

**THE COUNTERTRANSFERENCE EXPERIENCE OF  
BEGINNING FAMILY THERAPISTS**

**By**

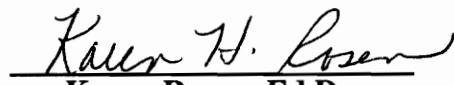
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**(ABSTRACT)**

The concept of countertransference is utilized by many mental health practitioners to denote the emotional response of the therapist to doing therapy. Family therapists do not often use the term "countertransference," and they have, with some exceptions, avoided exploring the emotional response of therapists in both research and training. The purpose of this study was to describe how the concept of countertransference is approached and utilized by beginning family therapists in their efforts to understand and conduct therapy.

The participants in this study were five family therapist interns beginning their practicum placement in one AAMFT-accredited Master's degree program in the campus clinic in August 1993. They attended five hour-long focus group meetings, and were interviewed about two different taped therapy sessions. The results illustrate aspects of the participants' countertransference experience:

the context, the countertransference reactions themselves, the participants' responses to those reactions, the effect of those responses on the therapist and the therapy, and the participants' personal equations which they brought to the therapeutic encounter. In addition, the results document the applicability of the concept of countertransference to the experience of beginning family therapists.

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I also wish to thank my colleagues who participated in this study, though they shall go unnamed here. They know who they are. They also need to know how much their participation has meant to me, how much fun it was, how very interesting, encouraging, supportive, generous, and courageous was their enthusiastic involvement in the focus group meetings and the individual interviews.

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## CHAPTER I

### INTRODUCTION

#### Statement of the Problem

The profession of family therapy has been based in large part on the understanding that the mental health of the individual is affected by the larger system of the family, and that the family system is affected by changes in the individual. In pursuit of understanding how the individual and the system are interrelated, family therapists have focused on intergenerational patterns (Bowen, 1985), communication patterns (Reusch & Bateson, 1951), family roles and structure (Minuchin, 1974), behavioral patterns, and on strategies that can disrupt old patterns and open new possibilities for families (DeShazer, 1982; Haley, 1987; Madanes, 1981; O'Hanlon & Weiner-Davis, 1989).

Each of these avenues has contributed much to our understanding and treatment of families and individual family members. However, rarely has the experience of the **therapist** in the therapeutic situation been the focus of family therapists' interest, research, or training (Whitaker, Felder, & Warkentin, 1965; Taffel, 1993). Indeed, it is the opinion of Smith, Osman, and Goding (1990) that "attention to the emotions of [therapists] and their patterns of interaction with families, while perhaps common enough in clinical practice, is currently seldom reported or sufficiently valued" (p. 140).

In exploring the family therapist's experience of and reaction to doing therapy, it is proposed that the concept of countertransference be retrieved from the vocabulary of psychoanalytically-oriented practitioners. As used in this research, countertransference is defined as all of the reactions of the therapist - emotional, intellectual, conscious, unconscious, contemporaneous, or delayed - to the client(s) and to the specific therapeutic environment. A number of family therapists have found the concept referred to by the term "countertransference" to be relevant in their work with clients. Taffel (1993) addresses what he sees as the need for family therapists to look carefully at their experience during therapy, and at the actions they take based on that experience, calling for "a heightened respect for our own internal emotional experiences" (Taffel, 1993, p. 52), as vital diagnostic indicators of family process. Reynolds-Mejia and Levitan (1990) advise that countertransference reactions "ought to be seized upon by the professional for mature digestion and processing, not merely reacted to," because countertransference material is valuable for understanding the client and is a potent force for therapeutic change (p. 60).

Just as the awareness of countertransference is utilized in therapy to benefit the client, that awareness needs to be recognized as an important aspect of therapists' efforts to maintain their own psychic health. If the therapist is to be regarded as a part of the family's system (as are the therapy setting and the greater social context), attention needs to be paid to how the family is part of the

therapist's system. From articles on therapist burnout (Wylie & Markowitz, 1992), or "compassion stress" (Figley, 1993), it is clear that families do affect therapists strongly, and that there is not always a structure in place to support or acknowledge the struggle of therapists with their reactions to clients (Passoth, 1993).

It is the endeavor of this research to describe how the concept of countertransference is approached and utilized by beginning family therapists in their efforts to understand and conduct therapy. This descriptive study is being pursued as one step toward acknowledging the concept of countertransference as an important aspect of family therapy practice and theory.

#### Purpose of the Study

The purpose of this study is to describe the nature of beginning family therapists' experience of countertransference. By gathering from beginning family therapists their thoughts, concerns, impressions, and questions about their responses to clients, there emerge issues and themes which may be generally relevant to beginning family therapists, and which may direct future research into the reactions of family therapists to the therapeutic situation.

#### Research Questions

This research study undertakes to describe the nature of the beginning family therapist's experience of countertransference by answering the following questions:

1. When beginning family therapy practicum students are encouraged to pay attention to countertransference, what themes and patterns emerge? This question addresses a number of qualities of the therapists' experiences: the kinds of countertransference reactions, the kinds of provoking situations, the types of awareness experienced, the types of responses to the countertransference awareness, the perceptions of usefulness of countertransference material, the perceived connections to family therapy theory, and changes in countertransference patterns or awareness.

2. Do the therapists report making use of countertransference in their clinical work? This question addresses the therapists' responses to countertransference: how it affected their work with specific clients, how the training context supported, directed, or evaluated their responses, and what they learned from their responses, either about themselves, about the clients, or about the therapy. It also takes into account the perceived effectiveness of their responses.

#### Need for this Study

This study is part of a trend in the field of family therapy to consider the impact of doing therapy upon the therapist (Smith, Osman, & Goding, 1990; Scharff, 1992; Taffel, 1993). The information gathered will be beneficial to several different groups. First, teachers and trainers of family therapists may wish to anticipate and address with their students some of the themes that seem

important for beginning family therapists. They also may consider incorporating some of the relevant countertransference literature into their course requirements. Second, supervisors of family therapists may wish to reconsider the level of attention paid and time spent on their supervisees' emotional reactions to clients, and the level of attention to parallel or isomorphic process in the supervisory situation. Third, practicing clinicians may be encouraged to accept the insights into therapists' responses that are available from other sectors of the mental health field, and to find connections that they had not expected to be fruitful for their work.

### Conceptual Framework

This study approaches the description and interpretation of the beginning therapists' countertransference experiences through the theoretical framework of systems theory. Systems theory as applied to family therapy states that an individual's situation is embedded within a larger context, and that changing any part of that larger context will generate a change in all other parts (Becvar & Becvar, 1982).

It is accepted that the therapist is not an agent who operates outside of the family system, affecting it like a cook stirring soup; rather, the therapist becomes a part of that system in some fashion, and affects it through the influence and authority of the therapist role (Minuchin, 1974). The explication of this influence on the family, how it works, through what techniques, to what purpose, of what

value, and with what ethics, has been the subject of numerous family therapy writings. In meagre contrast, the influence of the family upon the therapist is addressed, in general, by pithy warnings and cautionary essays and case studies.

Systems theory demands that we see problems as embedded in their context. The context that presently surrounds the experience of the family therapist in the therapeutic situation is one of unconscious, unacknowledged influence on the therapist by the client families, by the treatment setting, and by the therapist's personal life. One aim of this research has been to describe and interpret in a conscious fashion the countertransference experience of beginning family therapists.

#### Organization of the Study

Chapter one is an introduction to the concept of countertransference as it may be relevant to family therapy. Chapter one includes a statement of the problem, the research questions for the study, a description of the conceptual framework, and a presentation of the need for this study.

Chapter two is a review of the literature that is relevant to countertransference in general, and its historical and current usage and definitions. After presenting reasons that may account for the avoidance of the concept of countertransference by family therapists, a review is done of those terms that have been used by family therapists to express some aspects of the therapist's response to clients. Finally reviewed is the family therapy literature

that treats countertransference as it is experienced by therapists in response to particular client issues.

Chapter three presents the research design and methods used in this study. Chapter four offers a description of the results. Chapter five summarizes the study and offers conclusions and recommendations for further research.



## CHAPTER II

### LITERATURE REVIEW

#### Introduction

In this chapter, an examination of both the psychoanalytically-oriented literature and the family therapy literature will be made, in an effort to weave together from these two fields an understanding of the concept of countertransference that represents the depth of knowledge available from the past and that points to its relevance for the future of family therapy. First, the psychoanalytic perspective will be presented, with a brief history of the concept of countertransference, its current usage, and some examples of that usage that illustrate its relevance for the practice of family therapy. Second, the family therapy perspective will be presented. From this perspective, an overview of family therapy terms that have denoted aspects covered by the concept of countertransference is given, as is a history of the family therapy field's avoidance of the term "countertransference" and of the exploration of the therapist's emotions. Following that overview will be a review of current family therapy literature that treats or utilizes the concept of countertransference as it is more commonly understood by other psychotherapy practitioners, and also literature which addresses the emotional responses of family therapists. In summary, it will be shown through this literature review that the concept of countertransference

has continued to be considered important, useful, and often crucial for the conduct of therapy.

### The Psychoanalytic Perspective

**A History of Countertransference.** The term "countertransference," which is currently being rediscovered and revalued by family therapists (Taffel, 1993), refers to a concept that was used by Freud rather casually several times in his writings. He never explored the concept in depth, but rather succinctly described it as the analyst's response to the "patient's influence on his unconscious feelings" (Freud, 1910, p. 144). He considered countertransference to be the result of the analyst's unresolved conflicts, causing the analyst to respond to the patient as if he or she were a significant figure from the analyst's past, thus impeding proper analytic objectivity. Freud's recommendation, and later requirement, for analysts was that they pursue their own analysis, so as to rid themselves of these troubled responses to their clients.

While the idea that countertransference was destructive to treatment was maintained by the majority of mainstream analysts for many decades, some renegade early analysts like Ferenczi and Sullivan valued their countertransference responses and explored and utilized them in their work with patients (Gorkin, 1989). In the past 30 years, the psychoanalytic discussion of countertransference has broadened into a lively one, with the main arguments being about whether countertransference reflects the patient's reality as well as his

transference, whether the therapist's reactions are damaging, inevitable, useful and/or inappropriate, and what to do with them. Writers grappling with these questions have explored the informational and diagnostic value of countertransference (Casement, 1985; Giovacchini, 1989; Kernberg, 1965, 1993; Langs, 1976; Racker, 1957; Searles, 1979; Winnicott, 1949). Several writers have tried to define countertransference more usefully (Gorkin, 1987; Racker, 1957; Slatkin, 1987), and to categorize the different ways it operates (Geddes, 1990; Marshall & Marshall, 1988; Racker, 1957).

**The Current Usage of Countertransference.** According to Racker's (1957) seminal work, Freud "created the term countertransference in evident analogy to transference, which he defined as reimpression or re-editions of childhood experiences" (p. 310). The early assumption was that countertransference was the result of the therapist's own conflicts and defenses interfering with the interpretation and insight process of the patient. Racker defines countertransference as the "totality of the analyst's psychological response;" that is, the combination of the countertransference predisposition of the analyst and the present real experiences with the patient (p. 310). He then explores the different aspects of countertransference that need to be addressed in order to understand the concept fully.

Racker takes the term "objective countertransference" from Winnicott (1949) and defines it as responses that are derived from the client such that

almost any therapist would respond similarly to this particular client or circumstance. Objective countertransference can be further subdivided into concordant and complementary countertransference. Concordant countertransference refers to responses which mirror the client's own experience and thus result in an empathic understanding of the client. Complementary countertransference refers to responses that are reactions to, rather than mirrors of, the client's experience; that is, the client relates to the therapist as to some "object" in the client's life, and the therapist reacts just as that object would. Subjective countertransference, by contrast, refers to those responses that are not a reflection of the client's internal or external reality, but that emerge from the therapist's own personal experiences, and which limit the therapist's empathic and therapeutic abilities.

A more current typology exemplifies the present-day psychoanalytic understanding and usage of countertransference. Geddes (1990) states that the current emphasis is on "the indispensable role the therapist's feelings and reactions play as an organ of perception" (p. 259). He reviews the many aspects of countertransference. "Classic countertransference" refers to emotional responses that derive from the therapist's personal conflicts, that is, from unresolved issues of which the therapist is as yet unaware or that are still in the process of being reconciled by the therapist. The source of the countertransference is the therapist. In "complementary identification", the patient is the source of a pattern

in the therapeutic relationship in which the therapist unconsciously relates to the patient in a way that parallels the patient's other significant relationships. Such a complementary position holds information about how others view and relate to the patient. "Concordant identification" is a patient-induced response of the therapist in which the patient's self-experience is engendered in the therapist; such identification is considered the source of most empathy. "Indirect countertransference" describes the therapist's response to a significant but absent other person who is affecting the therapeutic relationship, creating in effect a triangular relationship. An example would be the emotional response of a therapist to the (absent) perpetrator during treatment of a sexual abuse survivor (Shay, 1992), or towards a child's absent parent (Springer, 1991).

Other aspects of countertransference are delineated by Geddes. He notes that, unlike the foregoing, more emotionally-charged aspects, "institutional countertransference" reveals itself in a lack of affective involvement of the patient to the therapist; rather, the patient has an attachment to the institution (agency, hospital, or clinic), which generates in the therapist a sense of rejection, unimportance, and impotence. "Stylistic countertransference" refers to the therapist's personal style and presentation of self as these affect the therapeutic process; included in this category would be the therapist's typical interpersonal style, and such "contextual markers" as the office furnishings, style of dress, and geographical location. "Ecological countertransference" refers to responses to

daily episodic events in the therapist's life which can temporarily affect therapy. These fairly self-explanatory categories are useful for transforming the complexity of therapists' responses to clients into more expressible ideas and therefore, hopefully, into more manageable and useful experiences.

Kernberg's (1993) review of contemporary psychoanalytic technique notes, among other topics, how the concept of countertransference no longer is dealt with in a negative, even phobic, way, but rather is regarded as an important tool for investigating the total patient-analyst interaction. Though major differences remain among schools of psychoanalytic thought, he contends that "all analysts utilise the exploration of their own affective responses to their patients in a consistent and much freer way than earlier clinicians did" (p. 662).

**Examples Considered Relevant to the Practice of Family Therapy.** The psychoanalytic understanding of countertransference, and the many anecdotal and thoughtful treatments of it in the psychoanalytic literature (Casement, 1985; Giovacchini, 1989; Gorkin, 1989; Langs, 1976; Scharff, 1992; Searles, 1979; Slatkin, 1987), offer a starting point for the family therapist interested in exploring how countertransference could be used in the practice of family therapy. For example, Gorkin, a psychoanalyst, writes expressively about the uses of countertransference in his psychoanalytic work (1989). Though his way of conceptualizing the therapeutic endeavor sounds different from a family

therapist's description of the endeavor, the quality of listening and empathy illustrated by his clinical vignettes is exemplary.

In his book, Gorkin details the history of the concept of countertransference and makes a case for its use as a source of information. He addresses the countertransference reactions one could expect from various personality types, speculates why such reactions are called forth, and presents ways that he has operated therapeutically using his countertransference as a guide.

Among the chapters he devotes to various types of countertransference, an interesting type which he calls sexualized countertransference will serve as an example of his approach to the various aspects of countertransference. In his chapter on sexualized countertransference, Gorkin notes that, "in spite of the burgeoning interest in countertransference issues, scant attention has been paid in the literature to the therapist's sexual feelings and fantasies toward patients" (p. 108). He goes on to enumerate types of sexualized countertransference that he has experienced with seductive female clients; with sexually repressed female clients; with masochistic female clients; and with aggressive ("phallic") male and female clients. He notes not only his feelings, but when and how he becomes aware of them, how he has subtly acted out his countertransference before becoming aware of it, and how he has repaired the therapeutic work after acting out. He summarizes by saying that this chapter is "an attempt to demonstrate that an awareness of sexualized countertransference can be valuable both as a means

of knowing the patient and as a way of eliminating subtle forms of evasion and acting out (p. 131). Family therapists would agree that knowing the client and eliminating therapists' acting out are worthy goals; awareness of countertransference can be a most valuable tool toward those ends.

Gorkin also addresses the countertransference experience in supervision, presenting transcribed sessions and commenting on what family therapists would call the parallel process between the therapist-client relationship and the supervisor-therapist relationship. The case studies from his clinical and teaching experience demonstrate techniques that are quite applicable to the training of family therapists.

As another example of ways in which the psychoanalytic usage of countertransference could be considered relevant to the practice of family therapy, the work of Casement (1985) could be cited. A psychoanalytically-oriented therapist, Casement explores countertransference with an emphasis on the interplay of conscious and unconscious communication in the therapy process. Much of what he addresses is directly relevant to the practice of Ericksonian hypnotherapy, with its emphasis on communicating indirectly so as to reach various levels or types of consciousness within the patient.

