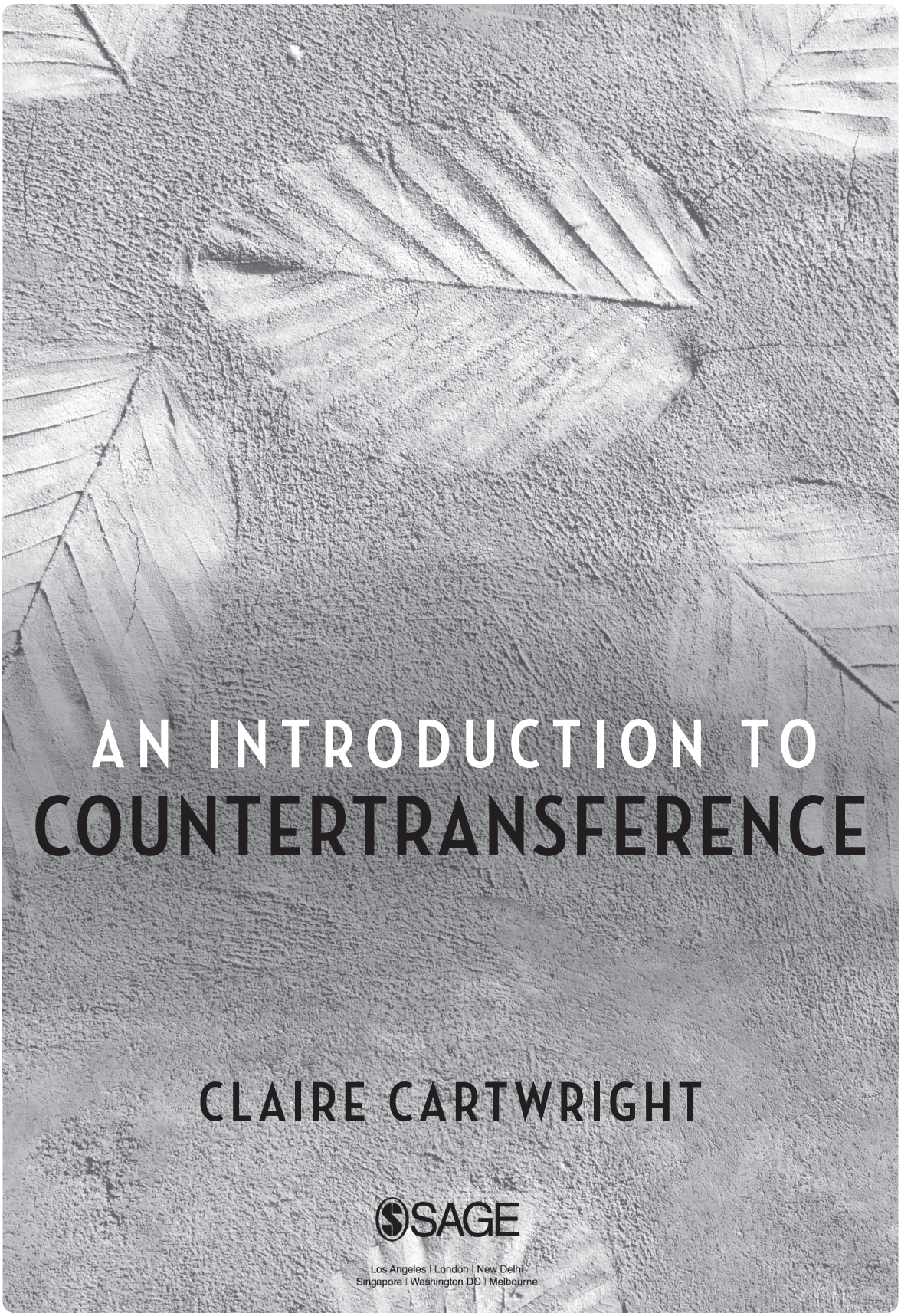

AN INTRODUCTION TO COUNTERTRANSFERENCE

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About the Author

Claire Cartwright is a clinical psychologist, an Associate Professor of Clinical Psychology at the University of Auckland, and a Fellow of the New Zealand College of Clinical Psychologists. Dr Cartwright initially trained in cognitive-behavioural and psychodynamic therapy approaches. Early on in her teaching of trainee therapists, Dr Cartwright observed that trainees often experience difficulty recognising, understanding, and managing countertransference reactions. She began experimenting with ways to make countertransference theory and practice accessible to trainees and therapists from a range of therapeutic approaches. This began the development of the approach to countertransference that she introduces in this book. For the last fifteen years, Dr Cartwright's primary teaching and research focus has been on countertransference. Along with colleagues, she has conducted and published research into teaching and learning about countertransference. She has presented her research at several international conferences and offered training workshops for mental health professionals in understanding and managing countertransference therapeutically.

