

A Trainee's Guide to Conceptualizing Countertransference in Marriage and Family Therapy Supervision

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Abstract

Countertransference has special significance in the field of marriage and family therapy because there are more points of countertransference activation when working with couple and family relationships than with an individual. While the typical self-awareness portion of graduate studies is important, this article prepares trainees to understand why their openness to working with their countertransference in supervision is critical to their development as a therapist. Through the presentation of a unique model of countertransference interactions, a case example, an exploration of the important role of clinical supervision in effectively addressing countertransference, and examples of how to explore countertransference, this article supports the trainee in learning both how to address countertransference that may inhibit the family's progress and how to enhance clinical results by making effective use of countertransference.

Keywords

countertransference, marriage and family therapy supervision, clinical supervision, supervisee, trainee

Typically, learning to be a marriage and family therapist begins in a classroom setting, which is quite familiar to the trainee, and continues into a lesser-known environment where the trainee conducts therapy with clients under the guidance and review of a clinical supervisor. Under the rubric of self-awareness, graduate students frequently attend in their classroom work to aspects of self-of-therapist that could affect their relationships with clients, for example, sociocultural values, gender, and sexual orientation. Not until they start clinical work, do they have an opportunity to work with countertransference, because it arises only in the interaction with an individual, couple, or family client. The purpose of this article is to help trainees set their expectations for this crucial part of their development, which they can undertake only when working with clients and assisted by the guidance of a supervisor. The article explains countertransference using a model of countertransference interactions, presents a sample case, and offers a practical guide to clinical growth through developing a more nuanced way of understanding countertransference reactions.

The present authors believe that clinical supervision that does not address countertransference will not attend to the full professional development of the trainee. Research points to a relationship between outcome and countertransference management. Hayes, Riker, and Ingram (1997) found poor management of countertransference in cases with poor to moderate outcomes. Gelso and Hayes (2001) found 10 investigations into the effects of countertransference on the outcome of therapy, all of which provided support to the adverse impact of

unmanaged countertransference. Even with a narrow definition of countertransference that implicated only therapists' unresolved conflicts, both practiced and newer therapists frequently exhibited countertransference. In a preliminary study of brief therapy outcomes, Gelso, Latts, Gomez, and Fassinger (2002) found that clients demonstrate more improvement as trainees are better able to manage their countertransference reactions. Through a meta-analytic review of the relationship of countertransference to therapy outcome, Hayes, Gelso, and Hummel (2011) established that countertransference is modestly associated with poorer outcomes in therapy and that effective management of countertransference is associated with fewer countertransference reactions.

Lum (2002) asserted that, while developing one's self-of-therapist, countertransference reactions to the clinical work need close examination (p. 181). Cook and Buirski (1990) found serious neglect of the role of countertransference in the supervision process. Frawley-O'Dea and Sarnat (2001) found

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that focusing on the supervisee's psychology and behavior in supervision allowed for a process that was more experiential than didactic and fostered the supervisee's learning. Thus, leaving these elements out may deprive trainees of knowledge about themselves as therapists-in-training that can speed their growth. Supervisors who have the wisdom, boundaries, and relationship-building skills (Falender & Shafranske, 2004) to help trainees address countertransference can make a greater difference for the trainees and for those they treat than those supervisors who pay attention only to theory, diagnosis, and technique (Aponte et al., 2009; Donnelly & Gosbee, 2009; Lutz & Irizarry, 2009).

Potentially, there is more countertransference in couples or family therapy because the dynamic within the system happens in front of the therapist. In individual therapy, the client instead provides a report on relational systems (Nichols, 1987). Kaslow (2001) asserted that addressing one's countertransference reactions is more complex and difficult when working with couples and families. Countertransference can arise (a) from the therapist's relationship with any individual in the system, (b) in reaction to the dynamics of the system, and (c) because of the culture, values, or other characteristics of the system. Family therapists may find themselves unintentionally mirroring the underlying problematic dynamics of the couple (Taffel, 1993).

Family members will frequently compete for the attention and approval of the therapist (Kaslow, 2001), and the risk of triangulation is always present when working with couples and families. The therapist may attempt to save a family member—or may regard one person as the identified patient who should be the focus of change, in much the same way the family does. The therapist must create an alliance with each family member (Storm, 2007) despite the fact that all the members of the client system observe and respond to the therapist's attitudes and behaviors toward all other members. The therapist's problematic countertransference reactions risk eliciting reactive behaviors from the client family members (Friedlander, Escudero, & Heatherington, 2006).