Casement's theory and practice as illustrated through the essays and case studies in his book demonstrate the kind of understanding that Beahrs (1982) attributes to Milton Erickson's practice of therapy. Beahrs states that Erickson



believed that "consciousness and behavior within a human being may occur simultaneously at more than one level.... [and therefore Erickson's] commonsense methods were directed to one aspect of consciousness that was important but not experienced as 'conscious' by the overall self and not visible to most observers" (p. 65). Casement, as do other psychoanalytically-oriented practitioners, not only takes seriously the unconscious communication of the client, but also studies scrupulously the unconscious communication within himself as therapist. He cites Freud's (1915) comment, "it is a very remarkable thing that the Unconscious of one human being can react upon that of another, without passing through the Conscious" (cited in Casement, 1985, p. 72). Then, using this as an introduction, he describes and illustrates a number of unconscious forms of communication he has found in the therapeutic encounter, that would only be received as communication by a therapist striving to remain aware of his or her own reactions.

The effect on the family therapist who reads about Casement's terms such as "communication by impact" or "communication through defensive behavior" may be to prompt that reader to examine the meaning of previously insignificant behavior or feelings. Such a search for meaning is almost always profitable for the therapist who is trying to bring to the charged setting of therapy a perspective that is helpful, that structures the therapy in a useful way, and that supports the resourceful solutions of the client.

Some family therapists need to be reminded of the catastrophic effects of unchecked therapist power upon their clients. Langs (1976) expresses concern that the therapist not confuse the fulfillment of personal ego needs with meeting the needs of the client, and he is unconvinced that therapists are equipped to monitor this delicate arena without a great deal of awareness to their countertransference reactions. Family therapists would understand this problem as one of boundaries between therapist and client.

Family therapists are more likely than psychoanalytically-oriented practitioners to believe that change follows from changed behavior and problem re-definition rather than from insight. They are more likely to see their therapeutic role as facilitator and provoker, than as interpreter of intrapsychic processes. They are less likely to define problems in terms of personality types and pathology. Though there is a difference between family therapy and psychoanalytic assumptions about how change occurs, the role of the therapist, and the origin of individual and family disturbance, what is most striking about effective therapists in both fields is the quality of their listening and interaction; in great part, this quality is a function of the therapist's commitment to and experience of heightened personal awareness on several levels, which could be called a commitment to utilizing countertransference information.

## The Family Therapy Perspective

**Family Therapy Terms Denoting Aspects of Countertransference.** Family therapists have occasionally discussed in writing their emotional reactions to clients, employing a variety of terms. Some family therapists actually do use the term "countertransference." A few terms are limited in usage to particular schools of family therapy, while some terms are more generally used. One term that seems to encompass much of the concept that is referred to by countertransference is the therapist's "use of self." The following discussion will address these various terms.

There are family therapists who do use the term and the concept of "countertransference" in their writing and conceptualizing. Lantz (1993), an existential family therapist, defines countertransference as the therapist's subjective, phenomenological experience of being with the family group (p. 213). Scholfield-McNab (1989) defines it as the whole of the therapist's responses to the stimulus presented by the patient family (p. 85), while Halperin (1991) terms it, simply, the reactions of the therapist to the clients in therapy (p. 127). Scharff (1992) is an object-relations family therapist, whose research and writings about countertransference focus on the "system-wide family or couple transference to us as therapists" (p. 243). Her understanding of how to utilize countertransference is through a continual process of reviewing how the clients are causing the therapist to feel. She notes that when countertransference is operating smoothly, it works

unconsciously to create empathy. At those times, it is necessary to deliberately stop and review the countertransference in order to be aware of it. She notes also that at other times, "the countertransference obtrudes, and calls for urgent attention" (p. 283). The above family therapists, while perhaps well-regarded, would not be considered among the mainstream of family therapy thought.

Bowenian family therapy (Bowen, 1985), acknowledged as a major school of family therapy, does endeavor to direct the therapist's attention during training and supervision to the therapist's own family of origin in search of issues, patterns of functioning, and levels of differentiation. This process is directly analogous to the individual analyst's undertaking a training analysis. "Working toward becoming a more responsible and differentiated individual in one's own family provides an avenue for lessening tendencies to become overinvolved with one's clinical families, and it helps the family therapist avoid emotional 'burn-out'" (Titelman, 1987, p. 3-4). Meyer (1987) asserts that, "regardless of the theoretical approach upon which a therapist bases clinical practice, subjectivity will be present to interfere with the therapeutic process unless the therapist has come to know his or her own subjectivity so well that it can be kept out of the individual's work" (p. 43). She mentions that this subjectivity leads to transference and countertransference issues (p. 68), and deems the striving for personal awareness to be a professional and ethical imperative (p. 69). It is apparent that Bowenian family therapists are very concerned with managing the experience of what Racker

called "subjective countertransference," and consider this management to be one of the main tasks of the family therapist.

When other mainstream family therapists have wished to refer to the emotional experience of the therapist in the therapeutic encounter, a number of other concepts have been used to address in some part that experience. Concepts such as induction (Nichols, 1987), transformation (Taffel, 1993), isomorphic process (Berenson, 1982; Imber-Black, 1988), accommodation and suction (Minuchin, et al., 1967), parallel process (List, 1986), and collusion (Whyffen & Byng-Hall, 1982) all refer in general to the therapist's unconscious tendency to become integrated into the family in a way that may limit the therapist's ability to maintain a helpful perspective. This experience has been seen by some to be related to hypnotic induction (Wright, Luckhurst, & Amundsen, 1990). Some of these terms (induction, suction, collusion) tend to connote the negative and involuntary aspects of countertransference. Transformation (Taffel's term for the therapist's internal emotional experiences), accommodation, isomorphic process and parallel process tend to connote a more neutral and informational aspect of countertransference. Other family therapists use no single term at all, preferring to discuss "our emotional experience of being with the family" (Smith, Osman, & Goding, 1990, p. 146), which is the more encompassing definition of countertransference that is used for this research study.

A broader concept akin to countertransference which is used in family therapy literature is the therapist's "use of self." The definition of use of self as "the therapist's feeling response to the family members" (Sauber, L'Abate, & Weeks, 1985, cited in Shadley, 1987) is modified by Shadley to include the verbal and non-verbal expression of those feelings and personal self-disclosure. She also acknowledges that a concise, comprehensive definition of the term is missing from the family therapy field. This situation of imprecision exists despite the contributions of many to exploring what the use of self is, how to therapeutically employ it, and how to cultivate it in supervision and training.

The concept of the use of self seems to be grounded in a view of the therapist as the main tool or resource used to promote clients' change or growth. "When the therapist uses his own reactions as a therapeutic tool, by sharing with the family how he is impacted by what is happening, and asking how his actions are impacting the family, he models a new way of operating which can effectively change the family system" (oral communication by Satir, cited in Baldwin, 1987, p. 8). Certainly there needs to be some understanding of who this self is before a therapist can employ the self as a tool. Some therapists speak of self-awareness, that is, of being in touch with themselves, their feelings, thoughts, and physical and emotional situation, as the essential path to knowing who the self is (Satir, 1987). Others emphasize the role of understanding one's beliefs, values, gender, and life experiences in the process of self-revelation (Shay, 1992).

In some of the family therapy literature, the proper use of self is implied to be the deployment of one's role as therapist in the most unconstricted, unlimited, creative ways for the benefit of the clients; a distinction is made between one's personal Self and the professional self, "a social role, [which] provides the structure for the personal Self to make appearances in family therapy" (Keith, 1987). In order to utilize one's self with both freedom and integrity, a process of self-knowledge and continuing awareness with an attitude of respect and nurture for oneself is advised (Reynolds-Mejia & Levitan, 1990).

Other family therapy writers have addressed the use of self as it applies to specific schools of family therapy, such as the systemic, the constructionist/systemic, the structural, and the contextual or intergenerational schools of family therapy. Haber (1990) made the systemic family therapy model the object of recommendations for training therapists in the use of self. He does not offer a definition for use of self, but focuses on the "personal-professional interface," that is, those areas where the therapist's personal issues affect clinical behavior. In developing a program for trainees wherein they may choose and experientially try to resolve particular issues that have lead to "professional handicaps," Haber recreates the early psychoanalytic stance of considering that impasses in therapy were due to the analyst's unresolved conflicts. Based on the description given, there appears to be no discussion during the training of how or what the client may be trying to communicate that might account for the

therapist's feelings of conflict. The focus is on helping the trainee "to engage and separate more clearly and flexibly within the client and therapeutic system" (p. 383). This article omits addressing the interactional aspects of the emotional experience of the therapist.

Another systemic family therapist, with a constructivist orientation, proposes to reconceptualize the therapeutic use of self. Real (1990) does define the use of self, as "[h]ow the therapist moves, the selections he makes, where he places his weight." But what is offered is a theoretical discussion of the history of systemic family therapy, and then five particular therapeutic stances which range between the extremes of pure interventionism and pure facilitation: the eliciting stance, the probing stance, the contextualizing stance, the matching stance, and the amplifying stance. It is not clear how these "stances" are reflections of the therapist's experience of being with the client or doing therapy; rather, they seem to be strategies used to promote more useful conversation between therapist and clients.

Aponte and Winter (1987), and later Aponte (1992), propose and illustrate a training model for structural family therapists that recognizes that

therapeutic affiliations can and do affect the lives of therapists. Each participant in the process takes back to his personal life... effects from the therapeutic association... [T]he positive outcome of treatment is dependent on the therapist's ability to harness himself within the social relationship of therapy. Successful clinicians learn to be aware of what material they currently bring into the therapeutic process, both strengths and problems, and how to



employ these resources for the client's growth and change" (Aponte & Winter, 1987, pp. 93-94).

Such a view of the therapist's use of self more closely than other schools' approximates the concept of countertransference as useful, necessary, informational and inevitable which is the current understanding of psychoanalytically oriented therapists.

Duhl (1987), writing about her understanding of the use of self in what she calls integrated contextual systems therapy, says, "Using oneself well then means to be involved in an ongoing research project: to be curious about one's own reactions and intentions in varying contexts, and to locate the source of reactivity in one's learned-to-learn patterns. These patterns, developed in earlier contexts, give clues to the current context as well as the context of clients" (p. 75). Her thought that clues from the therapist's patterns can hold information about the clients' context parallels the idea that countertransference reactions can contain the seeds of understanding, empathy, and direction for therapy. Other contextual family therapists find an emphasis on the use of self in therapy to be an important part of effective family therapy (Diamond, 1988; Nelson, Heilbron, & Figley, 1993). They find it particularly necessary for therapists to address their personal family transgenerational rules and patterns, so as to be able to lead clients where they have gone themselves. This attention to personal issues and legacies parallels the aspect of countertransference that relates to the therapist's personal equation, that is, what the therapist brings to the therapeutic encounter.

The concept of countertransference used in this research as "all of the reactions of the therapist - emotional, intellectual, conscious, unconscious, contemporaneous, or delayed - to the client(s) and to the specific therapeutic environment" has been utilized by a few family therapists. Some other family therapists have used other terms that denote certain aspects of countertransference, and the family therapy usage of the term "use of self" is broadly accepted, if ill-defined. In beginning to develop an understanding of the meaning of the emotional responses of the therapist, family therapists are getting closer to an understanding that mirrors the concept of countertransference as it is currently used by psychoanalytically-oriented practitioners. Some reasons for the existence of the historic gulf between family therapists' and other practitioners' interest in and understanding of the therapist's emotional responses are explored in the next section.

**Avoidance of the Term "Countertransference" and of the Therapist's Emotional Response.** Family therapists have not been entirely unmindful of the therapist's emotional response to therapy, though the founding practitioners did not choose to employ the term "countertransference" to describe it. There are a number of ways to account for the unwillingness of pioneering family therapists to explore or employ the concept of countertransference as it was being used by the psychoanalytic practitioners of that time, such as an unwitting undervaluing of

their early training, a desire to break from psychoanalytic thinking, or a male-oriented emphasis on technique rather than emotional responses.

List (1986) mentions that many family therapy teachers were taught and supervised with emphasis on the individual trainee, and having left that emphasis behind, tend to undervalue those skills and experiences in teaching new therapists about family systems. This is not to say that they did not use their own emotional responses to clients in doing therapy, but rather that they did not explicitly address this usage in their teachings or theoretical writings. A case in point would be the writings of Minuchin (1974) on structural family therapy. He explains a theory of healthy family structure, and techniques to help the family achieve such structure. Buried within the text are acknowledgements that the therapist's spontaneous responses to the family are useful and informational (p. 91). He describes diagnostic assessment as having an interpersonal focus, and as evolving from the therapist's experiences and observations upon joining the family (p. 129). On perusing a transcribed case for which Minuchin, as therapist, has included notes on various techniques and maneuvers used during the session, the reader observes how often and deftly he is using his experiences of boredom, anger, and powerlessness to continually reorient the therapy along a more helpful path.

In addition to the possibility that family therapy leaders undervalued their own training about countertransference, G. Goding (cited in Smith, Osman and M. Goding, 1990) suggests that the lack of emphasis in the family therapy

literature on the emotional experience of the therapist evolved because people usually write about new ideas. After family therapists broke away from psychoanalysis, "the last thing they were interested in writing about was the ramification of an interactional perspective on their understanding of transference and countertransference" (p. 143). They wanted to add to the literature of the newly created field of family therapy.

What the family therapy leaders chose to write about, Smith et al. (1990) go on to suggest, is a result of the historical dominance of men in the field of family therapy, leading to an emphasis on technical approaches, and a de-emphasis on utilizing emotional responses (p. 143). For example, in strategic therapy, it has been asserted that therapists need not have had any therapy or self-analysis in order to do the jobs of joining, problem clarification, goal specification, and homework assignment (Haley, 1987). The emphasis of training is on technique, which has a certain democratic appeal. As Kleckner, Frank, Bland, Amendt, and Bryant (1992, p. 49, cited in Coady, 1992) claim, "it's not that strategic therapists don't deal with feelings--it's just that they don't talk about it with each other, write about it in the literature, or teach it to trainees." When therapists' emotional experiences are discussed, usually the discussion "is confined to a descriptive and pragmatic consideration" of these experiences, according to Flaskas (1989); "the core concern of strategic family therapy with tactical interventions in behavioral sequences leads to a strictly pragmatic

acknowledgement of feelings, both of the family and the therapist... [which] mitigates against any reflection on the emotional interaction of therapist and family which is not immediately useful to the therapy" (Flaskas, 1989, p. 5).

As another example of the emphasis on technique, in solution-oriented brief therapy (O'Hanlon & Weiner-Davis, 1989), the family therapist is trained to be able to help clients set clear goals, to identify exceptions to the problem, to encourage clients to focus on making those exceptions happen more often, and to terminate therapy when goals are met. Little mention is made of the experience of the therapist in the session, except a suggestion that when the therapist is feeling stuck, he or she should switch gears quickly. The authors do mention being alert to nonverbal cues as signs that the client is agreeing or disagreeing.

Whatever the reasons for its avoidance, a perusal of family therapy textbooks supports the assertion that the term "countertransference" has not been widely used or explored in the literature (de Shazer, 1982; Gladding, 1992; Nichols & Schwartz, 1991; Thomas, 1992). Exceptions are found in the works of object relations family therapists (Scharff, 1992), and some existential family therapists (Lantz, 1993).

**Family Therapy Uses of Countertransference.** When family therapists have written about countertransference (that is, about the concept, whether they use the term or not) or the emotional experience of the family therapist, one issue of concern has been the prevention of therapist "burn-out", which is seen as an effect

of the emotional stress of dealing with clients and their problems. Another, larger area of concern has been to offer assistance to therapists in their quest to learn how to be therapeutic when treating very emotionally charged topics, such as AIDS, incest, domestic violence, and child physical and sexual abuse. In these areas, attention to the emotional response of the therapist in doing therapy has been seen to be imperative.

Therapist "Burn-out": One direction of family therapists' concern for the therapist's emotional experience has been toward understanding "compassion fatigue", and the similar condition known as "burn-out". Figley (1993) describes a therapist whose emotional state began to mirror those of her traumatized clients. Using her story as an illustration, he defines compassion fatigue as a state of tension and preoccupation with the individual or cumulative trauma of clients, manifested through re-experiencing the traumatic events, avoidance/numbing of reminders of the events, and persistent arousal (p. 3). He finds that, among mental health practitioners, family therapists are particularly vulnerable to compassion fatigue because most trauma takes place within families, family clients are more likely to talk about the traumatic events, and children's traumatic stress reactions are usually quite disturbing for therapists. He recommends preventive measures such as education about stress and coping, maintaining supportive networks, self-care and pleasure, and setting realistic goals, limits, and boundaries.