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Countertransference and the Therapeutic Relationship

This chapter considers the therapeutic relationship and its components – the real relationship, the working alliance, and the transference–countertransference relationship – and the influence that countertransference has on the therapeutic relationship. In order to assist therapists to be mindful and to recognise their own subjective responses to clients, it briefly examines the types of countertransference reactions that therapists and trainees experience in their therapeutic work, and the types of reactions that experienced therapists/supervisors view as characteristic of countertransference. The chapter then discusses different aspects of countertransference – positive and negative countertransference, and subjective and objective countertransference. We then turn to the question of cultural countertransference that arises in cross-cultural therapeutic relationships in which therapist and client are of different cultural background. The chapter ends with a brief discussion of the relationship between countertransference and professional and ethical issues.

The real relationship, the therapeutic alliance, and the transference–countertransference relationship

Gelso and Carter (1985) were the first to offer a definition of the therapeutic relationship as 'the feelings and attitudes that (therapist and client) have toward one another, and the manner in which these are expressed' (p. 159). A tripartite model of the therapeutic relationship has developed over recent decades (Gelso,

2014). According to this model, the therapeutic relationship can be viewed as having three components – a real relationship, a working or therapeutic alliance, and the transference and countertransference relationship. At any moment in a therapy session, one component may be more salient than the other two components and the salience of the different components will shift within therapy sessions and across time. Each component influences the other components. For example, therapeutic disruptions related to transference and/or countertransference issues that emerge in a therapy session, or across a series of therapy sessions, are likely to impact the therapeutic alliance and the therapist and client's abilities to work collaboratively together.

The real relationship

The term real relationship is most often used to refer to the personal relationship that develops between the therapist and client, which is genuine and contains realistic perceptions and experiences of the other (Gelso, 2014; Greenson & Wexler, 1969). This real relationship can also be thought of as providing the foundations for the therapeutic relationship (Gelso, 2014).

Pause and reflect: Carl and Jack

Thinking back on Carl (therapist) and Jack (client), can you see any evidence of a 'real' relationship between the two? And if so, what is the quality of this 'real' relationship?

The working alliance

The therapeutic or working alliance has been the focus of much research over the recent decades. In 1979, Bordin proposed that a strong working alliance is characterised by three conditions – a working bond between therapist and client, agreement on the goals of therapy, and agreement on the tasks that will be undertaken to reach these goals. A number of meta-analytic reviews of studies have examined the relationship between the working alliance and therapy outcomes (e.g., Flückiger, Del Re, Wampold, & Horvath, 2018; Martin, Garske, & Davis, 2000) and found a robust and positive relationship, which is consistent across outcomes measures, assessors, treatment approaches, and countries.

The transference–countertransference relationship

The third component of the therapeutic relationship is the transference and countertransference relationship or configuration (Gelso, 2014). Research into

the working alliance has been much more extensive than research into countertransference and its association with therapy outcomes. However, there have now been two meta-analytic studies of countertransference (Hayes, Gelso, & Hummel, 2011; Hayes et al., 2018). In the most recent meta-analysis, the researchers reviewed all studies that had examined the relationship between CT reactions or CT management and therapy outcomes. They found that the majority of these studies looked at what they referred to as immediate or proximate therapy outcomes rather than distal outcomes (Hayes et al., 2018). They reported on three analyses. The first analysis examined results from 14 studies and found an association between more frequent CT reactions and poorer therapy outcomes. While the association was relatively small, it was reliable across the studies. The second analysis of 13 studies found that better CT management was associated with fewer CT reactions. The third analysis included nine studies that had examined the relationship between CT management and therapy outcomes. The effect size was significant and of a large–medium effect size. Hence, the results suggest that CT reactions can have negative impacts on therapy outcomes and alternatively managing CT can have positive effects on therapy outcomes. These meta-analytic results support the views of psychodynamic therapists who have for many years argued that countertransference can have negative effects on the therapeutic relationship and therapy outcomes, while understanding and managing countertransference can enhance therapeutic relationships and outcomes.

Types of countertransference reactions

Countertransference manifests in feelings, thoughts and imagery, physiological or bodily reactions, and in urges and behaviours. A qualitative study conducted by colleagues and myself with 65 Australian and New Zealand clinical psychology trainees found that the trainees described a range of countertransference reactions in their client work (Cartwright et al., 2014). Trainees were asked to write about a recent countertransference reaction and to provide context in terms of what was happening in the session and how the client was responding to them or the therapy situation. Trainees reported six main types of countertransference reactions:

1. Wanting to protect or take care of
2. Empathising and identifying with the client
3. Feeling controlled, intimidated, or criticised
4. Feeling helpless or inadequate
5. Feeling overwhelmed, out of control, or immobilised
6. Feeling disengaged

The most common type of reaction described by trainees was *Wanting to protect or take care of* the client with whom they were working. Trainees described feelings of sadness, concern, or worry about a client and a desire to protect or

take care of them. These reactions were often triggered by witnessing the client's distress or by hearing about the difficult or traumatic events or relationships they had experienced. Sometimes trainees reflected that they had engaged in countertransference behaviours, such as trying to 'fix' the client, or by rescuing the client by not challenging or extending the client in sessions.