Countertransference Definition

All therapists, regardless of theoretical orientation, experience countertransference (Pearlman & Saakvitne, 1995). Yet concepts of countertransference vary widely, and there is little agreement in the literature or across theories as to the definition of countertransference (e.g., Dalenberg, 2000; Falender & Shafranske, 2004; Friedman & Gelso, 2000; Gelso & Hayes, 2007; Halperin, 1991; Kahn, 1997; Kiesler, 2001; Pearlman & Saakvitne, 1995; Shafranske & Falender, 2008; Tobin & McCurdy, 2006). Despite the various ideas about countertransference, what matters for trainee development is becoming aware of, analyzing, and putting countertransference to use as well as preventing its possible interference with the therapy.

As an introductory definition for trainees, the present authors endorse the description of Shafranske, Falender, and Daniel (2009) that countertransference is the therapist's reactions to and experiences of the client and concur with Kahn

(1997) that countertransference includes all reactions that the therapist has toward the client family. Countertransference manifests in therapist feelings, attitudes, thoughts, judgments, and behaviors. It manifests during an interaction with the client.

The concept of self-of-therapist describes the therapist's typical attitudes, beliefs, personal history, characteristics, and skills, which therapists take with them wherever they go. Countertransference, however, arises during interaction with the client, be it an individual, couple, or family. Sometimes there is confusion between self-of-therapist and countertransference because an aspect of self-of-therapist can serve as the origin of a countertransference reaction, but the key definitional aspect of countertransference is that it arises through interaction with the client. According to Kaslow (2001), countertransference terminology is often missing from marriage and family theories and literature, resulting in practitioners avoiding the discussion of it or denying its existence. Friedlander, Escudero, and Heatherington (2006) also indicated that few systems theorists acknowledge that family therapy includes countertransference processes. Theorists in family therapy, according to Friedlander et al., have recently begun to move beyond the traditional focus on technique and strategy, as it becomes more widely recognized that the therapist's subjectivity influences the counseling process. Despite all the variation in theorists' denying, accepting, and defining countertransference, Gelso and Hayes (2007) asserted that because emotional reactions are elicited in the therapist regardless of theoretical orientation, countertransference is a ubiquitous construct in psychotherapy.

Model: Countertransference Interactions

The interactional model of countertransference shown in Figure 1 differentiates among countertransference interactions in order to provide a language for discussing countertransference and to help trainees clarify what they are experiencing with their clients. The key distinctions in the model are (a) whether the client or the therapist is the origin of the countertransference reaction and (b) whether or not those reactions are problematic to the therapy. The model includes nonproblematic interactions to help the trainee identify and remain open to whatever reaction to the client occurs. In addition, the model recognizes the critical importance of supervision for integrating or transforming the countertransference in order to make it useful to the therapy. Unlike the Johari Window (Luft, 1969), which is sometimes used in supervision to understand the communication process in terms of what is known and unknown to the participants, the interactional model of countertransference supports clearer understanding of therapeutic possibilities and hindrances due to reactions and interactions which need to be known by the therapist (and the supervisor regarding the therapist).

Client or Therapist

The distinction in the interactional model of countertransference between client and therapist is whether the therapist's

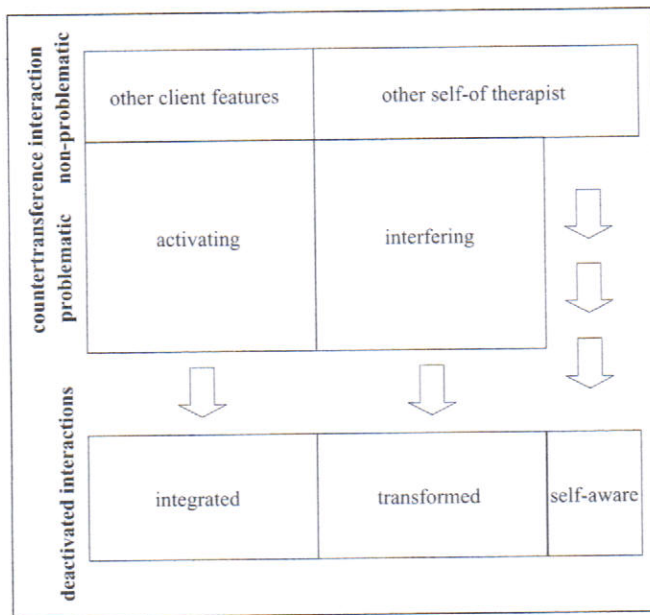


Figure 1. Countertransference interactions.