Such recommendations seem to echo a warning Figley made as editor of a volume on the use of self (1987):

The development of the self of the therapist must be a continuous and ongoing process... [I]t is easy to fall into a routine of daily life and work which denies the time and energy need for the nurture of the self... An alive and vibrant self is a source of energy and creativity which is of benefit to the therapeutic encounter as well as to the well-being of the therapist. When the therapist maintains such a direct person-to-person contact with his patients, his energies are renewed and the danger of burn-out is lessened (p. 155).

By focusing on taking care of oneself as a therapist, Figley is not directly addressing the emotional reaction of the therapist to doing therapy, but rather what to do in response to the effect of these reactions.

The family therapist's response to emotional reactions may be complicated by tendencies noted by Pope and Tabachnik (1993). They find that therapists may find it exceptionally difficult to acknowledge feelings of anger, hate, fear and sexuality engendered in the therapeutic encounter; that when such feelings are unacknowledged or inadequately addressed, they may have devastating consequences; and that such feelings, when promptly acknowledged and adequately addressed, may serve as a therapeutic resource (p. 142). Passoth (1993) writes of his personal experience of compassion fatigue, and attributes much of it to the inability of family therapy professionals to share their struggles, feelings, failures, and confusion. He suggests that they seem to prefer to work in isolation, and avoid genuine adult affiliation. As Wylie and Markowitz (1992)

indicate, "the therapeutic culture colludes in creating unreasonable expectations of therapists by making the possibility of failure a taboo topic" (p. 25).

Wylie and Markowitz also note that, though countertransference has been considered a "disreputable" term among family therapists, it is true that therapists' personal issues of insecurity, sadness, anger, values and attitudes have an impact on how they view clients. They quote Michael Elkin as saying, "Not acknowledging our emotions will make us vulnerable to fool ourselves into mistaking our needs for those of the client." (p. 28). Others speak about becoming more comfortable, over years of experience, with the emotions evoked by the therapeutic encounter, emotions such as ambiguity, anxiety, helplessness, and confusion.

The behavioral signs of burnout - excessive distancing from clients, impaired competence, low energy, increased irritability with supporters, and depression - are said to emerge gradually (Figley, 1993). Though Figley draws no such implications, one can imagine that such behavior would contribute to poor therapeutic interactions. Part of the rationale behind this study's focus on developing an awareness of our countertransference predisposition is to carefully calibrate our selves and our responses as therapeutic tools, tools that can measure degrees of personal and client distress and emotion. If we learn that certain "off-the-scale" responses are diagnostic of problems in the therapeutic relationship, we are more likely to promptly address the feelings and corresponding behaviors in a



useful way. In exploring the relationship between one's sense of self and access to one's unconscious process, and its importance for the conduct of therapy, Brown (1990) writes,

One aspect of many of the descriptions of distressed psychologists includes their failure to recognize the degree of distress they were in. Denial of distress is more simple when a therapist has no previous established criteria by which to know that his or her connection to the unconscious is working well (p. 138).

The clear implication of these articles is that without sufficient attention to the therapist's own responses to clients, the therapist can get dangerously lost.

Attention to these responses will be more likely when, as List (1986) proposes, no moral judgment is placed on the feelings a therapist experiences during and as a consequence of therapy; rather they are considered a fact of life and significant information (p. 8). Being able to maintain a flexible balance and boundary within the intimate therapeutic relationship is a skill which is valued by all therapists. Developing that skill is considered by some therapists to be crucial, particularly when dealing with very difficult issues with clients, as addressed under the next heading.

**Emotionally Charged Issues:** Family therapists have addressed the emotional response of the therapist when confronted with issues that are disturbing because of their violent, sexual, emotionally intense or terminal nature. Indeed, the intensity of the "normal" reactions of therapists to these issues seems to have mobilized extra efforts to find or produce helpful resources. It is

validating to therapists to realize that their reactions to violence or sexual issues are what could be called "objective countertransference," that is, responses that are derived from the client such that almost any therapist would responded similarly to this particular client or circumstance (Racker, 1957). Recent research, as reviewed below, addresses countertransference issues in the treatment of children of divorce, domestic violence, sex offenders, child sexual abuse, incest families, and AIDS victims and their families.

Though divorce is now so common as to be considered a "normal" experience, its effect upon children as the family makes the necessary transitions is not only intense, but also capable of arousing much feeling in the family therapist working with the divorcing family. Springer (1991) explores transference and countertransference issues within the context of agency-based, short-term work with adolescents and their parents, which she admits is "venturing into unexplored territory" (p. 406). She illustrates a countertransference reaction of intense anger toward an adolescent boy's abandoning and inappropriate parent, how it endangered her empathic work with the boy, how consultation helped her reorient to a therapeutic stance, what she did to repair the therapeutic bond, and how such a countertransference reaction may be generally applicable to divorce issues. This use of countertransference material by a family therapist, while conceptualized in object-relations language, is easy to understand and expressive of how countertransference and family therapy are capable of being woven together.

The issue of domestic violence has been the subject of much family therapy debate. The family therapist's emotional response to domestic violence often is one of repugnance and anger, which calls into question the non-blaming stance that characterizes a systemic perspective (Krugman, 1986; Mathias, 1986). One of the most common countertransference reactions experienced by therapists working with battered women is frustration and a sense of failure resulting from the client's decisions to stay in the abusive relationship (Rosen & Stith, 1993; Strawderman, 1994). In recent research which addresses violent relationships, Rosen and Stith (1992) develop a theoretical understanding of the process of leaving. Others have found that such an educational approach to understanding contributes to the therapist's ability to make sense of and thus deal with emotions evoked by the clients' process (Eastwood, Spielvogel, & Wile, 1990). Noting the difficulty with which the therapist approaches these situations, Strawderman (1994) recommends a number of techniques that have been found useful in helping therapists address and effectively utilize their countertransference responses to domestic violence issues.

The treatment of sexual abuse offenders was the subject of a qualitative study of therapists' objectivity and caring by Polson and McCollum (1992), and a section of the study deals with the emotional reactions of the therapists to the offenders and their issues. Typical countertransference reactions and the participants' coping responses were described. The reactions to perpetrators

described in the above study mirror those detailed by McElroy and McElroy (1991) in an article on countertransference issues in the treatment of incest families, and by Shay (1992) in his article on countertransference in the family therapy of survivors of sexual abuse. As an emotionally-charged issue, the treatment of perpetrators of sexual offenses has generated a number of efforts to delineate common countertransference reactions and suggested methods for managing these reactions.

In an article on countertransference issues in the in-home treatment of child sexual abuse, the theme of the authors (Reynolds-Mejia and Levitan, 1990) is that countertransference reactions can "weave a spell" upon therapists' emotions, upsetting the therapeutic agenda, but that what is experienced can be "an invaluable tool and resource available to the therapist who is aware of and able to accept and manage countertransference reactions" (p. 54). The authors acknowledge that working with traumas can profoundly affect the professional's own views of human life, in particular noting a "loss of innocence." A powerful countertransference reaction to involvement in families with child sexual abuse is a resistance to dealing with the pain of such a loss, a resistance to grieving the destruction of or assault upon one's view of reality.

In a rather personal and heartfelt way, Shay (1992) addresses these same reactions. He suggests that

our countertransference experience is made up not only of our individualized emotional reactions, conscious and

unconscious, evoked by the patient, but even more centrally by our political and moral beliefs and by our working assumptions of male-female interactions. This paper suggests that the therapist's sexual politics are inextricably interwoven with his or her countertransference experience. While our understanding of families in which there is sexual abuse shares some commonalities with our understanding of other dysfunctional families..., there are also profoundly important differences. Specifically, the differences are in the ways in which our societal institutions have been unable to integrate or deal constructively and progressively with the areas of sexuality, violence, and power. (p. 586)

Shay presents a case of father/daughter incest on which he worked ten years ago. His retrospective view of the progress and process of the case leaves him much to regret in his ignorant, arrogant, and fearful handling of it. In presenting the story, he notes many different feelings, provoked by all the different members of the family and by his supervisor and institutional setting.

He concludes that "[t]hese personal beliefs and values are the soil out of which our countertransference grows, **in combination** with the specific nutrients provided by the particular patients with whom we work. As with all countertransference, the goal is not to eliminate countertransference, even if that were possible, but to understand and appreciate it" (p. 591). He is particularly deft at engaging our examination of countertransference as a societally, culturally, and gender-influenced phenomenon.

McElroy and McElroy (1991) write on countertransference issues in the treatment of incest families. They explore the different reactions therapists may encounter with these families: reactions to the abused child, to the non-offending

parent, to the offending parent. The authors offers some hypotheses about the reasons behind the kind or intensity of therapist reactions to family therapy with incest families, and suggest that countertransference awareness can help the therapist avoid a non-therapeutic stance. They do not explore how countertransference could be utilized in the therapy itself.

Another emotionally-charged issue for therapists is the experience of working with AIDS victims and their families. Maloney (1988) writes about a three-stage therapeutic process that she follows with AIDS victims, and about the countertransference issues which threaten to disrupt that process. She lists her numerous countertransference reactions, and explores in depth different ways that she copes with and manages those feelings.

Emotionally-charged issues have inspired family therapists to explore the effect on therapists of working with clients, and to offer suggestions for understanding and utilizing that effect. Difficult client issues and concern about "burn-out" have been major impetuses prompting an interest in countertransference by family therapists.

### Summary

The literature from the field of psychoanalytically-oriented psychotherapy has been examined for both the history and the current usage of the concept of countertransference. Next were illustrated some ways that the psychoanalytic understanding of countertransference could be seen as useful to the practice of

family therapy. Then, an overview of family therapy terms that denote some of the aspects of the concept of countertransference were presented, as were some reasons for the family therapy field's avoidance of the concept. Finally, current family therapy literature was reviewed and instances were shown where countertransference was utilized as a concept.

It has been shown that the concept of countertransference, which addresses the understanding and utilization of the therapist's responses in the therapeutic encounter, has a place in the theory and practice of family therapy. As part of the attempt to discover whether countertransference is found to be useful in dealing with their emotional responses to doing therapy, the beginning family therapists participating in this study were encouraged to make use of a concept that has proven valuable and interesting to many earlier and contemporary therapists.

## CHAPTER III

### METHODS

#### Design of the Study

An exploratory multiple-case study qualitative design was used to describe the experience of beginning family therapists who were asked to discuss, in focus group discussion and individual interviews, their perceptions and experiences of countertransference in a family therapy clinical practicum setting. A qualitative study was chosen to address this research problem because, among other things, it allows the researcher to use the responses of the participants themselves to influence the path of the research (Lincoln & Guba, 1985). Such an influence is important to the development of a description, in their own terms, of the participants' emerging understanding and experience of a phenomenon.

Because countertransference is experienced in an interpersonal context, the boundary between it and its context is not clearly evident, making a qualitative study an appropriate method of inquiry into the phenomenon (Yin, 1989). One goal of this research study is to establish that the concept referred to by the term "countertransference" has both meaning and value for the practice of family therapy. Such an attempt at description would not be possible through other research methods such as a survey, an experiment, an archival analysis, or a written history, because of the way such research would involve imposing the



researcher's assumptions on the phenomenon, rather than allowing it to emerge from the context.

In summary, the exploratory multiple-case study qualitative design fits the needs of the research questions because of the nature of the phenomenon being studied and the purpose of the research inquiry, that is, countertransference and how it is experienced in a family therapy setting.

### Participants

The researcher enlisted the participation of all of the family therapist interns beginning their practicum placement in one AAMFT-accredited Master's degree program. This group of five graduate students began their practicum work at the campus clinic in August 1993. They attended an hour-long focus group meeting every four weeks for four months, and allowed two of their videotaped therapy sessions to be reviewed and were interviewed for an hour about each of these sessions.

Because this is a descriptive, revelatory study of a previously unresearched phenomenon, the small group of participants is not an impediment to analytical generalizability, that is, to the appropriateness of generalizing these results to some broader theory (Yin, 1989).

### Procedures

The procedures followed for this study were designed to allow multiple sources of evidence to be developed, so that various lines of inquiry could

converge, in a process called triangulation. Such multiple measures of the same phenomenon address the potential problems of construct validity by offering corroboration among the different sources (Yin, 1989). Therefore, the phenomenon of countertransference as experienced by the participants was explored in three ways: by a group process in focus group meetings, by observation by the researcher of taped therapy sessions, and by individual interviews by the researcher with the participants.

The participants were contacted by telephone, and presented with the purposes and procedures of the study. Upon agreeing to consider participating in the study, there was an initial meeting during the participant's first week of practicum, at which time the purposes and procedures were reviewed, and participants were asked to read and sign an informed consent form. This form described the basic study purposes and design, confidentiality, and their right to withdraw from the study at any time if desired (Appendix A). They were also shown the informed consent form that they could choose to sign at the time of the interviews about their videotaped therapy sessions (Appendix B).

The agenda for the initial meeting included a short presentation of the researcher's understanding of the concept of countertransference; the researcher asked the participants to relate their current understanding of the concept. The participants were given a schedule of the dates of the focus group meetings and a

list of questions that would help focus their thoughts for the meetings (Appendix C), some related journal articles and a list of suggested readings (Appendix D).

The researcher explained that focus group meetings and individual interviews would be audio-taped, and that all tapes will be erased at the end of the research project.

The researcher scheduled the videotape interviews, conducting approximately one a week throughout the semester; each participant was interviewed individually about a videotaped therapy session twice during the study. In preparation for the interview, the researcher prepared a videotape review and list of questions that pinpointed interesting sequences and related questions to be discussed with the interviewee.

The researcher kept notes throughout the course of the study to record insights, questions, theoretical concerns, and new understandings about countertransference and how it is experienced by family therapist interns. Also, the researcher recorded her impressions of the various experiences described by the participants, their perspectives and awareness, areas of interest or importance, their questions and concerns, and the researcher's evaluation of her level of involvement in the discussion. Ideas that emerged for guiding future meetings and interviews toward new or expanded questions were noted.

As a final effort to ensure an accurate description of the experience of the participants in this research, the therapists were asked to review a draft copy of

the research report and to comment on its findings and interpretations. These comments were incorporated into the final draft of the research report.

### Measures

The vehicles of data collection in this study were the group meeting discussions, and the videotape reviews and interviews. The questions covered by each of these avenues were intended to elicit the richest possible description of the participants's experiences, thoughts, and perceptions in their clinical work of their experience of the phenomenon of countertransference. Such questions sought to explore such areas as kinds of reactions (emotional, physical, behavioral), the types of provoking situations, the types and timing of awareness, their responses to the countertransference, and the input from the supporting environment.

The group meetings were used to explore whether there are common themes or experiences among the participants, and to examine whether there exists or could be developed a common understanding or perspective on countertransference as applicable to family therapy. The researcher attempted to moderate the focus group meetings with a low level of involvement, such that the content could emerge from the participants' experiences, rather than be imposed by the researcher's agenda. As Morgan (1988) explains, one can "use...focus groups...to guide the later construction of the interview questions. This is

obviously most useful when the topic...has not been extensively studied in the past" (p. 30).

The individual interviews were used to gather more detailed descriptions of the awareness and use of countertransference material in the immediate therapy setting. While the focus group meetings addressed the issue of the range of relevant topics, the individual interviews attempted to elicit specificity (concrete and detailed accounts of experiences), depth (the participants' feelings and involvement in the material), and personal context (whence comes each participant's perspective on the issue). The above four criteria are the basis for effective focus group interviews (Merton, Fiske, & Kendall, 1956, cited in Morgan, 1988). These criteria would seem to be applicable to the data needed to develop a detailed description of any interpersonal phenomenon, and as such will guide the exploration in the interviews.

#### Units of Analysis

The units of analysis for this research are the individual group members with their personal experiences of countertransference issues.

#### Data Analysis and Interpretation

The data collected came from two main sources of information: the taped group meetings plus contemporaneous notes and subsequent summaries, and the recorded videotape interviews and summaries.

**Focus group meetings:** The group meetings were taped, contemporaneous notes were taken, and a summary of impressions were written so as to capture the researcher's immediate understanding of the group's input. This data was examined to determine whether there are themes and patterns, experiences with certain types of families or family issues, or with the training setting that are common or diverse among the participants. Also, it was noted if there was disagreement or consensus among the participants about how or whether countertransference information is relevant to their clinical work.