The second theme was *Empathising and identifying with the client* (Cartwright et al., 2014). Trainees who described this type of countertransference reaction reported strong empathic responses to clients and found themselves identifying with the client. These reactions included strong feelings of sadness for clients who experienced significant loss, or identifying with a client's problems or concerns (such as worries about weight or appearance). On a small number of occasions, trainees felt it was hard to separate out what was theirs and what were the clients' feelings and concerns. At times this led to countertransference behaviours, for example, one trainee wrote that she realised later that she did not complete a full assessment with her client because she identified with the client's problems and normalised or minimised them internally.

The third type of countertransference reactions was titled *Feeling controlled, intimidated or criticised* (Cartwright et al., 2014). Trainees appeared to experience this reaction to clients who were being controlling or acting in critical or superior ways towards them. Trainees who described this type of countertransference reaction saw themselves as inadequate as therapists and sometimes dreaded sessions.

The fourth type of reaction was *Feeling helpless or inadequate* and this tended to occur with clients who were not progressing or who had difficulty setting goals or working towards them – clients who themselves may have been struggling with feelings of helplessness (Cartwright et al., 2014). These trainees also felt inadequate as therapists and tended to blame themselves for the client's lack of progress. Some thought these feelings of helplessness or inadequacy undermined their effectiveness with the clients.

A fifth type of reaction included *Feeling overwhelmed, out of control, or immobilised* and these reactions appeared to be in response to clients who were emotionally distressed, describing strong emotional states including anger, or had multiple problems that felt overwhelming to both the therapist and client (Cartwright et al., 2014).

In the final theme, *Feeling disengaged*, trainees described having difficulty connecting to or feeling disengaged from clients who appeared to be intellectualising or who were themselves lacking in emotional expression (Cartwright et al., 2014).

It is interesting to compare these countertransference reactions of trainees to the countertransference reactions of a group of experienced therapists who took part in a countertransference study (Betan et al., 2005). In this therapist study, 181 psychiatrists and clinical psychologists completed a number of

measures including a countertransference questionnaire in regard to one randomly selected client (the last adult client seen in the previous week). The methods used in the two studies were different. The study with trainees (Cartwright et al., 2014) collected qualitative data and Betan and colleagues used a measure of countertransference – the Countertransference Questionnaire.

The experienced therapists reported eight main types of countertransference reactions. These included: overwhelmed/disorganised; helpless/inadequate; positive; special/overinvolved; sexualised; disengaged; parental/protective; and criticised/mistreated. As can be seen, a number of these overlap with the countertransference described by trainees. Trainees did not, however, describe any sexualised countertransference reactions. This may reflect a lack of such experience amongst the group of trainees but may also reflect discomfort with writing or talking about sexual feelings in a therapy situation. It has also been my experience in doing the training that it is rare for trainees to talk about sexualised experiences although this has sometimes occurred. Trainees may be cautious about talking about their personal reactions as they fear that they might be judged by their supervisors or trainers. On the other hand, having clients fall in love with you or having sexual feelings towards a client is something that all therapists are likely to experience at some point and hence we will return to this topic in Chapter 6, once we have developed a greater depth of understanding about transference and countertransference.

Distinguishing countertransference

An interesting study with experienced therapists who were also experienced clinical supervisors found a high level of agreement about the types of therapist reactions that are seen as manifestations of countertransference and those therapist reactions that are not. Forty-five experienced psychologists who had also acted as clinical supervisors for 10 years took part in a study of countertransference prototypes in order to examine the degree of consensus around countertransference manifestations (Hofsess & Tracey, 2010). The psychologists completed an online survey in which they were asked to rate the extent to which each of 108 items were likely to be manifestations of countertransference. The authors found that there was a high level of agreement among the therapists as to which items were prototypical of countertransference manifestations. Examples of highly rated items included: acts flirtatious with a client, loves a client, daydreams about relationships or events related to a client, loses all neutrality and sides with a client, rejects the client in session, engages in too much self-disclosure, and expresses hostility toward or about a client. Items which were not viewed as examples of countertransference included: expresses empathy for a client's loss, is comfortable in the presence of strong affect from a client, is prepared for supervision, feels confident working with most clients, is supportive, is emotionally in tune with a client, looks up literature related to a client's problems, and understands the influence

of culture in a client's life. This study may be worth looking at in more depth as it will give you an understanding of a range of reactions that are seen, by experienced therapists, as prototypical of countertransference and those that are not.

Positive and negative countertransference

As will be seen from above, countertransference reactions can have a positive valence (feeling warm and protective, identifying empathically with a client) or a negative valence (feeling frustrated and critical or disengaged from a client). These can be thought about as positive and negative countertransference. It is important though to remember that both positive and negative countertransference reactions can be problematic if they are not understood and managed.

Positive countertransference tends to feel good or comfortable to the therapist and in my experience can be somewhat seductive or enticing; that is, the therapist can experience the positive feelings as congruent, enjoy them, and not question these reactions. A positive countertransference is likely to be made up of positive emotions and also complementary thoughts. For example, a client who is idealising a therapist may evoke thoughts such as, 'I'm doing really well with the client. We are such a good match. I think I am the right person for her. I will be able to help her move to a much better place in her life'.

