether I was intrinsically bad. I entertained such thoughts during Friday mass, in Catholic school. I now recognize that I also feared this when I felt angry with my parents and was not able to own my anger due to the organizing principle that good children do not have negative feelings towards their parents. At the time, I translated this to mean that I was not a good child. This is probably why I was feeling uncomfortable and guilty about having called Child Services.

Another reason I may have felt uncomfortable is because of my proclivity to question parents’ intentions. I have previously recognized that I feel angry at even the thought of parental abuse of children. This includes daily, systematic, covert abuse in which parents minimize their child’s right to have a voice. I was concerned that my anger, which easily rises in regards to parental failures, might have impacted my decision to file a report. I was not fully clear whether I had made the report out of a responsibility to my student or out of displaced anger at my own parents. The latter would have been an inappropriate, countertransference behavior.

Fortunately, in exploring and processing this incident and the feelings that accompanied it, I was able to separate the two sources of my anger. I was able to distinguish between my countertransference pain and my empathic and responsible decision to act on behalf of my student. In doing this, I became confident that I had made
the right decision. I was able to accept that I acted responsibly, and realized that a countertransference conflict had initially clouded my perception of my decision to report.

A different concern became evident a few days after the call. Having called protective services could be impacting my relationship with my student, and I did not understand how to bypass this consequence. Was this incident decreasing my student’s trust in me? Due to the nature of our relationship, we could not explore feelings about this incident, and I feared there was much being left unprocessed and unanswered for my student. There was a potential for this student to feel emotionally abandoned and/or betrayed by me. This triggered another childhood conflict of mine. I had often felt emotionally abandoned and neglected by adults during emotionally challenging incidents that were left unacknowledged. This countertransference reaction may have added to my continuing anxiety over this issue.

While exploring whether there existed an external influence to my countertransference in this exchange, I identified projective identification as an additional, possible factor to my reaction. My student may have been feeling afraid, betrayed, or abandoned. I may have been identifying with these affect states, at least in part. These feelings would be undoubtedly uncomfortable for any child, and containing them would be very difficult. Projecting them onto me would be a good way to communicate negative emotions and share the felt experience.

In this illustration, there is sound evidence of an external countertransference source. Interestingly, although I tend to explore internal countertransference first, and at times exclusively, the illumination of possible external countertransference offers unparalleled, emotional relief. While applying the concept of external countertransference,
I stop doubting my capacity for therapeutic relating and I begin perceiving my reactions as a tool to understanding and empathizing with another.

Reflecting, illuminating, and delving into this experience helped me process the described countertransference reactions and their root conflicts. I felt a noticeable, affective change as I delved into, and reflected on, the possible internal and external countertransference sources, shifting from an anxious state to a secure and comfortable one. This new affect state keeps me emotionally available to my student. I am no longer in a parallel child position with this student, but instead have access to mature understanding and empathic ability.

**Three case illustrations as a parent.** *Case #1: When sibling rivalry is magnified by a parent’s countertransference reaction.* When my children are engaged in sibling rivalry, my anxiety level rises. The stronger their rivalry, the more my anxiety increases. I have noticed this affect after a few moments or minutes of witnessing this interaction between them. My anxiety impacts my ability to respond to them reflectively, maturely, and responsibly. My reaction is often impulsive, and I am then unable to act with parental effectiveness.

On one of these occasions, I delved into the countertransference reaction by taking the time to sit with the anxiety. I was instantly flooded with memories of a common sensation I had in my parents’ home, growing up. I remembered feeling frightened and frozen when my parents exhibited hostility toward each other. I remembered feeling physically constricted as I tried to pause my breath and attempted to become very small. I experienced the dynamic between my parents as filled with resentment and mistrust. I did
not understand it as such, as a child. In the absence of my movement I was hoping to become invisible and impervious to their painful animosity. It may be my first memory of utilizing dissociation as a protective mechanism. In exploring this conflict, I realized that, even as an adult, it has taken a conscious effort on my part to breathe fully and stay present in the presence of one of their tense-filled interactions.

Submerging myself into the affect that gets triggered when my children bicker transported me into to the experience of my parents’ marital tension. This exploration illuminated the correlation between my reaction to my children’s rivalry and this countertransference conflict – a conflict that is clearly unresolved. My current maternal anxiety stems from my experience with my parents’ hostility towards each other. Additionally, in analyzing this childhood conflict, I realized that I experienced my parents’ antagonism as unchanging and unending. This experience with animosity led me to unconsciously fear that my children’s rivalry would also be unrelenting and forever unsettled. I feared that my children’s relationship would eternally lack warmth, nurturing, acceptance, and love, as my parents’ relationship did, and has. Ironically, this unconscious countertransference reaction to my children’s behavior has, undoubtedly, played a negative role in their rivalry and fueled their discourse.