**Videotape interviews:** The researcher came to the videotape interview with one or two sequences from the taped therapy session to be discussed. The researcher explored with the participant his or her perception of countertransference reactions during the sequence, what was going on for the therapist and client at the time, how the situation was resolved, what impact it had on the therapy, what insight was gained from this situation, and what was the response of the supervisory person. The researcher audiotaped these interviews.

The data collected from the group meetings was in the form of transcripts, and little identifying information was included in these notes, so as to protect the privacy of the participants. The videotaped interviews, which were identifiable, were also reviewed in transcript form with the advisor. Because of this, the participant was asked to sign a separate informed consent covering each particular videotape interview. Each participant chose to give consent.

The researcher kept notes of impressions, theoretical questions, ideas, and relevant professional literature, in order to enhance the generation of new ways of understanding the phenomenon being studied, and to seek better ways of testing that understanding against the group's perceptions. The researcher also tested her interpretations for validity and reasonableness by consulting with her advisor.

The researcher brought to the analysis of the data a theoretical understanding of the concept of countertransference, and a clinical experience of countertransference material. Though her assumption was that countertransference would be a part of the participants' experience in their work at the clinic, she had not developed a hypothetical model for how that countertransference experience could be understood. Instead, the model that is used to organize the results (Figure I in Chapter IV) was the result of combing the transcribed data for patterns, issues of importance, commonalities, and differences. In the process of reviewing the data many times through, and looking at it from several different perspectives (e.g., the group's process, the individual participants' perspectives, a theoretical construct of Robbins and Jolkovski [1987]), the organizing model was developed as a frame upon which to hang these particular results. The model is intended to represent the important aspects of the countertransference experience of these participants; the experience of the participants was not examined for its fit to a certain model or conception of countertransference.

This final report describes the experience of the participants as richly as possible in terms of themes and patterns that reflect the commonalities and differences, the range and the depth of their experiences and perspectives. Illustrative quotations are included to enhance the description. A review of the literature sets the context for the study within the scope of family therapy and psychotherapeutic thought.



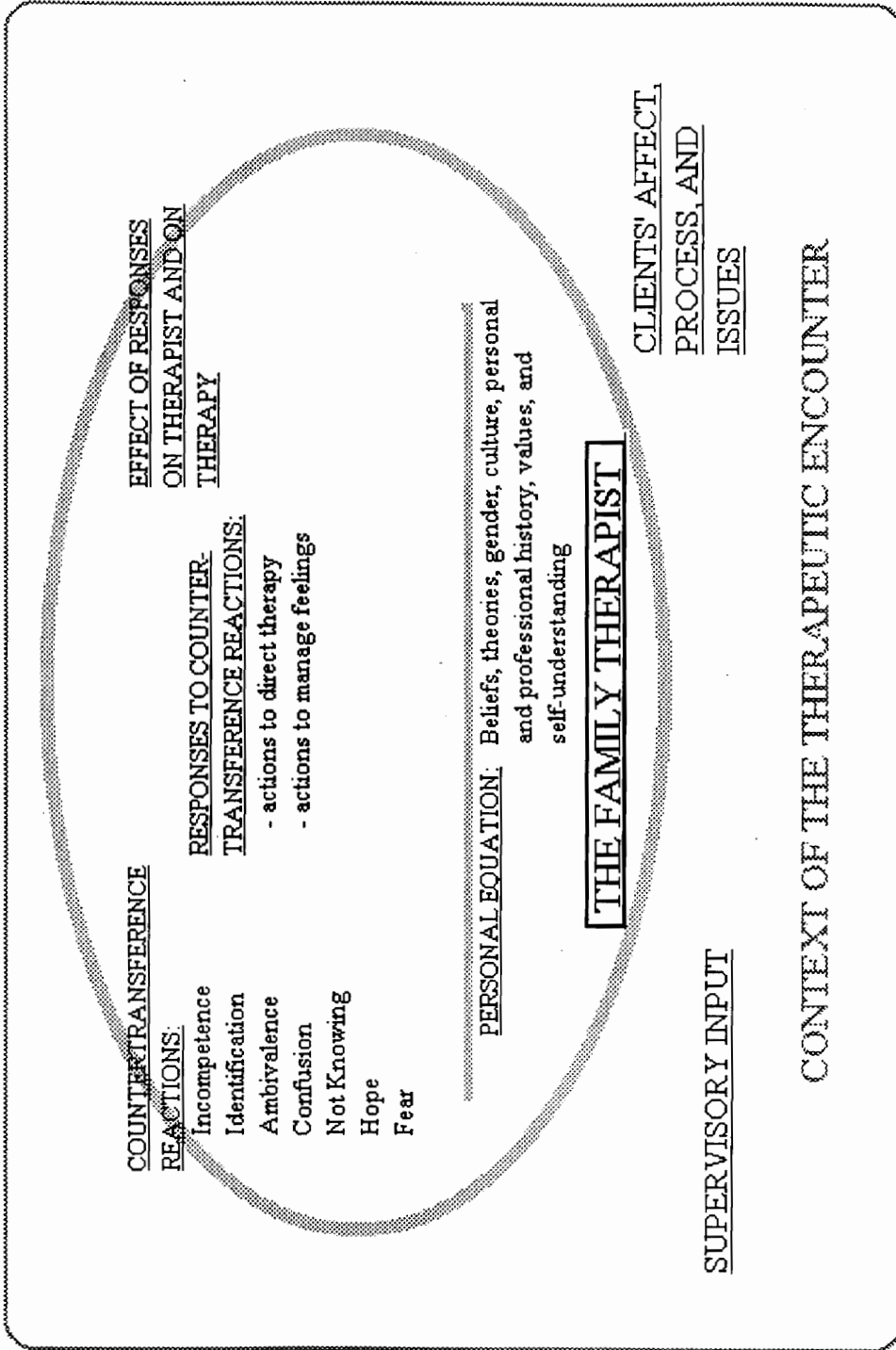
## CHAPTER IV

### RESULTS

#### Introduction

In this chapter, the countertransference experience of the study participants in all its aspects will be described. To begin to understand that experience, it is important to consider the context in which the countertransference emerged; discussion of the context includes describing the affect, process, and issues of the clients, and the supervisory input. Next, the countertransference itself is described, which is the feelings and behavior which constitute the responses of the participants; their awareness of these responses is also explored. Then the discussion focuses on describing what the participants chose to do with their countertransference responses, either to manage their personal feelings, or to direct the therapy. The effects of these choices on themselves or the therapy is also noted, if any. The participants' personal equations are the final topic under discussion, which comprise the beliefs, theories, values, self-understanding, personal histories, gender, culture, and professional experience brought into the therapeutic encounter and which influence the meaning to the participant of both the context and the countertransference response itself.

With the acknowledgement that, as the truism states, the map is not the territory, a schematic illustration of the above-noted aspects of countertransference is offered in Figure I. The diagram shows the aspects of their



**FIGURE I**  
**ASPECTS OF COUNTERTRANSFERENCE**

countertransference that emerged as important for the participants in this study, and the organization of those aspects into discreet segments. As will become obvious from the following results, none of the illustrated aspects of the countertransference experience are in fact discreet in the least, but rather are so intertwined and interactive that there is a certain redundancy in the model. The major example of this interaction and the organizational difficulty presented by it was in deciding whether to locate the therapist's personal equation within the context, or the context within the therapist's personal equation. Of course the actual physical setting of the therapy, the supervisors and their input, and the clients and their issues are on the outside of the therapist. But, the meaning of all of these exterior factors, and therefore the emotional impact of them, is located on the inside of the therapist. Because of such difficulties and limitations, the schematic design in Figure I is offered merely as an organizational tool, and not as a true or final representation of the actual and varied countertransference experiences of these beginning family therapists.

### The Context

When the participants described their countertransference reactions, an attempt was made to understand the context in which these reactions emerged. Often, it was clearly the affect or process of the client which evoked the participant's response. Some of the time, the kind of issue being addressed by the clients produced a strong reaction from the participant. Occasionally, the

supervisory input influenced the participant's reactions, as did the institutional context of being a student. The results discussed here were derived in fairly normal situations encountered by family therapists, so that the intensity of reactions of the participants to the clients, their issues, and the accompanying supervisory assistance often reflects the developmental level of these beginning family therapists.

**The Client(s)' Affect or Process.** There were several ways that the affect or the process of the client(s) produced a response from the participant that was strong enough to be noted or reported. One theme that emerged for the participants was a difficulty dealing with incongruity between the clients' words and their actions or demeanor, which seemed to produce skepticism, mistrust, confusion, or, depending on the issue, fear. In addition, a chaotic process in the therapy session was very disturbing for most of the participants. Clients' criticism of therapy or the therapist, their dramatic emotional outbursts, or desperate behavior were seen as difficult to endure and respond to properly. What follow are examples of situations in which the clients' affect or process engendered strong responses.

While incongruity of behavior and words may be more informational than anxiety-producing for experienced therapists, these beginning therapists found that their ability to stay with the clients was strained by taking in the conflicting messages sent by their clients. One participant feared for her own safety when

she began working with a young man who mutilated his hands and arms. When discussing her reactions to this client, she reported, "I could see the awful scarring on his hands and arms... He wanted to talk about his anger... He said to me he'd never hurt anybody else, he'd only hurt himself. But what I felt under there was that there was so much rage." This participant experienced a fear of physical harm, engendered by the incongruence of viewing the effects of the client's self-mutilation while hearing his reassuring words. The feeling of fear provoked by these double messages was corroborated by a participant who was observing from behind the one-way mirror: "[He was] like the wounded dog in the corner, you can't go near them, even though they may need the help and want the help, you're not sure what you're going to get back." Both participants experienced a fear and mistrust of the client; these feelings were not allayed but rather heightened by his words of reassurance.

Two other participants reported a feeling of mistrust or skepticism about clients, which in turn made them feel distanced from their clients, when the words and behaviors of the clients were at variance. In working with a woman and her son, one participant was taken aback by the mother's demeanor: "She was a really hard one, in the sense that I couldn't get a grip on her... When she first came in, I thought, this is one cool, detached lady... She said that he [her son] loves me a lot, and I love him a lot, but I didn't see any of that... I just had a lot of questions about the validity of what she was saying." This participant felt

rather hopeless about how she would make a connection with this client. A different participant was working with a poised, articulate young woman, who complained of lacking self-confidence: "My first reaction is disbelief... Is it her perception that is wrong or is my perception wrong... At this point, I'm still skeptical about her... I'm confused as to what the real problem is." As beginning therapists, these two participants were thrown off by their clients' incongruence, and had to strive to become clearer about how to work with these clients.

A client process that provoked intense feelings for beginning therapists was the process of a chaotic family. Several participants felt ineffective when clients interrupted them and each other; one reported, "I felt totally out of control, and I found myself getting impatient. Like, nothing's happening with this family, I don't know what to do, and they're not making any progress, and I'm incompetent, and the phone wasn't ringing. It was a zoo in there. These kids were totally out of control... I just felt totally incapacitated." Another participant, working with a crisis-oriented family, was dismayed by their process of avoiding therapy until there was another blow-up: "We're 40 minutes into it before all this comes out and I felt overwhelmed. Like, why do I sit and listen to all this stuff, and then ten minutes. I feel really pressured to say, Oh God, how do I handle this? And then I think I'm in a little panic, to see if we can salvage something out of all this." In contrast, one participant felt very comfortable with a more chaotic process, and joined right in; she felt that because she shared a minority ethnic background with

these clients, this process was not disruptive for her. For some of these beginning family therapists, working with a chaotic client process brought out strong feelings of anxiety and incompetence.

Feelings of incompetence or inadequacy, even of fear, were often the response when clients questioned or criticized the therapist or the direction of therapy. A participant working with a mother and daughters had strong emotional response to the mother's impatient complaints: "She came in... and she was furious, because she was convinced therapy wasn't going to help... The kid isn't fixed, and what are they doing there?... And I think it's part of what made me so uptight that night, and enhanced the [feeling of] incompetence." When clients were unhappy with the recommendations of the supervisory team, the participant's fear or anxiety often expressed itself in a desire to placate the client. One participant described a situation when the team decided that the client's first interview was to be only an assessment, which angered the client. "[My supervisor] comes in and confronts him,... and she's real cool but she's real firm. And he's getting really agitated... What I found myself doing was trying to soothe him... Instead of doing therapy, I was just trying to calm him down." When clients were confrontive and questioning, several of the beginning family therapists felt strongly pulled to be the peacemaker, sometimes at the expense of doing therapy.

When clients were dramatically emotional or desperately insistent rather than confrontive, the usual reaction of participants was to become very anxious or to take on the clients' emotions. For example, one participant found that when her clients began to cry, she reacted by becoming tearful herself. Another participant, confronted by a shouting mother and daughter, found that his heightened level of anxiety caused him to "get trapped in... the content" of the session. By contrast, even though it took a great deal of effort, some participants were able to resist becoming anxious in response to the emotional level of their clients. In the case of a session with a teenage girl, one participant reports, "there was so much drama there, it was sort of hard to separate the real from the drama... it's almost like she started to pull out all the stops because my chin hadn't hit the floor... So she had to keep putting hooks out there, hoping I would grab the hooks. Something was telling me, I don't know what, that I shouldn't grab the hooks." In the case of a woman self-described as MPD, another participant commented that, "she said, 'I need more time, maybe we could have a few long sessions.' [The supervisor] was back there writing notes, and thinking, Well, maybe we could give her some more time... And I found myself saying, with no coaching, You know, you have to figure out a way to tell those stories in a way that's important to you and to work within this time. When I came back, [my supervisor] said, You were great, because I had been suckered into thinking that maybe we could. That's how powerful [the client] was." In both of the above



instances, the participants were able to resist the demands of the clients, despite their discomfort and anxiety.

**The Clients' Issues.** Most of the clients' issues dealt with by these beginning family therapists were of less toxicity than those encountered by more experienced practitioners, although some issues were complex or involved chronically mentally ill clients. The issues brought up by the participants in this study were those that affected them strongly enough to warrant discussion. The issues ranged in difficulty from parent/child conflict, some with racial or ethnic overtones, to couples' communication issues, to separating or divorcing couples, to pedophilia, self-mutilation, and multiple personality disorder.

A familiarity with the psychoanalytic and family therapy literature on countertransference would lead one to anticipate a particular set of reactions when confronted with particular issues. It would be expected that those participants who are parents might have strong countertransference reactions to tales of parent/child problems. Couples' issues would be expected to tap into participants' issues from childhood experiences of their parents' relationship, and also from their own relationship experiences. A client's pedophilia would predictably provoke feelings such as anger and disgust, while a client's self-mutilation would engender horror and pity. Clients suffering from multiple personality disorder would be considered by many to be difficult to deal with in an optimistic manner. Almost any issue can be assumed to generate some

predictable countertransference reaction. It is interesting that there was one issue that recurred for the participants as they explored their countertransference responses to clients.

The issue that provoked the most discussion in the focus group meetings was couples who came to explore the possibility of separation and divorce. The participants in this study who had been divorced themselves had fairly strong reactions, ranging from a need to "fix" the marriage to feelings of hopelessness and guilt, depending on which one of the couple they identified with more closely. For example, one participant said, "I'm finding myself feeling uncomfortable in this position... I know I have to connect with him and I know he's terribly afraid,... and yet I also know all the guilt this woman is going through because I went through it." Another participant describes a strong reaction to a troubled couple: "[My old therapist] sort of failed to keep us together, and I felt like I wasn't going to do that. I was going to be different. I wasn't going to have anybody go through all that pain, I was going to fix it for them." When client couples were ambivalent about the marriage, one participant questioned, "how can I sit there with them being ambivalent? I would be helpless. I wouldn't know what to do. It's uncomfortable." When the clients' issue was marriage and its possible failure, strong emotions came up which reflect both the clients' and the participants' experiences, hopes, and fears.

**The Supervisory Input.** Beginning family therapists in the program under study have the benefit of much live supervision and abundant case planning opportunities. Within the context of this teaching institution's mission of providing affordable outpatient mental health services, the participants conduct therapy in order to learn how to do therapy. There are many layers to the participants' desire to offer high-quality therapy: to learn, to be well-evaluated, to do good for others. Underlying much of the intensity of their responses to clients was the participants' awareness of the teaching/learning context of the therapy. Participants reported that supervision heightened their ability to stay in touch with the process of the client, both in general and in particular sessions. They also reported instances when supervision heightened anxiety and was not found to be helpful.