It can feel pleasing or positive to be looked up to, to be idealised, or needed by a client – especially perhaps when we are in training and feeling uncertain about our own competencies as a therapist; or when we are working with many challenging clients. Feeling looked up to and needed by a client can also be personally comforting during difficult times in our lives and it might be easier to simply go with these feelings rather than to question what they mean for the client and the therapy plan. In accepting these thoughts and feeling unquestioningly, the therapist can miss what is really happening for the client. For example, a therapist may not perceive the problematic aspects of a client's idealisation of the therapist and the client's patterns of relating to others that underlie this idealisation. Positive countertransference reactions can also lead to rescue attempts, to avoiding the challenging of clients or not using interventions that might stretch them. These feelings can also impact our assessment and conceptualisation of the client's problems as we minimise them.

In terms of negative countertransference, a client who is being critical of a therapist is likely to evoke feelings of hurt, anger, frustration, or desire to withdraw and/or perhaps a sense of incompetence and feeling critical of oneself as well as the client. These emotional reactions are likely to be associated with negative thoughts which could include 'I've tried my best with this client. The client is just ungrateful and not willing to change. The client doesn't want to get better. He's quite a nasty person and I'm not good enough to be able to help this client'. As we will discuss more in the next chapter, these

thoughts and feelings are important and tell us something about the client's experiences and also that of the therapist. It may be, for example, that the client is feeling some of these feelings as well – hurt, anger, frustration or the desire to withdraw – or it may be that the client is acting towards the therapist as his caregiver/s acted towards him.

Objective and subjective countertransference

As noted earlier, these terms are used through this text as they provide a useful way for thinking about different aspects of our countertransference reactions. Objective countertransference is used to refer to those aspects of our countertransference reactions that are evoked, provoked, induced or pulled for by the client's behaviour and the therapy situation. Subjective (or personal) countertransference refers to those aspects of the therapist's countertransference that originate in the client's sensitivities or unresolved issues. Subjective countertransference can also be thought of as the therapist's transference to the client, in which the therapist's relationships with significant others in the past influence the therapist's reaction to the client's behaviour and the problems they are discussing.

It seems likely that many countertransference reactions contain elements of both subjective and objective countertransference. For example, a therapist may react with hurt and then anger at a client who expresses dissatisfaction with the therapist. The client may have experienced a failure of care and responsivity during childhood and is now experiencing the therapist as uncaring and unresponsive. The therapist feels himself trapped in being uncaring and unresponsive for no matter how hard he tries to relate to and engage with the client, the client still sees him in this way. The client's behaviour towards the therapist also triggers a personal countertransference reaction for the therapist. The therapist has often felt hurt and then angry with his father whom he felt treated him as being a disappointment throughout his childhood and these feelings are now triggered in the current situation with his client.

As you can see from the above example, it is important for the therapist to be able to separate out and understand each of these aspects of the countertransference – the objective and realistic reaction to the client's criticisms, and the therapist's personal or subjective reactions to the client's criticism. I place emphasis on understanding both of these aspects of countertransference, and how they can interact, throughout this text.

Understanding your personal countertransference reactions

Training programmes often emphasise the need for trainees to have therapy for themselves. Being a client is helpful for understanding the client's position in the therapeutic relationship and the vulnerability of this position.

Personal experience of therapy can help us to understand the challenges clients face in being open about very personal experiences and the coping strategies (or defences) that clients use when they are feeling challenged or vulnerable. It is also helpful to experience different types of therapist behaviours such as empathic responses, validation, challenge, and managing a therapeutic disruption. Another advantage of having one's own therapy is that it helps us to have greater understanding of our own formative experiences and how these have impacted our experiences of self, of others, and of relationships. Therapy helps us to become aware of our own templates for relationships that contribute to our countertransference reactions.

Robert Leahy (2007) has written about the effects of schematic mismatches that can occur in therapeutic relationships. According to this perspective, common problems in the therapeutic relationship can emerge from the schemas (or core beliefs) that clients and therapists bring to therapy situations that can lead to transference and countertransference reactions and create disruptions within therapeutic relationships. As discussed in Chapter 1, Leahy (2007) outlines a number of therapist schemas that he believes underlie countertransference reactions to clients. These therapist schemas influence our responses to clients and the clients we find challenging or alternatively with whom we feel comfortable working. As Leahy points out, it is a good idea for therapists to take notice of which types of clients or client problems push our buttons, and alternatively those we find easier to work with, some of whom may hold schemas that may match our own.

Therapists with a schema of control and the belief that they must be in control of their lives, and what is around them, may experience negative countertransference reactions to clients who are disorganised and have a chaotic lifestyle. Therapists who need approval may find critical clients very difficult to work with and may avoid challenging clients generally in order to avoid disapproval.

Positive countertransference reactions on the other hand may be evoked by clients whose schemas match ours (Leahy, 2007). Therapists with demanding standards may feel admiring towards clients who are perfectionistic and expect themselves to achieve in whatever they do. These therapists may be at risk of missing the clients' emotional problems and struggles that underlie the perfectionist tendencies. Becoming aware of our own self and relational schemas will help us to understand and manage our countertransference reactions to clients.