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countertransference reaction is to client material or the therapist's own material. The origin of the therapist's reaction is not limited to an unresolved or maladaptive personality feature of the client or the therapist, nor is it necessarily a persistent characteristic of either of them. For instance, cultural or value differences between the trainee and the client family can trigger a countertransference interaction. While the model shows different categories for client and therapist material, sometimes a countertransference reaction will include origins in both the client and the therapist.

Critical to understanding countertransference is to focus on its interpersonal nature. It is an artifact of the relationship, its dynamics, and interplay (Kaslow, 2001). Shafranske and Falender (2008) noted that the client and therapist each contribute to shape the response of the other and that the reaction of each of them is a result of the interaction between them. In effect, countertransference is something about the interaction that emerges in the therapist and has the potential to deleteriously impact the therapeutic work.

Countertransference Interactions—Problematic

The interactional model of countertransference places emphasis on whether the reaction in the trainee is problematic to the therapy. In the case of activating countertransference, the therapist's reaction has its origin in an aspect of the client. Conversely, in the case of interfering countertransference, the therapist's reactions are due to his or her own psychological material.

Activating. Activating countertransference is a reaction in the therapist (attitudes, feelings, or behaviors) that arises from the client's material and is a problem for the therapy. The client's

transference may be the origin of these reactions, but this category includes other possibilities such as the client's individual pathology, interpersonal style, and interfamilial relationships within a family system. Clients with particular diagnoses can evoke responses that are typical to many therapists. The therapist may experience the client the same way others experience him or her and reacts to the client similarly to others' reactions (Kiesler, 2001; Yalom, 2003). A family may have expectations for therapist roles in order to serve family patterns of need and relationship, or a member may present patterns of behavior toward the therapist that are similar to those toward other family members, including such dynamics as enmeshment or triangulation (Halperin, 1991).

As an example of activating countertransference, a client family of adults is dealing with changing roles and boundaries due to the father's dementia and the mounting pressures of caregiving. The therapist notices a reaction of horror when the second older child engages in discussion with the mother and the eldest child. Her reaction leads her to the realization that the second child is sowing dissension between the other two, even though the behavior is subtle and covert.

Interfering. In the instance of interfering countertransference, the therapist's unresolved psychological material results in a countertransference reaction to the client that is problematic to the therapy. Therapists may be triggered around a relationship similar to a previous one in their own lives (Kaslow, 2001), including triangulation with some client family members due to a family system similar to their own. When the family dynamics are present in the therapy room, novice therapists, especially, may be unaware that the family or the couple has touched their own unresolved family of origin issues (Aponte, 1994; Halperin, 1991; Harber & Hawley, 2004; Kane, 1995; Kaslow, 2001; Shafranske & Falender, 2008; Timm & Blow, 1999). A therapist's problematic family of origin can stimulate a desire to fix the family or may cause the trainee to overidentify with one family member and ignore another.

For example, a client reports her single mother died when she was 10. After the session, the therapist notices that he cannot let go of his sadness that the young client had nowhere to turn. At the beginning of the second session, the therapist provides the client a book on attachment theory instead of leading the client to explore her emotional response to the death. Later the therapist realizes the client touched his own experience of having an emotionally withdrawn mother, which had left him feeling motherless.

In marriage and family therapy (MFT), interfering countertransference may have its origin in trainee's self-of-therapist, such as values, beliefs, thoughts on gender roles and relationship equality, the meaning of commitment/marriage, same-sex couples, and cultural ideas of relationship (Storm, 2007). Those trainees whose anxiety arises in the interaction with the client may insert their own agenda for the client's behavior or actions, to the detriment of the family freely expressing itself (Cross & Papadopoulos, 1999). They are likely engaged in interfering countertransference.

Both Activating and Interfering. One of the complexities of countertransference reactions is that they can have an origin in both the client and the therapist. An example is when a client raises his voice because of feeling discounted by the therapist, with an origin in his childhood neglect, and the therapist reacts by feeling fearful and guilty, due to her childhood experience of a raging father who frequently blamed her for his rage. How much of the reaction is due to which origin is not as important as recognizing that the countertransference points to material belonging to each of them, as both the activating and the interfering countertransference have the potential to be dealt with to the client's benefit.