Supervision was helpful to these participants' ability to handle their emotional responses in the general sense of creating a context of support and trust for the participants. This sense of support, encouragement, collaboration, and being part of a team was considered by the participants to be vital to their doing good work. One participant related, "[My supervisor] was there supervising last night, and I was glad, because it was a real tough session with [my client]... It was going to be real hard to please her because I was having trouble seeing [her point of view]. It felt good last night because I felt supported by [my supervisor], he was real helpful... Just knowing he was there." Another participant commented

on the difference between her therapy work and her day job: "I always feel competent enough here," as opposed to never feeling okay at the day job. A third participant reported that the supervisors acted usually as technicians, not getting caught up on the emotions of the session, but rather offering encouragement and suggestions. This participant also noticed that as the semester progressed, supervision felt more like the reinforcement of the participant's own ideas, and it became a collaborative effort rather than a didactic one. A different participant commented on her experience of supervision as one of "being in synch," "feeling like a team, we're all together in this," "here's someone who believes that I have the potential to be good." The collaborative, team effort was experienced as very nurturing by the beginning family therapists.

The supportive context created by the supervisors at the training clinic was felt to be essential to the participants' willingness to engage in the risky venture of therapy. One participant asserted that if the supervisor or team were to criticize in a scathing manner, she would experience that as an invalidation of the therapeutic process, and her trust in the process and in her supervisor's ability to help would be diminished. Another participant's response to supervision is illustrated by the following exchange with the researcher: (researcher) - "Do you get the sense that your supervisor basically trusts what's going on, and is not really worried that you're going to screw up?" (therapist) - "Absolutely. It stuns me. But I feel that he has an incredible amount of confidence in me." (researcher) -

"So how does that feel when you want to try to go your own way on things?"

(therapist) - "It gives me courage to do that." The sense of trust created through the relationship of the supervisors with the supervisees was experienced as extremely positive and usually essential to the performance of effective therapy.

Looking at how supervision affected particular sessions, participants could point out interventions from their supervisors which prompted them to interrupt a fruitless conversation, and use their emotional responses to assess the process in the room and then reorient the therapy along more immediately useful lines. Several participants noticed that their supervisors would intervene to help the participant slow down the pace of the session. For example, one supervisor would have the participant take a break, come back, and discuss what was happening with the process in the room; in noticing the process, this participant was prompted to notice how the process was making her feel, and how what she was feeling was making her act. The participant experienced this intervention as very helpful. With another client, this same therapist and her supervisor acted in tandem to change the course of a session: "All of a sudden I said [to myself], I'm bored... I wasn't paying attention to process... Right about then my supervisor called me out and she said the same thing. So I went back in and became focused on everything that was happening in the room, and everything changed." Another participant described a session where the content had entranced him, and his supervisor buzzed in to remind him to pay attention to process. He became

aware of the pull of the clients' conversation, and was able use himself to focus the conversation more productively. These examples of the interaction between supervisor and therapist demonstrate that the supervisory input was important in guiding the participant to utilize countertransference reactions in conducting therapy.

In some instances, supervision or case planning created turmoil for the participant. The turmoil was found sometimes to be therapeutic, and sometimes not. What could be called therapeutic turmoil occurred for some participants when they were asked to convey to a client unwelcome information. For example, two different participants were required to let one of their clients know that the first session would be considered only an assessment or evaluation session, and that another referral might need to be given them. Because the clients would be and were dismayed by this news, the participants felt very uneasy about delivering it. In those instances, though, the participants recognized that what the supervisors were directing them to do was in the best interests of the clients.

Other types of turmoil for participants occurred in certain circumstances. For some participants, realizing that there was no one supervising them was an unpleasant surprise. For example, one participant wished she had gotten more coaching during a session with a certain client, so that she could have caught a problematic countertransference reaction sooner; "the phone wasn't ringing... and I felt real unsupported." Another participant stepped out to consult with the

supervisor and team and "found out they weren't paying any attention" to her case. For a different participant, her supervisor's habit of walking into sessions unannounced was extremely unnerving: "After I watched the tapes to see [the] result of this intervention,... I decided that I thought very strongly that that wasn't helpful to me." The participant was able to come to an agreement about this with her supervisor, and was able to work more comfortably thereafter.

While the case planning process was noted by one participant to be supportive, for another participant, the method of case planning used by a supervisor was an example of nontherapeutic turmoil. She recalled, "after case planning, my anxiety level was so high that I was not going into the sessions feeling... in the right place,... all my buttons were being pushed about my own sense of adequacy. So I sat down and made a list of what I needed from supervision, what was important to me... And so I came prepared to say, No... But I didn't have to, because she picked up on what was happening." After that, the supervisor was more able to give the participant the support she needed. As a rule, any turmoil created by the supervisory input was short-lived, and did not have a major impact on the quality of therapy for the clients.

In general, the participants experienced the student role as positive, even though it was unlike the usual position these adults occupied in their outside professions. Most of these beginning family therapists had pursued other careers, where they had or still held management positions in which they were responsible

for directing the work of other people. Only one was continuing graduate education directly after her undergraduate degree. For several of the participants, the student role was a non-issue; for several others, there was a degree of comfort in and appreciation for the kind of master/student relationship with their supervisors that allowed the participants both to relax and to stretch themselves. Only one participant had an occasional degree of discomfort with the student role; she worried that being in the student role meant she couldn't disagree with her supervisors in a safe way: "I was fearful that... I would find myself [upset] inside, and wanting to be confrontational perhaps in inappropriate ways, and what I would do with that, and how would I manage that?" Her experiences over the course of the semester proved to her that usually she could voice her concerns, such as "When can we say we don't want to do this [directive]? When can we say we don't want this client?," and that "it has been at a certain level much easier than I would have thought." Because the student role is at the bottom of the practicum experience of these beginning family therapists, it is part of the context within which the therapeutic encounter stirs up the emotional responses of the participants.

In summary, the context, as determined by their clients' affect, process, and issues and by the supervisory input, affected how the participants responded emotionally. When clients' feelings were intense, these beginning family therapists found that their own feelings intensified, resulting in anxiety about their



competence to manage the therapy. When clients presented with chaotic process, or with difficult issues, the participants were often overwhelmed by the desire to fix things, and the fear that it could not be fixed. Supervisory input was generally felt to be positive in creating a reliable supportive climate to take the emotional risks necessary to learn how to do family therapy, and in creating situations in the therapy sessions to experience how to use their emotional awareness to further therapy. Within this context in all its aspects, the beginning family therapists experienced a variety of emotional responses of which they were more or less aware, as discussed in the next section.

#### Countertransference Reactions and Awareness

Because each participant was able to choose which therapy situations to discuss for this study, usually the most inflammatory cases were the subject of scrutiny. Not every feeling experienced by therapists is of therapeutic interest or value; the experiences chosen by the participants were those that they found remarkable either in intensity or in discomfort or for their educational effect. The full range of possible countertransference reactions is not represented in this study, because the participants were limited both by number and kind of clients being seen, and by the amount of time available to discuss cases for this study. What reactions are noted, though, show consistent themes that may apply to normal family therapy practice, though possibly heightened by the anxiety of being a beginner.

Some of the participants were able to explain in detail their reactions and their growing awareness of these reactions; this usually resulted from concentrating on one case over several interview sessions. Other participants were still struggling with the awareness of their feelings, and with what that might mean for therapy. One participant seemed to have a high threshold for emotional reactions, and was not easily buffeted by external or internal emotional currents.

**Countertransference Themes of Beginning Family Therapists.** The major themes in the countertransference experiences of the study's beginning family therapists concern questions about competence; feelings of identification with clients; dealing with ambivalence, confusion, and "not knowing"; balancing hope and hopelessness, and handling fear and sadness. These themes emerged often for most of the participants in the study, both in the individual interviews about the conduct of therapy and in the more theoretical discussions of the focus group meetings. Some themes were more important to particular participants, but all provoked an effort on the part of the participants to understand and manage their feelings for the benefit of the therapy.

Competence. The major issue for beginning family therapists is whether they are competent to do the therapeutic task. Indeed, their internship is designed to help them become competent and to assess that competence. By virtue of having allowed them to pursue their practicum requirements, the faculty

of the university has expressed their opinion that the chosen students are academically and technically ready to work with clients. Yet, until they have actually done the work and experienced success, beginning family therapists have still not answered the question about their competence for themselves.

Given an underlying fear of incompetence, it was almost surprising that the feeling of incompetence was not a completely generalized reaction, but rather that it emerged in response to certain clients and their issues. As one participant found out through experience with a particular client, "I had continued to feel very incompetent with her all through therapy. I started to have enough other clients that I realized that I didn't have this feeling of incompetence with everybody else, at least not so intensely." She came to understand this intense feeling of incompetence as a reflection of the client's own internal state with regard to the parenting issues being addressed in therapy. For another participant, a sense of inadequacy and incompetence was specific to the chronic nature of a client's problem, as she explains, "Part of the intensity [of my feelings] is from a competency issue for me... That is, if I have to continue working with this case, can I make a difference?" In a way, the feeling of incompetence was chronic in the face of the long-term, hard-to-surmount disabilities of this client. For these participants, the intense feeling of incompetence were different from day-to-day worries about doing a good job, and they were able to come to an

understanding of what that feeling of incompetence might indicate about the specific therapeutic process.

Identification with the Client. Another countertransference theme which emerged from the data was a theme of identification with the clients or their issues. When the participants felt they had had quite similar experiences or issues as the clients, they were generally aware that such identification might distort their perception of what was required therapeutically. One participant was working with a conflictual mother and daughter, which paralleled her own adolescent experience: "I was real concerned about siding with the daughter," and "It's easier for me to sympathize with the 16-year old than her mom, because I've been in her shoes." For another participant, the manner and age of his young client brought up feelings he had both as a father and as a business manager: (researcher) - "So when she's talking about her work problems, you're feeling like, Oh no, she's blowing it." (therapist) - "And I can't tell her, because I've told my daughter, it doesn't work to tell them not to do it." This participant also recognizes that he tends to be overly responsible, which is the same process as this client's, so his identification with her takes place on several levels.

One participant was so concerned about identifying with a troubled married couple that an hour was spent with that participant's former therapist, discussing issues that still rankled from fourteen years before. "It wasn't worth the time to go back and do it... until I saw this couple who reminded me so much of

us." Another participant was startled and dismayed to find that she identified so personally with the unacceptable social interaction style of an unusual client. When she was asked to deal with this interactional style in therapy with the client, the participant was unable to address the problem in a direct fashion, choosing an indirect path to focus on the issue. She questioned, "I wonder whether, if I didn't feel so personally threatened by the observations they were making about her inappropriateness, because I was internally saying, Am I like that?" These participants struggled to become aware of the boundaries between their own experiences and those of their clients.

Ambivalence, Confusion, and "Not Knowing". Another theme that emerged from the participants' experiences came from the awareness of feelings of ambivalence, confusion, and "not knowing," and the attempt to understand the source of those feelings. In contrast to the feelings generated merely by virtue of being a beginner and being unfamiliar with how to proceed in a session, these ambivalent, confused feelings were more specific to particular clients. They also were meaningful in different degrees to the participants, some of whom attached a great deal of significance and discomfort to them, and others of whom were more comfortable with not knowing.

Ambivalence, particularly around the issue of marital separation, was especially difficult to endure for one participant, who said, "If they were going to stay together, I could see how to work with them; if they were going to break up,

I could see how to work with them; but having them come back ambivalent, I would feel helpless." The participant felt lost when presented with his clients' ambivalence, but came to understand that the ambivalence may be important for them to face and accept at this point.

The experience of confusion came up fairly often, but when separated from the participants' personal competency issues, it was often a good indicator of client experience. Working with a 16-year old girl had its moments of confusion for a participant, who listened to an outpouring of adolescent woe, and felt, "There's a churning up [feeling I had], like everything was all stirred up inside and it needed to settle out... I think it was mostly confusion, because at that time I was feeling like I don't know how much to believe, I'm not sure where to go with this, what to do with this." The participant's experience in being with this client was more a going along with the confusion and staying with the client, rather than questioning herself or feeling the need to alleviate the confusion.

The participants experienced "not knowing" in a number of ways, and came to see it as a legitimate response to the therapeutic needs of the clients, rather than as an evaluation of their ability to conduct therapy. One participant reported, "I walked out of there thinking, I'm incompetent, I don't know what I'm doing... [Later I understood] it was just what was going on in the room, there was a lot of 'I don't know, what do you think?'... It was the process the client was doing." Through processing the countertransference reaction, the participant

became more aware of how the client was experiencing her own situation. Another participant utilized "not knowing" to allow the client to teach him what the client needed to do to recover from a substance abuse relapse. For this participant, "not knowing" was anxiety-producing at first; accepting the "not knowing" and using strategic and competency techniques was the key to the participant's being able to stay with the client to foster the client's own solutions to the problem. One last way that "not knowing" was experienced by the participants was in the aftermath of terminating therapy with clients. The participants who addressed this topic expressed their difficulty with the lack of closure that occurs when clients leave; some of the difficulty was from not being able to help any longer, some was from not knowing whether they had been any help at all, and some was from feeling rejected by clients who did not want to return to therapy.

Ambivalence, confusion, and "not knowing" were experienced intensely by the participating beginning family therapists, and they struggled to do good therapy even in the face of situations that made them question their ability to help. Often, these feelings were utilized to explore the beliefs or theories that were the basis for the participants' desire and ability to be therapists. As one participant put it, "We know we've done good, if we followed the things we've learned and done it right... The good comes from knowing you've done the right thing. You've done the only thing that could be done, based on what we believe."

It was these beliefs that were examined and questioned when the participants dealt with situations that engendered hope and hopelessness, as discussed in the next section.

Hope and Hopelessness. The participants' experiences of hope and hopelessness seemed to interweave and evolve, based on their self-assessment and on supervisory support received. It can almost be assumed that beginning family therapists are an optimistic, hopeful group, given that they have chosen to learn how to promote healthy change for others. One participant put it, "I have this eternal optimist in me somewhere," and "I believe my motives are good,... that I have a genuine interest in the client... I also strongly believe that I have something to offer... to facilitate the process, to help see things differently." With hope undergirding the participants' willingness to engage in the therapeutic endeavor, hopelessness emerged usually as a temporary reaction to difficult, intractable, or complex cases.

Hopelessness was a reaction one participant felt after some chaotic sessions with a mother and two daughters. Not only had communication been quite difficult with the family, but also supervisory input had been too sparse. This led the participant to comment, "I was not feeling much hope at that moment, because I was incompetent. Not that they were a hopeless case. For me at that time, it felt like I was hopeless, not the case." By contrast, given supportive supervision in a later session ("the phone didn't ring much, but I just felt the



presence more"), the participant "felt kind of like I was on track. Even though she was angry, I felt in control of myself more... Able to handle it." Once this participant firmed up her stance toward these clients, with the help of supervision, her temporary hopelessness dissipated.

Another participant working with a self-mutilating man struggled continually with hopelessness over the course of treatment. Confronted by the chronic nature of his problem and his cognitive disabilities, and being anxious about her own inexperience, she stated, "There's a part of me that wants to run away from this case." Even though she often felt hopeless about her ability to be helpful, the participant was able to arrange a medical evaluation in a residential setting, which began providing the intensive care that she was not able to. The hopelessness she felt with this client did not incapacitate her, but rather seemed to motivate her to find a better setting for him.

Some of the effort to combat hopelessness, which usually engendered anxiety for the participants, was spent in trying to imagine a therapeutically valid goal for which to hope. Much group discussion centered on how to help married couples who were on the verge of separation. To hope for reconciliation was the most basic stance of the participants, but one which generated hopelessness when the clients did not respond to this goal. The participants found it helpful to consider that, "whether or not they stay in the marriage, it is important for them to be able to communicate, because there are... children. That's important to me,

because I know for those kids it will be helpful... That [goal] is very helpful,... in terms of my ability to go in there in a helpful and constructive way." Choosing a goal congruent with the clients' wishes led to more hopefulness in the therapeutic process.

Fear and Sadness. While hope and hopelessness seem to be experienced on a continuum, and to be much affected by the participants' own personal equation, fear and sadness were often quite distinct and specific to client situations. Fear of personal bodily harm was experienced by two of the participants, and it was very disconcerting. Sadness was experienced by several participants, and for one participant sadness produced a strong physical reaction.

As mentioned above in the section on client affect and process as part of the context, fear of physical harm was a very unpleasant experience. For the participant working with the self-mutilating man, the amount of personal fear she felt was very intense, even though she did not become aware of it until some hours after the initial session. She reported, "I felt as I walked into the office, I'm glad he's leaving now and I don't have to leave for three hours. It didn't hit me until much later what that was all about. And that was that I was afraid of him." This experience forced her to struggle with, "How am I going to work through this?" Another participant was not aware of his physical fear until the topic came up in the focus group sessions. In relating how he witnessed a confrontation between his supervisor and an angry client, he noted, "I hadn't thought about it,

being physically afraid, until you brought it up... I felt nervous because there was tension, I felt it might be physical." What most bothered the participant about this recollection was not the physical fear, but his retreat in the session from a therapeutic stance into placating behavior. Becoming aware of physical fear produced in these participants a desire to understand how to continue to be therapeutic under those circumstances.