Pause and reflect: Countertransference reaction

Have you noticed any types of client behaviour that appear to trigger you into a countertransference reaction? And if so, what is the schema that underlies your reaction?

Cultural countertransference

In this section of the chapter, we are going to first consider what is meant by cultural countertransference (and transference) and the influence of sociocultural and historical contexts on these therapist and client reactions. We will then briefly consider the challenges of working competently cross-culturally when many therapists are trained in psychotherapies that reflect Western perspectives of what it is to be human.

In the book so far, we have considered the influence of clients' and therapists' formative experiences on the development of our views or representations of self, of others, and of relationships. Thinking about cultural countertransference draws our attention to wider cultural influences – both past and present – that impact our personal development, and our place in the world in relation to others. Currently, there is only a small amount of published research in the area of cultural countertransference, and as with countertransference generally there is not an established definition of cultural countertransference, although many authors have contributed to discussions in this area.

Most commonly, cultural countertransference is seen as countertransference arising in cross-cultural therapy when therapist and client are of different cultural or ethnic/racial backgrounds. However, cultural countertransference can arguably arise also when therapists and clients are of different sexual orientation, gender, religion, and even socioeconomic status (Gelso & Hayes, 2007). Gelso and Mohr (2001) talk about the culture-related distortions that therapists can have in regard to clients in cross-cultural therapy, and the problematic behaviours that can result from therapists' internalisation of negative cultural narratives related to minority groups.

Comas-Diaz and Jacobsen (1995) developed a model of ethnocultural transference and countertransference reactions that they observed occur in psychotherapy dyads of the same ethnicity and of different ethnicities. Comas-Diaz (2012), in her text on cultural competence, describes culture as the elephant in the therapy room and argues that cultural differences in the therapist–client dyad can evoke strong unconscious reactions in clients and therapists. Gelso and Mohr (2001) also suggest that the intensity of the therapeutic relationship generally pulls for cultural transference and countertransference. For therapists working cross-culturally, countertransference reactions can result in 'ethnocultural disorientation' and empathic stumbling (Comas-Diaz & Jacobsen, 1991, p. 392).

Christopher Bonovitz (2005), a psychoanalyst, further argues that therapy is a microcosm of the sociocultural contexts of therapists and clients. According to Bonovitz, our sociocultural history shapes our representations of self and other, and transference and countertransference can be thought of as 'embodying aspects of the historical relations between (the therapist and client's) respective cultures' expressed within the therapeutic relationship (Bonovitz, 2005, p. 63).

Cultural transference

Many individuals from minority groups experience social stigma as part of their everyday lives. Stigmatisation and the associated cultural narratives result in misunderstandings and discriminatory behaviour. Minority clients also rarely see themselves reflected back to themselves by their therapists (Comas-Diaz, 2012). It seems likely then that minority-group clients beginning therapy may be apprehensive about how mainstream therapists will view them and respond to them.

Comas-Diaz and Jacobsen (1995) refer to ethnocultural transference and countertransference that can arise in inter-ethnic therapy dyads. Comas-Diaz (2012) in her text on cultural competence outlines a number of transference reactions that ethnic minority clients experience working with non-minority therapists. These include overcompliance and friendliness towards therapists, denial of the relevance of culture and ethnicity to the therapy process, reactions of mistrust, suspicion or hostility to therapists whose motivations and ability to understand they distrust (because they are not from a minority culture), and finally, ambivalence in which clients become attached to therapists, on the other hand, but have trouble identifying with therapists and continue to doubt that majority culture therapists can ever really understand.

When there has been a history of oppression and especially when the impact of oppression and cultural prejudice still exists, then cultural transference and countertransference may be inevitable (Gelso & Mohr, 2001). In Britain, this would be relevant to a white therapist working with clients of African Caribbean descent; in Aotearoa New Zealand, a Pākehā therapist (of European descent) with Māori or Pasifika clients; in Australia, a First Nations client with a white Australian therapist; and a black African American or First Nations American working with a white therapist in the United States. Gelso and Mohr (2001) also remind us to be cautious about classifying a client's reaction to a therapist as cultural transference as minority clients' reactions to majority therapists are not necessarily transferential – but rather can also be realistic reactions to actual therapist behaviours and to ongoing social discrimination and stigmatisation.

Cultural countertransference

Comas-Diaz and Jacobsen (1995) in their cross-cultural work also observed a number of therapist countertransference reactions in inter-ethnic dyads. According to Comas-Diaz (2012), these include the denial or lack of recognition of ethnic or cultural differences, which results in cultural issues being unavailable for the client to talk about, therapists being overly curious about the client's cultural background, feelings of pity or guilt, which can be demobilising for the therapist and unhelpful for the client, and aggression towards clients who arouse feelings of guilt or awareness of privilege, and also ambivalence.

A small number of studies have also provided insights into cultural countertransference.