For example, a husband and wife frequently move into loud arguments. When the therapist tries to contain the emotion, the wife increases her attacks, and the therapist notices himself becoming progressively quieter and feeling inadequate. The therapist concludes that part of his response may be a symptomatic characteristic of the wife in relationships and begins to look for the impact on the patterns in the relationship. At the same time, the therapist explores his own feelings of inadequacy to determine if some unresolved issue of his own has potential to interfere with the therapy, although it is possible the reaction only mirrors how others typically respond to the wife. This example points to the importance of clearly interpreting a countertransference interaction.

Countertransference Interactions—Nonproblematic

Some therapist reactions do not create problems in the therapy. Self-awareness can be the foundation for avoiding unintended behaviors toward the client. For trainees, the key element of nonproblematic countertransference is to be certain the reaction does not produce an interfering behavior of which the trainee is unaware, thereby becoming a problematic countertransference. For instance, a trainee may not recognize that he is more careful to listen to a Black member of the clergy than to her White husband. Until listening to the tape in supervision, the trainee thinks he is attending well to a possible racial bias (which would keep it nonproblematic), when he is actually privileging the wife's status in the spiritual realm. He is unaware that he has an interfering countertransference interaction. Clinical supervision plays a key role in raising the trainee's awareness of the impact his subjective reactions have on the encounter with the client family.

Other Client Features. A therapist may have a response to features of the client that is not problematic to the therapy. It is useful for trainees to be aware of their differences from the client in a variety of domains and notice any reactions to those differences. Important considerations are ways in which the clients' family values, sociocultural differences, sexual preferences, gender roles, spirituality, interpersonal style, lifestyle choices, or other characteristics differ from that of the trainee's. For example, a client may be an athlete who is strong in physical presence and in her presentation of herself, both with the trainee and with her partner. The male trainee notes this, but currently finds no reason

to assess her physical strength as activating, nor his response as interfering; therefore, it is nonproblematic and only a client characteristic. Consultation with his supervisor will help him assure that he is correct.

Other Self-of-Therapist. Sometimes therapists react to clients out of some aspect of themselves, without the reaction being problematic. For example, a trainee sees a couple, one of whom has the same life issue as her own husband does, but her self-awareness and consultation with her supervisor help her realize that she has strong enough differentiation from both clients to avoid bias in her relationship with them. Her identity in her own primary relationship does not affect her perception of the couple. There was countertransference, since she reacted to the similarity, but her reaction did not interfere with the therapy.

Deactivated Interactions

The arrows in Figure 1 represent the therapist's/trainee's understanding and making use of countertransference, resulting in enhanced therapeutic benefit to the client. Key elements of the trainee's ability to utilize countertransference will develop in supervision. Therefore, the arrows represent not only the integration or transformation of the countertransference but also the countertransference work the trainee undertakes during supervision.

Integrated. Therapists who successfully manage their countertransference responses to the client's activating behaviors are in a position to provide therapeutic interventions that integrate the client-based origins of the countertransference into the client's therapy. Through deeper self-awareness developed during supervision and a more nuanced way of intervening with the client, the trainee feels freer (a) to speak explicitly about the client's interpersonal behaviors, (b) to draw the client's attention and curiosity to explore how the behavior functions for the client, and (c) to process the unresolved emotional root of the triggering behavior. For example, a supervisor and trainee listen to a recording in which the trainee's voice becomes sharp, and the trainee realizes she is impatient with the client continually changing the topic away from his mother. The trainee integrates the countertransference into the therapy by asking the client about his avoidance.

Transformed. Therapists who successfully deal with their own interfering material can transform their reactions to the client. By using supervision to help decathect the emotional response to the troubling material, they are able to develop clearer insights into sources of client behaviors and deeper empathy with client dilemmas and affect. By transforming their own material through addressing it with a supervisor, trainees can deactivate it and listen to clients from an unbiased stance.

For example, a supervisor asks a trainee to describe the father in a family he sees. The trainee tells her the father is a nice man and that he approves of the father's decision to participate in therapy. The supervisor observes that the trainee

neither challenges the father's disengagement nor draws the family's attention to the father's dismissiveness of the child's emotions. The trainee realizes that his own loud and victimizing father led to his misperception of the client–father's behavior; therefore, he is able to incorporate his better insight of the system's dynamics into the therapy as well as increase his empathy for the child whose emotions the father dismissed.