The feeling of sadness was experienced intensely by several participants, but was not usually a problem in the therapy; often it was utilized to express empathy with the clients. The participant who did experience a difficulty with sadness had a very specific reaction: "When I'm in session with folks, I get very empathetic, and I've been on the verge of crying a couple of times... Usually, I'm listening..., or waiting because they're crying... It does [get in my way] because I get very conscious of controlling it [her urge to cry]." When it was suggested that this controlling effort was a way of distancing, the participant acknowledged that that may be so, but she also felt like crying when something happy occurred. For another participant, the sadness she felt with a client was akin to projective identification, in which she took on the unacceptable feelings of her client. As he spoke about all his losses, she related, "[I said to him,] 'I'm overwhelmed with the sadness of what you're telling me.'... He wasn't into his sadness. So I was trying to let him know how I was feeling as I heard the story." The sadness she felt was

strong, but made sense to her understanding of the client, and thus she was able to manage it directly in the session.

When beginning family therapists discussed their countertransference reactions to the therapeutic encounter, a number of themes emerged which addressed their experiences. Dealing with uncomfortable feelings like fear, sadness, ambivalence, and confusion in the special place created by therapy was an intense experience for the participants. Struggling with questions about their professional competence, the hope they bring to therapy, and the effect of personal identification with the clients was an ongoing task that the participants addressed in a variety of ways. After describing in the next section the various ways participants became or found themselves aware of their countertransference feelings, the subsequent section will focus on what the participants did to manage these reactions.

**Awareness of Countertransference.** It is probably safe to assume that participating in this study caused some of the participants to be more aware of their countertransference than they otherwise would have been. The participants who were most articulate about or interested in describing their countertransference awareness were not always the ones who experienced the most intense or frequent countertransference feelings. Also, the participants who did not mention awareness were nonetheless able to articulate how they utilized

their reactions directly in the therapy sessions, which is discussed further in later sections.

As described by the participants, awareness of their reactions ranged from being immediate to being the result of several weeks of processing. In the usual operation of the outpatient clinic setting in which participants saw clients, information about the clients taken in a preliminary phone conversation was entered on an intake summary sheet and was available to therapists before their initial session with the clients. In several cases, particularly with feelings of identification with the clients' situation, the participants were aware before the initial session of having strong reactions to the information on the summary sheet. These participants consulted with supervisors and colleagues before meeting with the clients in order to develop and maintain a stance that would prove beneficial for therapy.

In other cases, awareness of countertransference resulted from the participants' trying to understand their feelings of dissatisfaction with themselves and clients. One participant came to understand that her ineffectual behavior in session was the result of picking up the impatience of her client. She relates, "I had picked up on that impatience two sessions earlier... I didn't realize until later that I think it was her feelings of impatience... And I think it's part of what made me so uptight that night, and enhanced the incompetence." She struggled with this case over several sessions, and "I realized there was some kind of process

going on... [It] was nice to recognize that there was something going on and I'd gotten caught up in it." This awareness served the participant well in becoming clearer about what she needed to do in therapy.

Several participants commented on how the input of the supervisor provoked them to come out of the trance of focusing on content, and allowed them to become aware of their immediate internal state, which helped them to be more in touch with what was going on in therapy. For example, describing her work with a young woman who calls herself a multiple personality, one participant relates, "What's hardest is the difficulty in knowing how to determine which of the stimuli coming to me is important; responding to content therefore goes nowhere. My supervisor helps me slow down." She describes how the supervisor works with her during live supervision: "[The supervisor says], 'Are you noticing what's happening here?' And then when I start noticing what's happening here, I'm also noticing how I'm feeling with it. 'Are you noticing that you're feeling rushed? Can you slow that down?' And I realize that I'm rushed because I'm anxious." Utilizing the immediate awareness provided by the supervisor's intervention increased the participant's ability to maneuver in the session.

As a final look at awareness of countertransference reactions, it should be noted that sometimes the therapist becomes aware of behavior that is not therapeutic before becoming aware of the countertransference feelings which prompt the behavior. Vannicelli (1992) addresses this process when she states, "at

times the therapist will initially be more aware of the defense against his countertransference feelings than of the countertransference feelings themselves" (p. 197). An example of such a process was noted by a therapist upon viewing a videotape of a session: "I noticed one segment where I almost was talking over him, and I thought, what was going on with me then?" She did not know the answer. Another therapist struggled with behavior that she believed had not been helpful to her client: "I had not given him the space over four sessions to tell me how bad it was... and he couldn't tell me, it wasn't safe enough, it wasn't okay enough for him to tell me what was really happening... I certainly didn't want to know how bad it was. That made me really scared, because I couldn't fix it." She became aware of her fear that she could not fix things when she noticed her behavior in the therapy; she felt it was possible that her drive to relentlessly pursue only the positive aspects of the client's life was a defense against that fear.

Some of the participants were able to show awareness of their countertransference feelings through actions such as taking a break, seeking assistance, or switching tactics in the session, but were not able to articulate this awareness or pinpoint when or how it occurred. Others, more given to processing the events of therapy internally, were able to recreate a rough picture of the process of awareness. At this time, the understanding of how these beginning family therapists became aware of their countertransference must be considered preliminary at best. The next section addresses how the participants managed the

countertransference responses they experienced, with varying degrees of awareness, with clients.

### Managing Countertransference Reactions

When the participants experienced countertransference, they had some choices about what to do in response to their reactions. The responses can be roughly divided into those that were directed toward affecting the conduct of therapy, and those that were directed toward handling the participant's own countertransference reactions. The effect on therapy and on the participant of these choices will be examined in the next section. This section will first address the actions taken in the course of therapy that resulted from the countertransference of the participant. Then, the actions taken to deal personally with countertransference feelings will be explored.

**Actions Taken in Session in Response to Countertransference.** When participants were in the middle of a session and experiencing a strong reaction to the affect or process of the client, to the issue being discussed, or to the supervisory input, some responded immediately in the session with behavior that affected the course of therapy. For some participants, the response to a strong pull from a family to act a certain way led them to resist that pull. For other participants, their countertransference led them to drop therapeutically valuable topics, to focus on content too long, to work too hard or quickly, or to not follow their supervisor's directions. Several of the participants used their emotional



responses to the clients immediately in the session by sharing that response with the client. In all these ways, countertransference affected what happened in therapy.

When clients exerted a strong influence on the participant to act in a certain way, some participants commented on what they did in the sessions to resist that influence. For example, a participant who was working with a family who very much wanted her to "fix" the daughter felt strongly pulled by them to comply with their wishes. Watching the session on videotape with the researcher, the participant was asked about how she dealt with this pull from the family: "Over and over, I have stated in all my sessions, This is not [the daughter's] problem, this is a family problem. Each of you has a role to play in this, this is not one person's fault, there is no one to blame here. I said, each one of you has had a part in this problem, and each one of you has a part in resolving it." This participant dealt with the influence of the family in the sessions by making clear her understanding of the situation, which was different from their understanding. A different participant worked with a teenager who seemed to want to astonish or shock her; the participant felt the invitation from the client to become involved in the content of her accusations, but resisted the invitation: (researcher) - "You obviously didn't talk much at all... You weren't trying to placate her". (therapist) - "I was just trying to be there with her... [Her concerns] may be valid, all that stuff may be true... In this session, the hooks felt powerful, but they felt like

somehow it was better to not be grabbing at them, just to be there and to listen to her." For this participant, the behavior that was necessary in response to feeling pulled by the client's distress was to stay in a listening mode, and not to join in with the anxious behavior. One could call this response to the countertransference reaction "going against the client process," which is effective in maintaining maneuverability with the therapeutic process.

In some instances, the choices of behavior made in response to countertransference, though not catastrophic, were possibly less than therapeutic. Discomfort with problematic feelings led one participant to notice, upon reviewing a taped session, "I don't [want to see the negative side] either, because it doesn't come up again... We sort of dropped this... stuff." Another participant broached a topic that was difficult for the client to address; the discomfort of the conversation "scared the s\_\_\_ out of me and we changed the subject." The tendency to shy away from topics which were personally difficult or which upset the client led the participants to drop some promising avenues in session. Another behavior in response to countertransference feelings was a tendency to focus on the content presented by the clients: "They were shouting at each other... they're talking a mile a minute, but I guess I just wasn't processing it as fast as they could dish it out. And so I think I get in this loop of trying to keep up with it this close." The high emotional level of the clients produced a desire in

this participant to take in every detail, rather than a sifting of the material for relevant information.

Several participants reported behavior in sessions in response to the emotional impact of the therapeutic situation that consisted of working harder or more quickly than was necessary or useful. One participant, aware of how pulled he felt to help a couple, asked his supervisor for assistance: "She said, how will I know you're in countertransference, what will I see?... Well, I'll probably want to be solving things, and I'll want to be moving too fast." Another participant described her reaction to anxiety about a client: "I work harder." A third participant found that, confronted with a client's fear and sadness, she "moved on too quickly," as noted by her supervisory team. When these participants were aware of working too hard or moving too quickly, they usually were aware that it reflected a response to anxiety on their part.

One further example of behavior in session in response to countertransference was idiosyncratic to a particular participant, but probably not unusual in training situations. One participant found, in response to a very subjective countertransference reaction, that she disagreed with her supervisors' directives for a session. She was given the instruction to let her client know that the client's behavior had become disruptive in the clinic (e.g., coming early for sessions, interrupting secretaries and faculty working in their offices). The participant felt this was not her responsibility. Instead, she dealt with the issue

indirectly: (therapist) - "How do you know when people have time to talk to you?" (client) - "Well, if they don't, they'll tell me." (t) - "Well, not all the time." The participant went on to discuss ways of picking up signals from others. "When I was in the room with her, she said to me, Am I bothering people in the building here? And I couldn't say yes. I said, I don't know, do you think you are bothering people? And I came out, and [my supervisors said], Why couldn't you say yes? And I said I don't know why, but I couldn't say yes. And the reason I couldn't say yes was because it was touching me so deeply. I went back to the more indirect approach with her." Though this was the only clear example in the study of supervisory directives being unacceptable because of countertransference, such behavior is likely to happen occasionally in any training setting.

Some of the participants chose to express to their clients their countertransference reactions. When done judiciously, such a response to countertransference is well-recognized as therapeutically justified by psychoanalytically-oriented therapists. Two of the participants in the study utilized their countertransference responses in this fashion, with good effect upon their engagement with the clients. One participant felt that presenting her client with information about the effect on her (the participant) of the client's manner was the basis for building a trusting relationship and for helping the client develop reality-testing skills. This same participant worked with another client who brought up a great number of emotions in her; she communicated to him her

feelings both as information for the client, and as a way of managing them for herself. For example, when he was afraid he has disappointed her by bringing in bad news, she told him, "I feel like I've disappointed you because I guess I haven't given you permission in this room to let me know how bad things were at work." The other participant utilized his reactions to a client by giving her information about her impact on him. His client was struggling with handling her anger in an appropriate yet assertive way. In response to some situations which she brought up to be examined for problems and resources in her anger management skills, he offered her feedback. For example, he told the client, "I think if you were to get mad at me, I would be intimidated," (a comment on her manner, not his timidity); and also, "I can see when you want to say, Hey I'm angry about this, you use your voice. It's wonderful." In the session, the client responded very positively to this input, and the therapeutic relationship was strengthened.

Countertransference affected what happened in therapy with these beginning family therapists. Some helpful ways it affected therapy were when the participant was able to resist the unhelpful process of the family and to go against their process, and when the immediate expression of countertransference feelings were used to connect with clients. Less helpful ways that countertransference affected the course of therapy were when useful topics were dropped, the focus remained on content, the participant worked too hard or quickly, or the supervisor's directives were not followed. The expression of countertransference

feelings directly in the session can be seen both as a therapeutic technique, pursued to further therapeutic goals, and also as a way for therapists to manage, or stay aware of, their countertransference so that it does not overwhelm them or slip underground. The next section will address what participants did to handle the effect of countertransference on themselves personally.

**Actions Taken to Personally Manage Countertransference.** When participants had an intense reaction to the therapeutic situation, sometimes they responded through some actions in the therapy session, and sometimes they responded through actions to help themselves make sense of or moderate the countertransference feelings. To make sense of their feelings, often the participants engaged in thoughtful processing of the events and context surrounding their countertransference. To moderate their feelings, some participants learned to utilize discussion with colleagues and taking breaks during sessions to pull back and collect their thoughts. These actions can be seen to affect therapy, but the effect was indirect and sometimes delayed, because it came through the subsequent, more focused and conscious behavior of the participants.

Several participants dealt with intense countertransference, once they were aware of it, through extensive thought: "That's when, by getting so terribly hurt, that I started giving it a lot of thought, and getting clearer about what my stance was and needed to be," explained one participant. Another participant's countertransference "threw me into a real questioning." A different participant

worked on understanding a client who brought up parental issues for the participant: "Well, is it her perception that is wrong or is my perception wrong?... I get real thoughtful." As one participant put it, "Just being able to recognize that I was caught up in the process helped me realize that I didn't have to be, and helped me get clear on the fact that I could extricate myself from that emotional process." Taking time to reflect on the meaning of the countertransference was useful in gaining understanding and control of the countertransference feelings.

In focus group sessions, participants discussed what they considered helpful in dealing with their countertransference feelings: "One of the ways I am best able to deal with my feelings about these things is to say them out loud." The focus group sessions were an opportunity to say things out loud, and were utilized by the participants to explore the management of countertransference. One participant remarked, "I'm having this anxiety about the situation, and how do I manage that in a constructive way for me?" Several participants noted that helpful strategies included utilizing case planning and consultation with colleagues. Supervision was also helpful in the personal management of countertransference, especially when it reinforced the participant's choosing to take a break in therapy: "Now I think I've learned it's okay for me to look at the clock and realize I need a break and just excuse myself. And that was a real valuable lesson." Personal management of countertransference was a task that these beginning family therapists took seriously and dealt with in a number of ways.

Of the actions that the participants took in response to their countertransference reactions, some directly affected the conduct of therapy through actions taken in the session, and some affected therapy only indirectly through their effect on the internal experience of the participant. The consequences of the choices made in response to countertransference on the therapeutic endeavor and on the participant are the topic of the following section.

### Effect on Therapy and the Therapist of Actions Taken

#### In Response to Countertransference

As the focus of discussion ranges further and further from the provoking situation and the feelings provoked, it becomes more difficult to separate the responses of the therapist from the ordinary process of therapy. This difficulty presents itself because, in the ordinary process of therapy, the therapist is utilizing a great deal of information coming in from many directions in choosing useful therapeutic actions, and awareness of the source of all this information is not always or even usually available at the conscious level. Nevertheless, an effort was made to determine what effect the actions taken by participants in response to countertransference had on themselves or the therapy.

The clients' responses to strategies used in response to the participants' countertransference were mixed, with some positive and some negative responses. For example, after one participant took a one-down position in reaction to his feelings of ignorance about a topic, the client was able to respond very effectively



with his own solutions; the participant explained, "I played dumb. But it is true, so I said, You're the expert, you've done this three times before, you know what you've got to do, tell me what you've got to do. So he said, I've got to do this, this and this..." In another instance, a participant who had been working hard to deal with a client's dissatisfaction found that, after having made the effort to become clearer about her countertransference reactions, she "felt kind of like I was on track. Even though she was angry, I felt in control of myself more... Able to handle it." The client's response to this ability to handle it was that "she seemed less anxious, her arms were unfolded, her voice was much calmer."

One participant's behavior in response to a tense session with her client produced less positive results for the client: "I was feeling all this tension, and saying [to myself], Let's see now, how can I help him release some of all that internal tension that he's feeling, in a way that's unhurtful to anyone else. Of course, when I made a couple of suggestions, I got 'Yes, but, yes, but,' so he wasn't ready to hear that." Her tendency when anxious was to move more quickly and go into a teaching mode. This was not helpful for the client. Another participant, in responding to his fear of physical harm from a client, related, "Instead of doing therapy, I was just trying to calm him down so that there wasn't going to be any violence." The participant did not feel that this calming, placating stance was therapeutically helpful for the client.

The participants' personal consequences of strategies taken in response to countertransference reactions were generally more positive. The participant who dealt with her feelings by saying them out loud felt that that helped her to come to terms with them: "At least I can look at it and say, Now, how am I going to work through this?" Another participant who asked the supervisor to monitor his countertransference behavior in response to concern about his strong feelings found that the process of asking specifically for help was beneficial: "Once I told [her and] myself all that, I could get over the emotional feeling." When countertransference was noticed and actions were taken in response to it, most participants reported both positive and negative consequences of these actions for themselves and for their clients.