Studies of cross-cultural countertransference

Stampey (2008) interviewed 17 social workers in the United States about their experiences of working cross-culturally. Stampey concluded that key sources of countertransference reactions discussed by participants appeared to be beliefs that originated in participants' families of origin and also social influences including the media. Examples of countertransference included a participant expressing a lack of understanding of families who are not supportive of each other in times of difficulty, not understanding why a First Nations client kept talking about the loss of the tribe's land, and seeing a potential violent offender in every young male African American service user.

Tummala-Narra and colleagues (2018) interviewed 20 psychoanalytic psychologists about their experiences of working with clients from diverse backgrounds. A number of themes emerged that were relevant to countertransference. These include the therapists' observations that they needed to be able to tolerate anxiety, uncertainty, and also painful feelings such as racial guilt, when working with clients from minority groups. The participants commented on cultural differences in relation to race, gender, class, religion, and sexual identity and how these were reflected in transference and countertransference. Some reported a tendency to want to avoid talking about race/ethnic differences, although participants recognised that these cultural differences emerged in transference and countertransference reactions and were a central part of therapy (Tummala-Narra et al., 2018).

Minority group therapists

Comas-Diaz (2012) also observed that therapists from minority groups experience cultural countertransference. She observed a tendency for clients from the dominant culture to see the minority group professionals as belonging to a minority group first, and second, to see them as a professional. The cultural countertransference reactions for therapists from minority groups can include urges to engage in behaviours that prove their competence, feelings of anger or resentment for feeling they have to prove themselves, and attempting to avoid working with dominant culture clients (Comas-Diaz, 2012). Therapists can also be triggered by clients' culturally based transferences related to clients' defensiveness and lack of trust.

All of the participants in Tummala-Narra et al.'s (2018) study, who identified as belonging to an ethnic or sexual minority group, reported experiencing discrimination by clients, supervisors, and/or lecturers, and also reported that some clients made negative comments about their sociocultural group. Sometimes white clients did not continue with the minority therapist after the first session. Hence, therapists from a minority and mainstream background are likely to experience countertransference reactions that are evoked by cultural differences. Below are some brief vignettes that will allow you to explore how these issues may emerge in cross-cultural therapy.

Pause and reflect: Cases for discussion

A gay male client (Tom, Caucasian descent) experienced bullying as a teenager related to his sexual preference and is seeing a male therapist whom he perceives as heterosexual and a bit 'macho'. The male therapist feels that Tom is suspicious and untrusting of him, a feeling which he always struggles with. How might their relationship evolve?

A young British woman (Genia, Afro-Caribbean descent) is assigned to a woman therapist whom she perceives as 'upper crust'. The therapist listens as Genia reveals the poverty her family still experiences. This is very different from her wealthy upbringing. What issues might arise for both therapist and client?

A young Māori therapist (Kara) is working with a 15-year-old Māori girl (Ana) who is being bullied at school by Pākehā girls. The referring teacher who is Māori says that Ana's group of friends were also involved in the conflict with the Pākehā girls. She said, 'Both groups are responsible for what is happening'. Ana, however, seems to be more distressed about it than the other students and Kara can understand how she feels as she herself was bullied by Pākehā girls at school. What challenges does Ana face in working with Kara?

Viewing clients through a cultural lens

Finally, it is also important to note that psychological knowledge and theories, and psychotherapeutic practices used in Western countries have emerged mainly from European, British, and North American cultures. Psychotherapy training in Western countries has often reflected the cultural knowledge and practices of Western traditions and many aspects of these traditions do not fit with clients of different ethnic/racial backgrounds (Koç & Kafa, 2019). There is a risk that therapists will view clients and their struggles through their own culturally influenced psychotherapy theory and practice lens. While counselling, psychology, and psychotherapy professions emphasise the importance of cultural competence in their professional standards and ethics, there may be some way to go before many majority therapists are competent to work cross-culturally. This is one of the reasons given as an explanation for the findings that ethnic minority clients are much less likely to access and then maintain contact with mainstream therapy services (Knifton, 2012). As we discussed earlier, minority clients may not see themselves as validated or understood by practices based on Western psychotherapy. Viewing clients from the position of one's own cultural perspectives – values, beliefs systems, language, and cultural narratives – can be considered countertransferential as this involves viewing clients and their problems through a lens that does not fit, and therefore offering a psychotherapy service that does not meet the needs of the client.

Countertransference and professional and ethical behaviour

As therapists and trainees, we can find ourselves in complex situations with a number of competing factors to consider. Codes of ethical and professional conduct are important in situations where we are confronted with difficult situations that involve difficult decisions. We can think of codes of ethics or codes of conduct as important to follow in order to avoid engaging in behaviours that could lead to criticism or judgment from other professionals and clients. We can also view these codes as having a really positive role to fulfil in our lives as professionals – that is, to help keep us and our clients safe. When we are in doubt about how to behave in some situations, or feeling pulled in different directions in terms of our decision-making, we can reflect on the situation we are dealing with in the light of the guidelines provided by ethical standards.