Self-Aware. According to Aponte and Carlsen (2009), attending to issues in MFT supervision that involve personal reactions requires a self-exploratory process in which supervisees uncover and recognize psychological, relational, spiritual, and cultural issues they bring to the work with clients. Graduate schools prepare trainees to be aware of aspects of self that have the potential for future problematic interactions with clients, although frequently without referring to it as countertransference. The self-awareness becomes a key component of trainee development in that it alerts the trainee to the potential for problematic countertransference. For example, an agnostic trainee may have explored his possible reaction to clients with a strong religious belief. In a session, he notices the client often refers to her Christianity in her therapy. His self-awareness helps him remain alert to the potential for problematic countertransference that may arise from their difference, and the difference does not interfere with the therapy. Trainees' awareness of themselves can deepen during supervision, especially when the work with clients triggers unexpected reactions or touches deeper material within the trainee.

A Case

The following case provides examples to further define the terms in the model:

Justin, a trainee, receives an email from his bank that his account is overdrawn, and he is worried about getting a service charge. Sam and Sally, who are married, present for their couples session. Justin successfully puts the overdraft out of his mind, despite the couple's initial low level of engagement with him and each other. He is able to stay focused because of his experience as a child helping his dad when his father was upset. The couple came to therapy because Sally had an affair. Justin presented the case for supervision because Sally is charming, and he is afraid he aligns more with her.

When the supervisor views the tape, she notices that Justin uses psychoeducation and problem solving; he avoids exploring Sam's emotions about the affair. In working with the supervisor, Justin discovers he did not explore more deeply because his own mother had an affair, and his father would cry and rely on him for advice about what to do, which resulted in Justin feeling special. Upon reflection, he realizes it was overwhelming for him during childhood because he did not know what to do. He is afraid that Sam will become too upset, as his father did. The supervisor hears Justin as more aligned with the husband, even though he worried he was more aligned with the wife.

From Activating to Integrated. Perhaps Justin's focus on Sally's charm and his sense of greater alignment with her replicate Sally's way of being with men outside the therapy room. If this is the case, Justin's fear of being more aligned with her is useful information to prompt him to help Sally explore her interpersonal style with men and to help the couple explore the effect on their system. In doing so, he integrates his countertransference into the therapy.

From Interfering to Transformed. Since Justin has a fear of exploring Sam's affect more deeply, the countertransference interferes with the therapeutic process. Justin's concern is that Sam will flood with emotion, thereby overwhelming the trainee in a manner similar to how, with his own father, he did not know what to do. This restricts the client's opportunity to explore his emotion more deeply. After realizing that his own childhood history is the origin of his countertransference, Justin transforms the countertransference into a greater understanding of Sam's need to be heard about the affair, which provides enhanced empathy and an ability to listen without emotionally withdrawing.

Other Client Features. The case demonstrates Justin noticing Sally's charm and worrying about his alignment with her because of it. The supervisor's assessment is that Justin aligns more with Sam. Therefore, Sally's charm may not be activating but instead just be a client characteristic, which would not need integration into the therapy.

Other Self-of-Therapist. Justin is aware of the potential for distraction from his bank overdraft, but keeps it in check because he is aware that his worry outside the session might lead to an interfering countertransference in-session. He is able to focus on the couple. In this case, his potential countertransference is only another feature of his self-of-therapist.

Necessity of Addressing Countertransference in MFT Supervision

Clinical supervision is the primary way in which students learn the practice of psychotherapy (Ladany, Walker, Pate-Carolan, & Evans, 2008). Working with countertransference in supervision is critical to the trainee's clinical development. "Our attunement to our countertransference requires the same evenly hovering attention with which we listen to our clients' material" (Pearlman & Saakvitne, 1995, p. 23). Trainees learn in supervision how to provide that attention to their own experiences in the clinical encounter and over time will discover how to pick up on their own patterns and reflect on possible countertransference utilization. They will frequently require supervisory assistance to recognize that a subtle countertransference reaction is happening, to interpret what is happening, and to decide what to do about it or how to use it.

Supervision is the critical element in transforming countertransference from potentially problematic to therapeutically useful. Supervised client work is an opportunity for student

therapists to learn to appreciate how countertransference reactions can inform the understanding of clients and influence the clinical encounter (Shafranske, Falender, & Daniel, 2009). Trainees develop sensitivities and tools for identification, analysis, and self-reflection as well as initiate a career-long appreciation for the need to continuously reflect on the therapeutic process and one's experience of it (La Torre, 2005).