#### The Personal Equation of the Therapist

As described above, within the greater context of the therapeutic setting determined by client and supervisory input, the individual therapist experiences many emotional responses, makes choices to deal with these responses, and is affected by the consequences of these choices. The personal significance of the emotional responses of the therapist is determined by the unique personal equation that the therapist brings to the therapeutic encounter. In this section, the focus is on the beliefs, theories, gender, culture, personal and professional history, self-understanding, and values of the participants, because the assumption is made that these personal factors predispose the participants to make meaning

of their emotional responses, and subsequently affect the actions chosen to manage those responses.

As a framework underpinning the assumption that the personal equation of the therapist is important in therapy, the conclusions of a study by Robbins and Jolkovski (1987) are extended here. In the study, the authors examined how two independent variables, awareness of countertransference feeling and theoretical framework, affected the dependent variable, involvement with the client. Their results suggest that greater awareness of feeling relates to less withdrawal of involvement, and that a combination of high awareness of feeling with high theoretical framework provides the least withdrawal of involvement.

Robbins and Jolkovski state that theoretical framework "refers to any formal or informal theoretical structures used to explain the events in the therapy hour, to render them intelligible" (p. 277). Extending this definition slightly further, one could propose that the beliefs, culture, gender, values, self-understanding, and personal and professional history of the therapist are also used by the therapist to render the events in the therapy hour meaningful. How these factors affect the meaning given by the participants to the therapeutic experience and to their countertransference feelings are beyond the scope of this present research. However, that these factors do affect how the participants make sense of what goes on in therapy and in themselves is a basic assumption. Thus, the

following description is given of some of the beliefs and other personal factors deemed relevant by the participants.

**Beliefs and Theories.** The beliefs and theories described below were identified by the participants as significant to their understanding of their reactions in therapy. Many of them came up during focus group discussions in a group effort to examine why a colleague proceeded a certain way or had a particular therapeutic goal, or in a theoretical discussion about countertransference and the conduct of therapy.

As mentioned before, the struggle of couples in marital relationships was an issue that provoked many feelings for the beginning family therapists. The resulting efforts to deal with these feelings led to the expression of many beliefs and theories regarding marriage, such as, "Maybe the thing to do is not to save the marriage. Maybe the thing for you is to help them decide if they want to break up;" "I believe, independent of [my own] countertransference, that there's as much pain in breaking up a marriage as in putting it back together... My thing would be to keep people together unless it's clear it's not going to work for them;" "Even if, in the end, they decide they're not going to stay together, they need to put some work into that relationship, because it's going to carry them over into the next. They need to face it with each other;" "It's important for the couple to be able to communicate, because there are two children;" and, "I don't think we can help couples stay together or come apart, I think it's going to happen. I think

we can be supportive, I think we can help be there. I think we can help the couple be there." These beliefs can also be seen as reflections of the participants' personal experiences, as described later.

Some of the discussion of theories focused on understanding the countertransference experience, and some focused more generally on the job or role of the therapist. When the participants addressed countertransference as an issue in their work as therapists, they asked theoretical questions and drew some tentative conclusions. Some of their remarks follow: "The therapeutic purpose [in giving clients feedback about countertransference] would be, I think sometimes people don't know how things they do affect other people... That sort of opens the gate to talk about how what they do affects other people;" "We all have to decide at what level this countertransference is getting in the way of our doing really good therapy;" "[The supervisors are] saying, Whoa, you need to keep the boundary there. But maybe the reason I need to keep it is the countertransference that's going on;" "I've noticed while you talked that your anxiety level went way up... even today, two weeks later,... I'm amazed at how transmittable all those [feelings] are. Because I see it in all of us, and it's really powerful stuff;" and, "Here are emotions emanating out [of the client]. The therapist has two possibilities, either taking it or pushing it back... Owning the emotion." Even though these beginning family therapists had to occasionally search for vocabulary that expressed their understanding of their emotional

responses ("transmittable," "emanating," "push it back"), they tried to explore theoretically what was happening to them emotionally, and what that meant for their work. These theories emerged along with the refining of their understanding of the job or role of therapist.

The beliefs and theories about the therapist role emerged as the participants noticed and questioned their actions in therapy. Following are some of the comments the participants made on this topic: "I think feeling empathy goes a long way,... but I don't know if that's enough... So besides your empathy, [you need to be] smart about what you're doing;" "If I have this feeling that this [therapy] is useless, I'm not going to be of any use to them... That will come through at some point, my disbelief in the whole process;" "My responsibility is to be as real a person for him as I can be;" "It's not helpful to be a crutch, it's better to be a coach;" "What would happen if, while being treated by me, he hurt somebody else, what kind of sense of responsibility would I feel for that?" "A lot of what [therapy] is about is not necessarily joyful, and how am I going to be able to put that away, so that I can still bring to the process that part of me which is spontaneous and joyful and hopeful and optimistic?" and as one participant answered, "There's some passion in feeling like I'm sad about this and I wish I could have done better. I think it's important to say, Hey, this is part of the juices, too, the ups and the downs, and it's all part of the goodness of it." In sharing the questions and ideas about the role of the therapist which came up

while they were focusing on their emotional responses, the participants demonstrated that, for them, there was a connection between what they experienced in the therapeutic encounter and what they might choose to do later, whether they were conscious of the connection at the moment of choice or not.

**Gender and Culture.** Though not a primary concern of this study, gender and culture must be considered very basic factors which predispose the therapist to a particular understanding of the therapeutic encounter. The participants comprise four woman and one man, ranging in age from mid-20s to early 50s, with backgrounds varying from east coast Jewish, to mid-West Catholic, to homogenous Protestant, to Indian. When gender was commented upon, it was usually in the context of a discussion of marriage, separation, and divorce, for which one set of comments can serve as an example: "I'm wondering whether our reactions are gender-based... I have a more cynical view when we've got a [client] who happens to be a woman who's helping this guy who's a heroin addict... I get angry at women like that... If it were reversed, I wonder what my reaction would be. But I think it's a variation on domestic violence, women not taking care of themselves." To which a (male) participant replied, "That's amazing. Here's this woman who's powerful, beating this guy into the ground, and [you say] Poor woman! She should get out of this terrible relationship!" Besides some other general comments such as the above, gender was not explored as a way of understanding countertransference reactions.

Culture came up occasionally as a topic, usually when the difference or the similarity between participant and client culture were extreme. For example, when a white male participant was working with African-American female clients, he was directed to acknowledge the cultural difference early in the therapy, so that if it was a concern for the clients, they could choose to address it or not. Though the clients did not choose to pursue the topic, the participant felt he was able to develop a great deal of rapport with the clients despite the differences, as evidenced by one of the client's remarking, "I talk to you because I want to talk to you. And I never thought about what conclusions you draw... [as opposed to other authorities who] come with an idea, they come with their mind made up... I just kind of resent them extra-hard." Another way that culture came up as a topic of countertransference was when the clients and therapist shared a minority culture. One participant of a minority culture, though greatly assimilated to the dominant culture, found that working with clients from the same background allowed her to work in a different mode from usual. She found that she shared an appreciation for social hierarchy and family expectations that enhanced her credibility with the clients, and also gave her a great deal of empathy for their struggles in this country. The hierarchical status in the minority culture of the therapist role gave this participant a kind of therapeutic leverage that she did not find available to her with clients from the dominant culture. She reported, "I feel very much in control... I know I have a position of power there, and I also know I



have to use it. I think [it is therapeutic for the family], because if they saw me as someone they could walk over, I wouldn't get any respect from them, and the whole therapy would be useless, so I have to really make very clear statements about myself. And I like doing that." This participant was able to use her ethnic background for the benefit of her clients, and to use her responses to the clients' culture to conduct therapy in a way that fit for them.

**Personal History and Professional Experience.** Often, when the participants discussed their countertransference reactions, they found that what emerged as significant was related to their own personal history. Usually this significance related to their identification with the clients themselves or with their issues, but sometimes the significance had to do with their neophyte status as family therapists, and the attendant lack of knowledge or confidence.

Identification with clients, as mentioned earlier, was considered a boundary issue by most participants, and they struggled to gain command over the part of the countertransference intensity that was from their own personal history. One participant was concerned for her clients who were dealing with marital separation, "because I went through it... So I'm bringing this [personal] stuff into the thing, instead of just receiving." The same participant identified with the rage of her client, "that ability as a human being to do terrible things," which she identified with the experience of raising a colicky baby; this metaphor perfectly expressed her current feelings of helplessness and inability to physically or

mentally comfort a client who mutilated himself. Another participant identified from her childhood experience with the distress of a family dealing with busy schedules and not enough attention to go around. A different participant found that her client's abandonment issues were powerful for her, being connected as they were to her own childhood experiences. Finally, one participant commented that her understanding of what her married clients needed from her were derived from her personal experience of separation and divorce: "I don't know if we have to have a position. What I wanted from my therapist... is someone that I feel is supportive, that helps the story unfold, that at least is an anchor while all the craziness... and ambiguities unfold... She never gave me an answer, she never said, I don't think this is going to work." Struggling with how to helpfully conduct therapy while carrying significant experiences from the past was for these participants an exercise in awareness of themselves and of the clients' messages and needs.

Coming to therapy as they did without a great deal of professional experience in family therapy, these beginning family therapists found it necessary to question whether their responses to clients derived from inexperience and ignorance. One participant, confronted with substance abuse issues, remarked, "I didn't know a thing to do." Another participant commented, "I didn't know how to stay with the feeling," and "I don't know where to go with that." And one other participant stated, "My process was being an incompetent neophyte," which nicely

dovetailed with the client's own feelings of incompetence about parenting, and was not easily separated by the participant. Bringing to the therapy their personal positions as beginners in the family therapy field made the participants' experience of countertransference somewhat more intense; in the process of discussing these experiences, some participants found that they were more able to be aware of which parts of the experience reflected their personal contribution and which parts were information about the therapeutic situation.

**Self-Understanding and Values.** Most participants recognized the effect of bringing their own idiosyncratic self-understanding and values into the therapeutic encounter. When trying to identify how rapport had been created with a difficult client, one participant suggested, "I'm a very non-critical, non-judging person." In working with a couple to promote a positive exchange of feelings, one participant drew on the understanding received from hard-won experience: "At least I've come to the point where I understand where [my ex-spouse] was, and was able to do some good stuff with [the client]... Now, I knew she was never going to say it, so I didn't say to her, Can you tell him [I love you]? So then when I saw her alone the next time, she said, You know, when you had him tell me he loved me, I was afraid that you were going to say to me, Tell him." The participant's sensitivity to the possibility that this telling might be a coercive or negative intervention was due to the participant's self-understanding from past experience.

Other evidence of self-understanding brought to the therapeutic encounter is shown in the remarks of one participant about her confrontational nature, her overfunctioner role, and her assessment of herself: "I'm not usually afraid to ask hard questions." Based on this self-assessment, this participant was alert to situations where she was afraid to ask hard questions, and examined her countertransference reactions for the meaning of such behavior.

Values were not a central topic of discussion, and therefore how the participants' values impacted their countertransference reactions was not explicitly addressed in this study. The one participant who did comment on them as relevant to her countertransference experience acknowledged, "It's hard for me to respect narrow-mindedness. I was brought up by very open-minded people, and... [this was a value in my family], to be flexible and to respect someone else's difference in opinion." Because of her values, this participant struggled with clients who were not receptive to new ideas that might be helpful to their family.

In summary, the personal equations of these beginning family therapists influenced the significance of their emotional responses to clients and to the therapeutic situation. The participants chose to proceed in therapy based in some part on their understanding of their emotional responses, and the range of beliefs, theories, gender, cultures, personal and professional history, self-understanding and values that underlie that understanding was described in the above section.

## Summary

This chapter was devoted to describing the countertransference experience of beginning family therapists in its many aspects. The context in which the countertransference emerged, as determined by the clients' affect, process, and issues and the supervisory input, was described as it was experienced by the participants. Next, the countertransference feelings and behaviors themselves were delineated, as they seemed to fit into particular themes; the participants' awareness of their countertransference reactions was also explored. Then, the discussion focused on describing the actions the participants took in response to their countertransference reactions, both to direct therapy and to personally manage their emotional responses. The consequences of these actions on both the therapy and on the participants were noted. In the final section on the participants' personal equations, the unique aspects of a therapist which influence the personal meaning of the context and the countertransference responses were described, comprising the participants' beliefs, theories, gender, culture, personal and professional history, self-understanding and values. In the next chapter, a discussion of the implications of this research for training and research will be presented.

## CHAPTER V

### DISCUSSION

#### Introduction

The purpose of this study was to develop a description of the countertransference experience of beginning family therapists, based on the assumption that the concept of countertransference was applicable to their experiences in therapy. A description of that experience emerged through discussions and interviews with the participants, the contents of which were then organized into patterns and themes that reflected the most important aspects of their countertransference experience. A case was made through the review of literature that the concept of countertransference could be found useful by family therapists. The experiences described by the participants of the study and their own assessments of them indicate that countertransference was a concept that made sense of and expressed their experience of emotional responses to clients and to the therapeutic situation.

#### Conclusions of the Study

The conclusions that can be drawn from this study which apply to the field of family therapy corroborate in part the assumptions that the researcher brought to the research. The assumptions underlying this research are based on the researcher's experiences as a beginning family therapist. In her development as a family therapist, she noticed that, apart from the theoretical and academic

learning she had received, the one thing that carried her through therapy sessions was an awareness of her own state of being. This awareness was found to be the most valuable tool she could wield in the service of the clients. From it, she found the prompting and the strength to pursue difficult issues; within in, she found the faith to continue in boring, hopeless, or fearful situations; based on it, she developed greater technical understanding; through it came the empathy that knit the experience of the client with her own; apart from it, she was lost.

Because of this experience, she wanted to know more about honing this tool of awareness. To her dismay, her favorite family therapy theorists had virtually nothing to offer. To her surprise, the untapped knowledge of the psychoanalytic field offered very specific and entertaining help in recognizing, understanding, and utilizing that self-awareness in the therapeutic relationship. A desire to cross-fertilize the field of family therapy grew, as did a desire to talk to other family therapists about their experiences, perception, understanding and utilization of emotional responses in the therapeutic encounter; hence, the creation of this research study as an opportunity to do that.

Conclusions that can be drawn from the results of this study are related in the following sections to the particular experience of the beginning family therapists participating in the study, and then to the generalization of their experience to the field of family therapy.

**The Participants' Experience.** Even though the participants had never studied the topic of countertransference, on being presented with an introduction to the concept and requested to try to discuss their awareness of countertransference, they responded easily and enthusiastically to the challenge. Far from being a difficult intellectual exercise, the discussion of their countertransference experiences and of the accompanying contexts and actions flowed easily with minimal direction from the researcher. This ease seems to demonstrate that these beginning family therapists were able to grasp the concept of countertransference and were able to find ways that the concept was applicable to their conduct of family therapy. They were able to articulate how their emotional responses affected them and their therapeutic choices.

Most of the participants found that their awareness of countertransference reactions contributed to their being more aware of and thus more often using process-based information in the conduct of therapy. Also, most of the participants found that the discussion of their emotional responses was helpful in the management of their feelings, either in making better therapeutic choices or in achieving a more comfortable internal emotional state. And finally, most of the participants report that the awareness of countertransference has continued to be important in their conduct of therapy over the past year and a half since the study ended.



Therefore, it is reasonable to conclude, based on the experiences of the participants, that for these beginning family therapists the concept of countertransference was expressive of their experiences, was easy to understand, was utilized in the practice of therapy, and was considered valuable in their work.

**The Family Therapy Field.** As stated earlier in the Methods section, because this is a descriptive, revelatory study of a previously unresearched phenomenon, the small group of participants is not an impediment to analytical generalizability, that is, to the appropriateness of generalizing these results to some broader theory. These results are generalizable to the broader systems theory of family therapy, in that they show that the countertransference experience of beginning family therapists is profoundly interactional and is not capable of being adequately understood outside of its context. The interaction of the context, the emotional responses, and the personal equation of the participant does not happen in discreet movements but rather in a organic, even tidal, fashion.

Based on this interactional understanding of the concept of countertransference, there are several, simple conclusions that can be drawn from this study as the results apply to family therapy. The first conclusion is that concept of countertransference, and the experiences it refers to, are significant for the conduct of family therapy. The second is that countertransference reactions can be useful in the conduct of family therapy. And the third is that, because it is

significant and can be useful, the concept of countertransference is applicable to and has a place in the field of family therapy.