Psychology, counselling, and psychotherapy ethics and conduct codes focus on a number of principles that aim to guide us in our decision-making in regard to our practices with clients. These are organised and presented somewhat differently across countries and professional bodies but share common concerns. These include the importance of making decisions that are in the best interest of the client, demonstrating respect for clients, acting in an honest and trustworthy way, working only with clients when competent to do so, and respecting diversity of clients and the equality, rights, and dignity of all people. Codes also emphasise the collective responsibilities of psychologists and psychotherapists for the welfare of people within the societies in which they live and work.

There is not much written about countertransference and ethical behaviour and there has been no research in this area as far as I am aware. The term countertransference is also not used in ethics codes. For example, the codes of the British Psychological Society (2018), American Psychological Society (2017), Australian Psychological Society (2007), New Zealand Psychological Society (2012) and the UK Council for Psychotherapy (2019) do not use the word countertransference. On the other hand, ethical codes of conduct are developed with the understanding that professionals in all walks of life are fallible and at risk of harm (as well as benefit) to clients in some situations. The codes recognise that we are subject to our own beliefs and biases, personal values, emotional reactions, and our own needs and desires – the latter of which can vary depending on our circumstances. As the BPS *Code of Ethics and Conduct* (2018) notes, our motivation and ability to engage in ethical reasoning and act on ethical standards can be compromised through competing biases:

> Maintaining awareness of such biases is important when trying to think through ethical challenges. These considerations currently include but are not limited to, salience (how readily something comes to mind), confirmation bias (the human tendency to look for evidence that confirms their belief and to ignore other evidence),

> loss aversion (behaviour to avoid loss), beliefs about disclosure (tendency to be honest when they believe their actions will be known by others), and dissonance reduction (acting to maintain consistent beliefs). … Psychologists are well placed and encouraged to consider these factors in their own decision-making. (p. 2)

Hence, from the understanding we have been developing about countertransference it becomes clear that countertransference reactions are likely, in some instances, to impact ethical reasoning or lead therapists to somehow avoid acknowledging that they are engaging, or thinking of engaging, in behaviours which are outside the safe boundaries of professional practice. I think too there is a general acceptance that countertransference reactions can influence therapists' decision-making and, in some situations, lead to problematic responses to clients that can have negative effects on clients and those around them.

In the section below, we will consider two scenarios in which countertransference reactions are leading therapists to consider engaging in what would be behaviours that could be deleterious for the client and for the therapeutic relationship. We will also reflect on sections of codes of practice that guide the therapist in appropriate behaviours given the circumstances.

Pause and reflect: Scenarios

Scenario one

Bob is a 32-year-old final year clinical psychology trainee. He has just broken up with his partner of 5 years and has to leave the apartment as it is in his partner's name. Bob is having difficulty finding another place to live as accommodation is really tight and also expensive in his university town. In the last session, one of Bob's older clients (a man in his seventies whose wife died six months previously) mentioned that an apartment he owned was becoming empty and he was looking for someone to take it over, someone he could rely on to look after it. Bob is thinking of asking his client if he could rent the apartment. He's been thinking that he could make sure that the client did not feel pressured but that it would be a solution for both of them. Bob thinks that his client would probably say Yes as his client seems to have a grandfatherly attitude towards Bob some of the time.

What are the ethical and professional issues relevant to Bob's decision?

Scenario two

Angela has been practising for three years. She places a lot of value on safe boundaries with clients. However, she is struggling currently. A client of hers is showing personal interest in her. The client compliments what she wears and how she looks. She shows interest in her thoughts and feelings. And last week

she asked her if it would be possible to go out together once their therapy had ended. (They had another six sessions planned.) The client said she had never met anyone like Angela. Angela thought about it during the week and would really like to go out with her client. She is really attracted to her and feels this is different somehow in a positive way. She feels they were meant to be and she feels a bit relieved her supervisor is away as she really wants to think on this alone.

What are the ethical and professional issues relevant to Angela's decision?

Scenario one

In both the instances above, the therapists are at risk of putting their own needs – need for accommodation or a partner – before the needs of their clients. Bob is in a helping relationship with his client but is considering asking the client if he can rent his apartment. If he does this it is likely that the client's view of Bob as therapist will shift, and the client may begin to see Bob as someone who needs support rather than as someone who is there to support him. If Bob takes this action and the client accepts his proposal it will also lead to ongoing boundary issues as Bob will find himself in a position of regularly paying his client rent.

Bob is insecure currently because of the loss of his relationship with his partner and his home, and is at risk of convincing himself that renting his client's apartment would be mutually beneficial. This is an example of how our own needs can impact our thoughts and decision-making. Bob's reaction can be understood as a personal countertransference based on Bob's insecurity and needs at the current time. However, it is possible that there is an aspect of an objective countertransference in this situation. Bob's client, for example, is used to looking after others, and has a tendency to adopt a fatherly or paternal stance towards others. This paternal stance is, in part, a strategy that the client has developed as a way of coping with and minimising his own needs. Hence, Bob could be responding to a paternal attitude of the client towards him.