Trust and belief in the supervisor's positive intentions are paramount, as supervisees begin to explore personal reactions that emerge in their work with clients (Gauthier, 1984). While the supervisor will work to cultivate the trust required for exploring vulnerabilities, the supervisee needs to understand the supervisor's intent and rationale (Agass, 2002). Therefore, supervisors should directly address the importance of countertransference constructs early in the supervisory relationship in order to normalize their existence (Pearlman & Saakvitne, 1995) and to decrease the likelihood that trainees will be surprised when these issues emerge in their clinical work. Worthen and McNeill (1996) reported that supervisees described ideal supervision as conveying an attitude of empathy, acceptance, validation, and encouragement to experiment. Skovholt (2001) pointed out that once trainees understand that they can bring their full selves to the supervision hour, they are then better able to sit with clients and allow themselves to be fully present during the therapy hour.

The trainee's developmental process includes moving from being unaware of countertransference and worrying about its part in negative supervisor judgments and self-judgments to making countertransference one more tool of therapy. Trainees' development often includes their newfound belief in the critical importance of exploring their own vulnerability (Scharff & Scharff, 1987, as cited in Halperin, 1991). Supervisors recognize what Skovholt (2001) described as supervisees' great need for support, empathy, encouragement, presence, exploration, and validation.

Approaches and Examples for Using the Interactive Countertransference Model

Trainees develop their awareness and use of countertransference working through a three-step process: recognizing the countertransference, analyzing the countertransference, and capturing the benefit of countertransference. As development proceeds, trainees may come to appreciate the complexity of these interactions between clients and therapists. In addition, they may understand the hidden nature of some reactions and experience the normal confusions between activating and interfering countertransference that stand in the way of beneficial use.

Recognizing Countertransference. The present authors include in the definition of countertransference all reactions, feelings, and attitudes, in order that trainees do not discount *whatever* may emerge in reaction to the client. Given the complexity of interactions in family therapy, it is not realistic to expect trainees to be fully aware of how they respond emotionally to the family (Aponte, 1994) or to recognize every countertransference event. Use of observational tools, such as audio or video

recordings or live supervision, will help supervisors guide trainees to recognize their own reactions (Ashurst, 1993; Aveline, 1992; Halperin, 1991; Ladany et al., 2008). In particular, recordings can provide a common reference point in discussions about countertransference reactions. Reliance upon self-report and case consultation risks missing key countertransference issues that may be present (Reese et al., 2009).

Trainees' anxiety inherently limits their ability to accurately identify personal issues that may be impacting the counseling process (Kaslow, 2001; Talbot, 1995). For example, a supervisee might seek pragmatic ideas from the supervisor on how to help alleviate the pain that the client is suffering. Listening to a recording, the supervisor may instead focus on the trainee's urgency to rush in and assuage the pain rather than helping the client family explore their distress more completely.

To assist in identifying countertransference, supervisors may look for places where trainees lose empathic attunement with the family or where trainees struggle with basic skills for which they have previously demonstrated mastery (e.g., paraphrasing and reframing). Kiesler (2001) referenced the need to attend to ways of experiencing or interacting with a client that diverges from what is typical for the therapist. Shafranske et al. (2009) emphasized the importance of therapists harvesting unique or unusual reactions to the clinical encounter. Halperin (1991) suggested recognizing clues by the intensity of the trainee's feelings, by trainee behavior that is not typical, and by the trainee feeling guilty or vulnerable. Satir (1987) described other possibilities, such as the trainee protecting, rejecting, or taking sides with the client. Therapists also might feel disguised shame. Shame can remain hidden from awareness in a number of ways, including grandiosity, compulsive self-reliance, hostility, and boredom (Talbot, 1995). Falender and Shafranske (2004) highlighted another possible clue: unintended self-disclosure or giving opinions and advice. Examples of other clues trainees can use to begin managing countertransference and recognize an event include catching themselves (a) changing the topic, (b) being less or more active and directive than usual, (c) self-disclosing without a therapeutic reason, (d) providing the family with the theory of the intervention the therapist is using, (e) feeling bored or distracted or disengaged, (f) giving selective attention to certain family members, (g) colluding with the family, (h) telling the client what to do, (i) talking too much, or (j) interrupting too often.

Analyzing the Countertransference Interaction. As the trainee and supervisor identify countertransference reactions, they will move to the second step, analyzing the countertransference, in order to help trainees understand the countertransference interaction, so that they do not collude with the client in unknowingly repeating the client's life experience (Agass, 2002). They will analyze the level of the trainee's emotional arousal and the context of the reaction. "The supervisor explores the enactment of the countertransference and provides the supervisee structure to elaborate, understand the dynamic, and respond in the clinical session to the stimuli that provoked

the disproportionate reaction in the student-trainee” (Falender & Shafranske, 2008, p. 12).