Delving into this countertransference reaction and illuminating its trigger, as well as surrendering to the anxiety that accompanies it, has unearthed a childhood conflict that may play a role in other interactions, as well. I can now continue exploring this conflict and work to further resolve it. Perhaps I will then be able to meet my children’s needs in this area more effectively, and respond to their conflict in a more competent manner. This
type of countertransference work creates an opportunity for greater differentiation and increased empathic attunement.

The reader may wonder if projective identification played a role in this illustration. After all, my children may have been projecting anxiety, jealousy, and anger towards each other and me, which I may have been identifying with. I believe that had this conflict been further resolved, I would have been better able to distinguish between my children’s projected feelings and my internal countertransference reactions. However, my internal conflict was most probably the primary source of my countertransference behavior and only further resolution of this conflict would inform me as to the level of projective identification present. The more I resolve my childhood conflict, the greater differentiation I can achieve, the more I can sustain and manage my internal countertransference, and the more I can hope to separate projected feelings from subjective countertransference reactions.

**Case #2:** *When a transference conflict triggers a transference and countertransference reaction, which results in unconscious countertransference behavior.*

In this illustration, a transference conflict triggered a countertransference interaction with my child. My countertransference was not triggered by this interaction with my child, but rather by an imagined, future interaction with a third party. The imagined interaction resulted in a countertransference reaction and behavior during an exchange with my child, in which I displaced negative feelings onto my child and engaged in toxic relating.

My child was late in getting ready for school. On this particular occasion, I suddenly felt completely overwhelmed, and incorrectly attributed my feeling to the current event. I chastised my child for being late, and then for talking back to me, further angered
by my child’s defensive responses. I even promised a consequence after school. My attempts at withstanding the anxiety I was feeling, were failing.

I actually did not want to give a consequence, as I did not truly believe one was deserved. I knew I had instigated the entire ineffective exchange. However, I seemed to be lacking the ability to control myself, to act logically and mindfully, and to disarm an oppositional interaction that was rapidly developing between us – an interaction I was creating. I also began to catastrophize the current dynamic with my child as having the potential to escalate to a permanent and extensive mother-child battle. Where was this coming from and why?

I then illuminated that, in addition to experiencing this upsetting exchange with my child, I had a meeting at work that morning that was causing me tremendous anxiety. In this meeting, I predicted that I would be expected to prove my professional competence as a teacher; to demonstrate that I was effective despite the fact that my students had performed poorly on state testing – currently a definitive sign in public education that instruction is ineffective. I rejected that my value as a teacher could, or should, be measured by test scores.

I then recognized that this type of evaluation triggered a transference reaction from a childhood conflict of feeling judged and unworthy. The imagined interaction at the meeting was being created by a transference conflict with my mother, and I realized I was displacing this onto my child, engaging in a countertransference behavior. The fact that my child was running a few minutes late was not the trigger and neither was our interaction. My imagined conflict at work was the cause of this countertransference.
reaction of heightened distress. My child was responding, appropriately so, with resistance and rejection of my behavior.

I thought this countertransference experience was important to document because my child did not influence my countertransference reaction, at least not initially. My reaction and countertransference behavior would have just as easily occurred with any other individual that crossed paths with me while I was distressed over the imagined meeting at work. I suspect this type of countertransference dynamic also occurs in psychotherapy settings. This particular type of countertransference exchange is likely to be ubiquitous.

In exploring the negative experience that occurred between my child and I, I have identified and explored negative affect from an imagined interaction (which was triggered by a childhood transference conflict) that was displaced onto my child. This phenomenon was consciously unformulated until I explored the affect that surrounded and informed it. I felt so incredibly overwhelmed, exasperated, and angry during this interaction with my child that I behaved in a toxic manner and was unable to shift into a mature position.

The first step, identifying the feelings, illuminated the possibility that my reaction was generated by a complex countertransference experience. My empathic failure, however, caused my child to respond defensively and, in that moment, I found this unacceptable. In fact, my child had done nothing wrong except encounter me during a challenging countertransference occurrence. Fortunately, this exploration created an opportunity for growth, and increased my awareness and understanding of multi-layered countertransference reactions.