### Relationship of the Findings to the Literature

As a demonstration of the linkage that can be made between the previously-cited literature on countertransference and the findings of this research, this section offers two examples. First, a comparison of Geddes' (1990) typology of countertransference with the experiences of the participants is offered. Then, Racker's terms "objective" and "subjective countertransference" are explored in connection with this study's results.

The results of this study show that the participants could sometimes identify those emotional responses that derived from their own personal conflicts, which Geddes calls "classic countertransference." Though none of the participants persisted in acting out their own issues with the clients, they were able to take note of the areas where they felt particularly sensitive to the influence of their personal histories. The participants showed themselves to be in "complementary identification" with clients when they reacted with the same attitude as that held by significant others in the clients' lives, for example, wanting to hurry in and fix things for a helpless-acting client. "Concordant identification" was experienced quite often by the participants, in their feelings of emotional congruence with the experience of the clients. The experience of "indirect countertransference" toward significant but absent others in the client's life occurred occasionally, as for

example when a participant became angry at the client's abandoning parent. None of the clients discussed by the participants had been in the clinic setting long enough for "institutional countertransference" to emerge, that is, a client's special relationship to the clinic itself. When the participants spoke about their own personal equations, they addressed what Geddes calls "stylistic countertransference," those idiosyncratic presentations of self that have an effect on the therapy. Occasionally participants noted that they came to a session feeling unusually tired or under stress, an example of the category Geddes calls "ecological countertransference," which is the effect of daily episodic events in the therapist's life on the therapy.

Though the participants' experiences can be placed after the fact within Geddes' typology, the participants did not themselves distinguish among their emotional responses or try to categorize them, except when they attempted to separate their countertransference responses into those that were "objective," that is, similar to the reaction that almost any therapist would have, and those that were "subjective," that is, reflecting the participant's own personal, meaningful, and usually problematic response. It seemed important to the participants to understand whether their reactions were within some normal or expectable range for therapists, and to pinpoint if and when their reactions went beyond that normal range. Much of the focus group meetings' discussion centered on debating or exploring the intensity of reactions or the notion of "proper" reactions of a

therapist. The idea of calibrating oneself and one's emotional responses as a way of increasing one's sensitivity as a therapeutic tool, mentioned in a previous chapter, was an idea that made sense to the participants, even as they were in the early stages of that process.

The results of this study demonstrate that concepts from the field of psychoanalytic psychotherapy offer ways to understand and make meaningful the emotional experiences of beginning family therapists, and that some of these concepts had practical application to the issues that were important to the participants.

#### Relationship of the Findings to Systems Theory

As the results of the study illustrate, the countertransference experience of these beginning family therapists derived from the interaction of the therapists and their personal equations with the clients, the supervisors, and the milieu of the treatment setting. In no way were the participants unaffected by the process of therapy; rather, they had reactions that were physical, emotional, cognitive, conscious, and unconscious. They received stimuli from internal and external sources, and had to decide on actions that furthered their relational and therapeutic bonds with clients. The meaning that the participants gave to their countertransference was based on their own personal equation, on their understanding of the clients, and on the input from the supervisors. It seems reasonable to say that though the relational ties that make up the therapeutic

relationship are understood and acted upon by the individual therapist, these ties owe their very existence to the systemic interaction of the many actors within and supporting the therapy drama.

The acknowledgement that the therapists are affected by the clients and the therapeutic situation is one conclusion that can be drawn from the results of this study. The results demonstrate clearly that the concept of countertransference refers to a phenomenon that exists within a system and can be used to understand the workings of that system.

### Implications of the Study

The implications drawn from the results of this study apply to all of the various groups interested in promoting knowledge in the field of family therapy, but in particular to teachers and trainers, to supervisors, and to practicing family therapists.

**Teachers and trainers.** The fact that the participants in this study found their countertransference experiences not only interesting but also important implies that teachers and trainers may wish to address this topic in academic courses and training programs. Trainers can anticipate and predict the kinds of themes that may emerge in the emotional responses of their beginning family therapists, as a way of making the training setting a safe context in which the trainees can share their experiences. Teachers can incorporate some of the best relevant countertransference literature into their course requirements (see, for

example, Appendix D). On doing so, teachers and trainers would need to help the students explore the distinctions between the fields of psychoanalytically-oriented and family therapy practice and theory to find the countertransference ideas that fit with the conduct of family therapy and those that do not. The trainers and teachers can rest assured that most students will find focusing on their own personal experience within a meaningful structure to be an interesting exercise.

**Supervisors.** The results of this study show that the participants, as supervisees, were very aware of the interaction of their supervisors as it impacted their emotional responses to the therapeutic encounter. Supervisors may wish to reconsider the level of attention paid to their supervisees' emotional reactions to clients, and to increase the amount of time spent on helping them make sense of and utilize those reactions. Most supervisors are familiar with the dynamics of parallel or isomorphic process in the supervisor-therapist-client relationship. Attention to the countertransference responses of the supervisees may increase the awareness of those processes, both for the supervisor and for the supervisees.

Supervisors may also want to prepare themselves for the emergence of the kind of countertransference reactions found to be themes in the experiences of this study's participants. In addition, they may wish to more often use the emotional responses of the supervisees in reorienting the therapists toward the family process in the session, based on the effectiveness of this technique for the

participants in this study. As with trainers and teachers, supervisors may wish to explore their own knowledge and beliefs about the usefulness of countertransference as a tool in family therapy.

**Family therapy practitioners.** Family therapy practitioners should be the last ones who need to be reminded that the therapeutic encounter affects them in many ways. But given that traditional family therapy training has not often addressed the emotional responses of the therapist, it is entirely possible that many family therapists are not familiar with ways to understand and utilize these responses. One implication of the results of this study is that being able to make meaning of the countertransference experience leads to more informed choices in the conduct of therapy and to better choices to personally manage the emotional upheaval associated with doing therapy. Another implication is that the concept of countertransference is a useful one for family therapists, and that there are fruitful insights to be gained about it from the literature from other mental health fields. One last implication for family therapy clinicians is that they are not isolated in their experience of intense emotions generated by the therapeutic encounter, and that an interest in the countertransference experience is a way to connect with an understanding and supportive network of fellow practitioners.

#### Limitations of the Study

There are a number of limitations of this study. First, the participants were not selected through a random sample. Rather, they were recruited from

among the researcher's colleagues. Second, as behooves an exploratory study, the relatively unstructured nature of the interviews and focus group discussions led to a wide range of information, not all of it relevant to the subject. And third, the concept of countertransference itself and the lack of formal instruction concerning it led the participants to use many metaphorical and imaginative expressions to convey their experience. This colloquial language was vivid, but did not lend itself to precise description in the presentation of the results.

### Recommendations for Further Research

This study has shown that when beginning family therapists are asked to discuss their countertransference experiences, they find the process easy to do, helpful and important to their work, and relevant to family therapy. Just how and when these experiences are useful would be the subject of various paths in future research.

Future research could profitably pursue the question, "Are certain emotional responses of therapists diagnostic of particular chronic family processes?" Such research would parallel that of psychoanalytically-oriented researchers, who find that certain responses of the therapist are predictable with certain types of personalities at certain stages in therapy. Other questions of interest would be, "How does awareness of countertransference occur and how can it be increased?" Such questions might take the researcher into areas of study that address levels and kinds of consciousness. Another question might be asked



about the proper timing, amount, and manner of expressing countertransference material to clients.

It would be profitable to inquire about the countertransference experience of more experienced family therapists, to explore whether the themes that emerge from their descriptions are significantly different, whether the actions taken in response to that countertransference are more effective, and whether countertransference continues to be seen as useful in therapy. Also, inquiring about the opinions and experience of family therapy supervisors concerning the countertransference reactions of their supervisees might yield information that would corroborate or give new perspective to the countertransference experience reported by their family therapy supervisees.

A different line of inquiry would be to assess whether certain personality types of family therapists are more or less likely to utilize countertransference awareness in therapy, and whether personality type is a significant factor in the therapist's personal equation that impacts the kind of meaning attributed to the countertransference reactions. Also, gender differences in countertransference awareness could be investigated for any possible significant differences in types of countertransference, or in methods of countertransference management.

Research that proposes to explore the concept of countertransference and to understand how it operates in a family therapy setting will have many avenues open to it. Understanding the interrelatedness of context, countertransference,

and therapist's personal equation is both complex and fascinating, and as such parallels the daring venture of family therapy itself.

### Summary

This research study was undertaken to develop a description of the countertransference experience of beginning family therapists, on the assumption that countertransference was a useful concept that could be used to understand the emotional responses of family therapists to the therapeutic encounter. The results of the study illustrate in detail not only the experiences of the participants, but also the applicability of the concept of countertransference to their experiences. The implications of the study for the family therapy field are that the concept of countertransference refers to a phenomenon that is an important aspect of the practice of family therapy, that increased interest in and research on the emotional aspects of the family therapist's response to therapy is called for, and that some of the research on countertransference from the psychoanalytic field offers insight and direction that would be profitable for family therapists. By contributing to the resurgence of interest by family therapists in countertransference, this study hopes to add to the creation of a professional context that supports and acknowledges the struggles of family therapists in their work with clients.

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## APPENDIX A

### PARTICIPANT INFORMED CONSENT

Title of the Study: The Countertransference Experience of  
Beginning Family Therapists

**Investigator:**

This study is being conducted by Julia C. Stone, candidate for the Master's degree in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. Her advisor is Dr. Sandra Stith. Julie Stone can be reached at (703) 237-2006.

**Study Purpose and Procedures:**

The purpose of this study is to develop a rich description of the experience of beginning family therapists who are asked to attend to and discuss their experience of countertransference in their clinical work with families. We are interested in the variety of your countertransference experience, in its impact on your work, and in your perceptions and evaluations of its usefulness. Participation in this study will consist of attending a group discussion meeting every four weeks and of being interviewed in depth about two different videotaped therapy sessions with your clients. The researcher will be consulting with her advisor during the process of data collection. Data from the group meetings will not be identified by participant. Review of the videotape interviews with the advisor will produce information identifiable by participant, and therefore your consent, should you wish to give it, will be obtained separately after each interview.

**Potential Benefits and Risks of Participating:**

A potential benefit of participating in this study may be the opportunity to process your clinical work outside of the training situation, and to be exposed to and develop new ideas about family therapy. No guarantee of benefits has been made to encourage you to participate. A potential risk of participating may be a feeling of too much input at a very busy time in your academic career.

**Confidentiality:**

Any oral or written presentations associated with this study will not include your real name, and every effort will be made to eliminate any identifying features from information you provide. All conversations and group discussions will be considered confidential. Your conversations will be audio- or videotaped. These tapes will be reviewed only by the researcher unless you

sign a separate consent statement for that interview. Tapes will be erased after September 1994.

**Freedom to Withdraw:** If at any time you change your mind about participating in the study, you are encouraged to withdraw your consent and to cancel your participation.

**Approval of Research:** This research project has been approved, as required, by the Institutional Review Board for projects involving human subjects at Virginia Polytechnic Institute and State University.

**Permission:** I have read and understand the informed consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

If I participate, I may withdraw at any time.

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Participant's signature	Researcher's signature	Date
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Should I have any questions about this research or its conduct, I will contact:

Julia C. Stone (703) 237-2006  
Researcher

Sandra Stith, Ph.D. (703) 698-6031  
Faculty Advisor

Janet M. Johnson (703) 231-6077  
Chair, Virginia Tech Institutional Review Board

## APPENDIX B

### PARTICIPANT VIDEOTAPE INTERVIEW INFORMED CONSENT

Dated \_\_\_\_\_

**Title of the Study:** The Countertransference Experience of Beginning Family Therapists

**Study Purpose and Procedures:**

The purpose of this study is to describe the experience of beginning family therapists who are asked to attend to and discuss their experience of countertransference in their clinical work with families. As part of this study, you are asked to participate in two in-depth interviews, using your videotaped work with clients as the basis for inquiry. As part of the researcher's data analysis, she will be consulting with her advisor, Sandra Stith, and may present some excerpts from the videotape interviews for her review. Thus, some of your responses and your clinical work may be identifiable by Dr. Stith.

**Investigator:** This study is being conducted by Julia C. Stone, candidate for the Master's degree in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. Her advisor is Dr. Sandra Stith. Julie Stone can be reached at (703) 237-2006.

**Potential Risks and Benefits:** A potential benefit of participating in this study may be the opportunity to process your clinical work outside of the training situation, and to be exposed to and develop new ideas about family therapy. A potential risk of participating may be a feeling of too much input at a very busy time in your academic career. Another potential risk is a feeling of concern in having your work reviewed by the director of your program.

**PERMISSION:** I understand that this informed consent applies only to the interview on the above date. I understand that the researcher may or may not review this interview with her advisor. I give my permission for this interview to be reviewed by the researcher with her advisor.

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
Researcher's signature

\_\_\_\_\_  
Date

Should I have any questions about this research or its conduct, I will contact:

**Julia C. Stone**  
**(703) 237-2006**  
**Researcher**

**Janet M. Johnson**  
**(703) 231-6077**  
**Chair, Virginia Tech Institutional**  
**Review Board**



## **APPENDIX C**

### **FOCUS GROUP MEETINGS**

Meetings are scheduled for after practicum meetings on the following Wednesdays:

September 22, October 20, November 17, December 8

Please help us all go home on time by getting started promptly.

The main focus for the group's discussion will be your experiences from your clinical work. Questions such as the ones below will guide the group's exploration of countertransference experiences.

#### **QUESTIONS:**

Describe the situation in which your strongest (positive or negative) reaction occurred in a therapy session this week:

What was the kind of reaction (emotional, physical, behavioral)?

When and how did you notice your reaction?

What was the source of your reaction (your self, the client, the context)?

Once noticed, what did you do with your reaction?

Did your supervisor have input about the situation?

What did you learn - about yourself?  
- about your client?

What impact did your countertransference reaction have on the therapy?

Any other thoughts, questions, or comments?

#### **OTHER POSSIBLE TOPICS WE MAY GET TO DURING THE SEMESTER:**

Countertransference with individuals versus with families, countertransference related to specific issues and to types of clients, the art of listening, countertransference and therapeutic boundaries.

## APPENDIX D

### RECOMMENDED READING

Handed out:

Casement, P. (1985). On learning from the patient. London: Tavistock Publications. Chapter 1.

Reynolds-Mejia, p., & Levitan, S. (1990). Countertransference issues in the in-home treatment of child sexual abuse. Child Welfare, 69(1), 56-61.

Taffel, R. (1993). In praise of countertransference. Family Therapy Networker, 7(1), 52-57.

Other recommended reading:

Beahrs, J. (1982). Understanding Erickson's approach. In J. K. Zeig (Ed.), Ericksonian approaches to hypnosis and psychotherapy (pp. 58-84). New York: Brunner/Mazel.

Giovacchini, P. (1989). Countertransference triumphs and catastrophes. Northvale, NJ: Jason Aronson, Inc.

Gorkin, M. (1989). The uses of countertransference. Northvale, NJ: Jason Aronson, Inc.

Scharff, J. (1992). Projective and introjective identification and the use of the therapist's self. Northvale, NJ: Jason Aronson, Inc.

## VITA

**Julia Clarke Stone**

### EDUCATION

M.S., 1995, Department of Family and Child Development, Virginia Polytechnic Institute and State University  
Major Area: Marriage and Family Therapy  
Thesis: The Countertransference Experience of Beginning Family Therapists

B.S., 1979, School of Business Administration, George Mason University  
Major Area: Accounting

### OTHER EDUCATION

Graduate studies, Department of Business Administration  
Georgia State University (1980-1981)

Undergraduate studies, School of Language and Linguistics  
Georgetown University (1974-75)

### PROFESSIONAL EXPERIENCE

1994-1995      Mental health therapist intern, Prince William County  
Community Services Board

1991-1993      Family therapist intern, Center for Family Services,  
Virginia Tech, Falls Church, Virginia

1982-1989      Self-employed Certified Public Accountant

1979-1982      Certified Public Accountant, A. M. Pullen & Co.,  
Atlanta, Georgia

**PRESENTATIONS**

"Handling Conflict for Your Child's Benefit"  
Workshop presented at the Falls Church (Episcopal)  
Falls Church, Virginia (March, 1994)

"How Women Become Entrapped in Violent Dating  
Relationships"  
Poster presentation at the National Council on Family  
Relations annual conference, Baltimore, Maryland  
(November, 1993)

*Julia Clarke Stone*  
\_\_\_\_\_  
**Julia Clarke Stone**

*April 25, 1995*  
\_\_\_\_\_  
**Date**