Trainees frequently benefit from a process of analyzing three concepts related to countertransference: trigger, origin, and impact. For example, a therapist may yawn frequently with a client whose flat affect may be due to medication or a reluctance to engage in the therapeutic process (Kahn, 1997). The yawn is the countertransference reaction. The flat affect is the trigger. The client’s medication or reluctance is the origin. The impact is how the client interprets the therapist’s yawns and how the therapeutic relationship or process is affected.

- *Trigger.* The trigger is frequently the answer to the question: What happened just before I reacted? In the case mentioned earlier, Sally’s charm and her affair as well as Sam’s reactions to the affair are triggers. The trainee and supervisor can start with the clues of countertransference and work back to the question of the trigger for each reaction. The exploration of triggers includes looking at both the content and the process of the work.
- *Origin.* The origin of the countertransference is the answer to the question: Is this my material or the client’s? The origin, in terms of the model, may be activating or interfering or a complex combination of both. In the case, Justin’s reaction to Sally’s affair has an (interfering) origin in his own father’s response to his mother’s affair. Sally’s interpersonal style with men is a possible (activating) origin of Justin’s sense of greater alignment with her.

As for activating countertransference, “What is it that the family is trying to ‘tell’ the therapist about itself and the way members experience each other?” (Halperin, 1991, p. 138). Almost any feature of the family’s system or the individuals’ maladaptation may be the origin of activating countertransference. The trigger creates a reaction in the therapist to material that belongs to the client.

As for interfering countertransference, an appropriate question is as follows: What is going on with me? Some countertransference reactions could be from “emotional wounds, conflicts, and what may be referred to as sore points to which the therapist has not found an internal solution . . . Even when an emotional conflict is mostly resolved, it may be activated in the treatment hour” (Gelso & Hayes, 2007, p. 130). Often with countertransference reactions, the initial internal response of the therapist is to assume the event is about the client (Shafranske & Falender, 2008). Trainees who do not understand their own part risk misattributing the origin to the client and therefore misinterpreting the interaction and interfering with the therapy. An example is the way some therapists excuse themselves from further investigation of the clinical experience by summing up the event as client resistance. Satir (1987) warned that therapists may be tempted to blame the client when they feel stuck due to their countertransference.

- *Impact.* The impact of the countertransference, if it is not contained, would be the answer to questions such as: What happened next? What did the therapist do because

of the countertransference reaction? What might the client have taken from the therapist’s reaction? What did an individual do, or how did the family dynamics shift? What was useful to the therapy? What was harmful? In the case, Justin misread his alignment with Sally and Sam due to Sally’s activating countertransference; he also became cautious about exploring Sam’s affect because of his interfering family-of-origin countertransference. It will be important to look at how these countertransference reactions impact the counseling process (Kaslow, 2001) because countertransference can be either hard to recognize or hard to ignore, as well as hard to interpret (Agass, 2002).

Countertransference interactions require more insight into the therapist’s typical ways of interacting with others, sensitivities to others, and nonintegrated material than simply being aware of differences and biases. These reactions can require the supervisee’s increased understanding of his or her own psychology, in order to discover the signature themes (Aponte & Carlsen, 2009) of interfering countertransference reactions that repeat across clients. Robbins and Jolkovski (1987) suggested that training counselors to effectively manage countertransference necessitates identifying, attending to, and giving meaning to internal states.

Capturing the Benefit. Another challenge for new therapists, beyond analyzing the countertransference interaction, is to determine how to make use of their reactions in beneficial ways while guarding against actions that may impede the therapy.

- *Examples of Beneficial Effects.* According to Gelso and Hayes (2001), effective management of countertransference reactions can enhance therapy outcomes, while unmanaged reactions can have a deleterious impact on therapy or risk bringing it to a halt. Kahn (1997) stated that “the purpose of increasing one’s awareness of countertransference forces is not to eliminate countertransference, [which] . . . would be like trying to eliminate the unconscious. It can’t be done, nor should it be, since countertransference is the source of empathy” (p. 144). Instead of trying to get rid of it, he said that therapists should intend to shorten the time it takes to realize something is happening. Then the therapist can utilize it through integrating or transforming the reaction. The results are to avoid adverse effects on the clinical encounter and to capture the hidden benefits of understanding the reaction. Agass (2002) stated that regardless of one’s willingness to acknowledge it, countertransference is a cornerstone of the therapy process. The moment-to-moment feelings that arise in the therapist during the session are useful to further the therapeutic experience (Shafranske & Falender, 2008).