Case #3: When my childhood needs sabotage good parenting. I was recently trying
to talk with my husband and had a strong countertransference reaction when one of my children interfered with my ability to keep his attention. My child began dancing and singing, interrupting our conversation. I felt thoroughly frustrated, eventually gave up on speaking with my husband, and walked away, visibly sulking. I immediately recognized my visible sulking as a countertransference behavior. I felt upstaged, defeated, and had no ability to respond from an adult perspective.

With some professional awareness, I walked into my bedroom and gave myself, and the overwhelming feelings, the attention and validation I was seeking from my husband. I felt so overpowered by my affect state that I knew I needed to listen. I lay down and submitted myself to affect exploration. I illuminated a feeling of anger towards my child, and an undercurrent of feeling insignificant. I felt unloved. My child’s demand for attention made me angry because I was demanding attention, too. I was competing for my husband’s focus, and I was losing.

Underneath my anger was an intense need for validation. Internal, low self worth had been triggered and I felt the shame of having that knowledge. I also felt ashamed of seeking validation in this current interaction. My family of origin was accustomed to minimizing feelings and individual needs, and I had attempted to fight for mine with my child. Now I felt ashamed. How sad I began to feel, about the life-long consequences that resulted from the unmet childhood need of being seen and heard.

I also illuminated an anxiety that had been present in my conversation with my husband. I had been attempting to impress my husband with a compliment I had just received in an email and which validated my self worth. I realized I had been seeking to impress my husband and get further validation. I suddenly felt flooded with a deep
understanding of countertransference: that these types of reactions are primarily a result of a childhood conflict from insecure attachment, which results in one’s lacking sufficient attunement to develop a strong and positive sense of worth or a sense of feeling loved, approved of, and accepted. This conflict then disrupts the interaction in which the therapist, parent, or teacher is called upon to attune to the needs of another.

I felt overwhelmed, frustrated, and lonely. Tucked underneath the umbrella feelings, I identified feelings of betrayal and abandonment. In that moment when our child was demanding attention, I could not attune empathically because I was focused on the attention I desperately needed. The complimenting email I had just received had triggered this childhood conflict. It had unearthed the question of whether it could be true that I had real, substantial value and, thus, deserved the compliment. This question was clearly unanswered internally, and the childhood conflict very much unresolved. I was attempting to resolve it by sharing the compliment with my husband and observing his reaction. Clearly, this was a paramount phenomenon that I had been unaware of while trying to talk to my husband. My child’s behavior was interrupting this tremendous process, and so these complex feelings suddenly found a target in my child.

In surrendering to the countertransference, I realized that a childhood conflict had sharply pierced through my ability to react from the position of responsible parent. The countertransference had disabled my capacity to maintain an effective balance of patience and assertiveness, and responsibly manage my needs. Through the process of exploring this countertransference phenomenon, I began to feel nourished and valued. As this painful conflict was identified, I empathized with my sense of abandonment, and gained further resolution. I no longer felt the need to get external validation from my husband, or
anyone else, because I was listened to, accepted, and validated by me.

I experienced a sort of empathic self-parenting of my injured, child self. I then felt emotionally available, and no longer in agony. In this manner, self-exploration can be very healing. Self-exploration helps me differentiate further, regain a strong sense of self, and be emotionally available to my children, who need me to provide the kind of parenting that I was able to provide for myself in this exploration.
CHAPTER V
Conclusion

In this chapter I will, first, summarize what the previous chapters have presented. I will then discuss my culminating thoughts on the multi-relational self-analysis, exploring recurring themes. Finally, I will examine areas for future work in countertransference understanding and exploration.

Summary

The preceding chapters have established that countertransference is ubiquitous, and that its illumination and exploration offers a tremendous opportunity for growth. Countertransference exploration is very complex, consisting of layered, emotional and cognitive discoveries, as well as contradictions that are often challenging to interpret. Yet countertransference analysis has the potential to reach down to the soul of the explorer and transform her or his ability to relate therapeutically with another. Most countertransference research is limited in that studies examine the countertransference reactions of third parties. My project has detailed what countertransference exploration can look like on a day-by-day basis. The reader gets to appreciate countertransference from a very personal perspective.

This analysis was presented in an effort to stimulate the exploration of multi-relational countertransference reactions in Mental Health Providers and any other interested parties. In illuminating and exploring my personal countertransference in a variety of relationships, I have emphasized the value of exploring these reactions and
conflicts as a tool towards greater self-awareness and differentiation of self, heightened understanding of relational dynamics, and increased ability to engage in therapeutic relating. Mental Health Providers and other interested individuals who are now encouraged to submit to a process of self-examination, will be better equipped to comprehend and transform their personal and professional relationships.

**Culminating Thoughts**

Anytime someone is looking to us for guidance, they are requesting our attention and attunement. We are called upon to attune to others in order to help them listen to their inner selves. Only then can they clarify ideas, thoughts and feelings, and take advantage of opportunities. In public school, students are described as paying or not paying attention, but it is teachers who must pay attention to students. Similarly, parents must pay attention to their children to find how best to adjust their parenting to their children’s needs, and therapists must attend to the needs of their clients. It is the individual in the professional or “authority” position who must place his or her attention on another.

In order to be able to truly attune, however, we must have our own needs met. Otherwise, empathic attunement becomes impossible. Exploration of countertransference reactions is one way to meet our own internal, childhood needs. The process of illuminating feelings, exploring root conflicts, and empathizing with our own, inner pain often meets those needs that have been neglected. Looking, listening, and feeling within gets us heard by the only individual that can truly know us – our self. This provides ultimate, personal value in that it enables unconditional love. We are the only ones who can truly love us unconditionally.
There is a definite theme illuminated in my self-analysis, one of fear of inadequacy and lack of self worth. This has often created a feeling of threat. When I was emotionally invalidated as a child, my existence felt threatened. This unmet need left a psychological development gap. The development of a self-identity was not accomplished in my childhood. I have had to nurture myself in order to flourish. When an interaction triggers this countertransference conflict, countertransference behavior is difficult to avoid.

The illumination of countertransference reactions and conflicts, as is seen in this self-analysis, equally creates positive feelings. These feelings include inspiration, acceptance, joy, reassurance, contentment, peace, thankfulness, confidence, satisfaction, competence, and a sense of freedom, and promote a non-judgmental presence toward self and others. These co-exist with the uncomfortable countertransference reactions described in the case illustrations to produce a new, fulfilling experience: one in which repressed, dissociated feelings and unresolved conflicts can be managed and accepted because they no longer exist in a vacuum. A self-analysis, thus, creates a corrective recapitulation of the primary family dynamic (Yalom, 2005). It is my experience that this type of exploration and analysis further resolves childhood conflicts and diminishes their negative impact.

In reflecting on the entire process of self-exploration as described in the previous chapters, a final theme or pattern emerged. As evidenced throughout the self-analysis and in my culminating thoughts above, an organizing principle of self-reliance and denial of dependency needs infiltrated my method of exploration, or at least my perception of that method. My choice to “self-analyze” demonstrates this theme, as well my persistent decision to utilize intrapersonal strategies as primary during the case illustrations, such as in exploring my affect states internally, versus interpersonally in a dyad.
It is important to note, however, that although the intrapersonal appears to be my preferred method, my process was aided by an array of ongoing, interpersonal strategies, as well. These strategies were incorporated and utilized throughout the months prior to, and during, the self-analysis. These strategies can be identified as supervision during my traineeship, continuing personal psychotherapy prior to and during the self-analysis, informal analysis through interactions and ongoing communication, mentoring, and relationships with psychotherapists of psychodynamic and psychoanalytic orientations, attendance in various psychoanalytic conferences, and extensive study of psychoanalytic concepts through listening of podcast interviews and lectures. Additionally, these strategies greatly impacted my willingness and ability to risk the independent exploration, analysis, and disclosure documented in the previous pages. To simplify, this self-analysis was made possible through the use of multiple interpersonal and intrapersonal methods.

**Future Work/Research**

A valuable place to take this project in the future would be into the seminar arena, presenting the research and personal case illustrations in a half or full-day conference for individuals in the mental health field and any additional, interested parties. Another idea would be to further research the impact of countertransference disclosure, since this project seems to emphasize the value of, and desire for, self-disclosure to aid in increasing therapeutic outcome.

Another area of interest for further exploration is multi-generational countertransference reactions, or feelings toward one’s children, students, or clients that have unconsciously been passed down from generation to generation. I often witnessed
what I believe to be regular, countertransference behaviors in parenting interventions or strategies utilized by my parents. I suspect many of my parents’ emotional, childhood needs went unmet, as was probably the case in previous generations, and that countertransference behaviors can be traced back to these injuries. This pattern can be seen in my relationships, as well.

Adults seem to look to children to fill emotional gaps left from their childhoods, and to look to children to resolve their childhood conflicts, which they cannot. Left unchecked, adults’ countertransference reactions easily turn into countertransference behaviors, and toxic organizing principles get passed down, creating a cycle that gets repeated, indefinitely. I would like to further explore this idea of tracing countertransference down its generational roots, in order to call attention to the detrimental effects of parental blindness and of the toxic effects of repressing negative emotions toward one’s attachment figures.
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