When the therapist’s activating countertransference picks up on the interpersonal patterns of the client, the therapist is more informed. This tool greatly benefits the therapeutic work

and is important to “further understanding of the patient, the patient’s impact on others, and hidden parts of the patient’s internal world . . . What the therapist feels at a given moment may well reveal what the patient is pulling for” (Shafranske & Falender, 2008, p. 7).

When working with families, therapists can develop detailed information about the system through awareness of internal reactions that emerge when engaging the client family and how these mirror parts of the therapist’s past and present self (Wallerstein, 1997). Thus, trainees, as they grow in experience, come to read their countertransference reactions to clients. These reactions become a means of interpreting the client’s needs, understanding the system rules and boundaries, or beginning a clinical diagnosis. Other examples of the results of attending to countertransference include (a) gaining new insights to the family and its members, dynamics, rules, boundaries, or interpretations of each other’s pathology; (b) finding new possibilities for interacting with the client; (c) using therapist feelings and reactions to develop, maintain, deepen, and monitor the alliance; (d) overcoming personal values or rigidities; and (e) reframing therapists’ vulnerabilities into deeper empathy.

- *Examples of Adverse Effects.* Because countertransference frequently intensifies the therapist’s reactivity, it can result in unintended responses and behaviors that can diminish the therapeutic alliance or put the treatment outcome at risk (Shafranske & Falender, 2008). A risk with activating countertransference is that the trainee recreates what is present in the client’s interpersonal world. For instance, if a client with a submissive posture invites the therapist to dominate, such a reaction by the therapist would limit the client’s ability to behave differently. If the therapist’s countertransference reaction to a controlling client is to feel hurt or disempowered (Pearlman & Saakvitne, 1995), the trainee may move to exercise more control, with a potential result of escalating the client’s behaviors.

A therapist might attend to his or her own arena rather than the client’s (Kahn, 1997). For example, a therapist may experience fear or a sense of incompetence when the client shares information previously withheld. A therapist acting out the countertransference might emphasize to the client why it is important to share all relevant information, instead of bringing the client to explore the content of the hidden material, the processes of why it needed to be hidden, and why the client shared it at the time it was revealed. The therapist may meet his or her own needs (Kahn, 1997), either vicariously or directly. For instance, a therapist might work too hard at making sure the client understands correctly the points he or she makes, in an attempt at self-gratification. The therapist may subtly provide cues that the client reads as expectations (Kahn, 1997). The cues can be as inadvertent as shifting in the chair, a movement of the eyes, or a sigh. The therapeutic risk is that the client may react out of fear of therapist judgment or lose engagement in the therapy by opposing or trying to please the therapist.

Countertransference may prompt the therapist to intervene in a way that circumvents the client’s interest (Kahn, 1997). For example, a client who has not found the motivation to initiate change, even in an area she or he has described as important, may induce the therapist to identify a step-by-step plan of action instead of having the client determine what to do. The result may be either to develop client dependency on the therapist for guidance or to evoke the client’s shame for not doing what he or she thinks is important to the therapist.

Finally, the therapist may unwittingly acquiesce to the unspoken expectations of the client’s transference (Kahn, 1997), which would be an activating countertransference. For instance, if the client’s unconscious wishes manifest in relating to the therapist as a mother figure and the therapist starts attending to the client in a maternal way, compromise of the counseling process may follow. If this dynamic remains out of the counselor’s awareness, a therapeutic impasse is the likely result.

The Reward of Working With Countertransference. Examining the ways countertransference affects the clients’ therapy requires trainees to be open to and examine the vulnerabilities inherent in their own history and psychology (Dalenberg, 2000; Falender & Shafranske, 2004; Gelso & Hayes, 2007). These are courageous undertakings that may be new to the trainee. The ultimate goal is for trainees to use self-awareness in a positive way that enhances the clinical moment (Aponte & Carlsen, 2009).

Engaging in countertransference work with a supervisor may leave the trainee feeling invaded, afraid, leery, and overwhelmed—but also stimulated, intrigued, and rewarded. Once trainees understand the value of countertransference to their clients’ therapy and to their own growth, they may welcome and feel invigorated by how their own developmental process benefits client families. Searching out and openly discussing with their supervisors their countertransference events and patterns will help them grow into effective partners with their client families (Gelso & Hayes, 2001, 2007). They will be prepared to notice their reactions, identify triggers, reflect on origins, as well as analyze and manage the impact of their countertransference interactions.

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