If Bob makes the suggestion and it is taken up by the client, it will be detrimental to their therapeutic relationship. Bob will have developed a dual relationship with his client – as his therapist and his tenant. Bob, as therapist, is the one who needs to take responsibility for protecting the therapeutic relationship from the difficulties associated with dual relationships. As the UK Council for Psychotherapy (2019) code states,

> Be aware of the power imbalance between the practitioner and client, and avoid dual or multiple relationships, which risk confusing an existing relationship and may impact adversely on a client. (p. 3)

Other aspects of codes are also relevant for Bob's decision-making. Codes of ethics generally emphasise the importance of prioritising the client's needs over self-interest. As an example, the British Psychological Society (2018) states that psychologists should act with integrity, which includes 'avoidance of exploitation and conflicts of interest (including self-interest)' and 'maintaining personal and professional boundaries' (p. 7). Hence, there is clear guidance available for Bob within the codes of practice. If Bob revisits his guidelines and reflects on these it will be clear to him that he should not consider asking to rent his client's apartment, nor take up an offer from the client should the client suggest it. This will preserve the relationship with safe and professional boundaries and enhance the likelihood that Bob will be helpful to his client.

On the other hand, it is important to note that Bob deserves some self-compassion. This is a difficult time. He is in training with all of the pressures that involves, and has lost his partner and his home. He will need support for this.

Scenario two

We will discuss sexual countertransference in Chapter 6. However, we can briefly discuss Angela's dilemma here. Angela has had personal experience of relationships that make her vulnerable in this situation. She has had difficulty finding a partner and she feels as if women generally are not very interested in her. She is aware that some of these feelings come from her relationships within her family but does not think this accounts for how she feels towards her client. The young woman client, on the other hand, has never had the type of attention that Angela is giving her now. The therapist seems so interested in her and so caring. She finds Angela's interest in her very sexy. Angela is also so different from her previous partner who was very self-centred. Rather Angela seems to really like hearing about her, she laughs at her jokes, and she seems to also really care. She really hopes that Angela will go out with her.

Angela feels attracted to her client and would like to take up her client's offer. She knows that this would be a 'bad thing' to do but it feels like the right thing to do. She revisits her ethics guidelines. These state that psychologists must not engage in sexual activity with a client, or within two years of the ending of the professional relationship, and even two years later, the psychologist must first explore, with a senior psychologist, if the client may be vulnerable and at risk of exploitation as a result of the previous professional relationship (Australian Psychological Society, 2007).

We discuss in Chapter 6 ways therapists can manage sexual attraction in therapy. What is important here is that Angela remembers that her role is to assist her client with the issues that she brought to therapy. However, it is also possible that Angela may struggle with her feelings of attraction to the client throughout the therapy. Angela's codes of ethics may help her to maintain the professional boundaries of the

relationship but may not be enough to help her cope with her emotions in this situation. The activities that we learn about in Chapters 3 and 4 will assist Angela in this situation. She will be able to remind herself to centre herself and to remain in her therapist role with her client, while acknowledging that there is part of her that really wants to find a good partner. She can remind herself that it is just not possible with this person. It is also important that Angela talks this through with her supervisor when she returns and considers reflecting on it in her own therapy. Sharing this with her supervisor and her therapist is likely to be really helpful for Angela in remaining in a therapeutic position with her client and keeping herself and her client safe.

Pause and reflect: A case example

Here is another scenario for you to reflect on.

Jacqueline has 5 years' therapeutic experience and is just beginning to set up a part-time private practice. A transgender woman contacts Jacqueline and says that she would like some assistance with coping with 'coming out' at work. Jacqueline does not have any experience working with transgender women but would like to take on the client as the work could be interesting and it could help her build her practice. The woman tells Jacqueline on the phone that she has heard she is empathic and this is what she needs right now from a therapist. Jacqueline works hard at being empathic and values her empathic style. She thinks she could be good for this client.

What are the professional and/or ethical issues that arise here? And could Jacqueline's own personal issues influence her reaction to taking on the client, and if so, how?

Summary

This chapter considered the three components of the therapeutic relationship – the real relationship, the working alliance, and transference–countertransference – and their relationship to each other. In order to increase awareness of the nature of countertransference reactions, the chapter then examined different types of countertransference reactions reported by therapists and trainees, along with the types of reactions that experienced therapists/supervisors view as characteristic of countertransference. The chapter then differentiated between different aspects of countertransference – positive and negative countertransference, and subjective and objective countertransference.

The second part of the chapter turned to the question of cultural countertransference that arises in cross-cultural therapeutic relationships in which therapist and client are of different cultural backgrounds. It considered the types of transference and countertransference reactions that can be evoked in these situations. The chapter ended with a discussion of the relationship between

countertransference and professional and ethical issues, and used therapy vignettes to illustrate the role that professional guidelines and codes of conduct can play in professional decision-making.

Recommended readings

Cartwright, C., Rhodes, P., King, R., & Shires, A. (2014). Experiences of countertransference: Reports of clinical psychology students. *Australian Psychologist*, *49*, 232–240.

Comas-Diaz, L. (2012). *Multi-cultural care: A clinician's guide to cultural competence.* Washington, DC: American Psychological Association.

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Hayes, J. A., Gelso, C. J., Goldberg, S., & Kivlighan, D. M. (2018). Countertransference management and effective psychotherapy: Meta-analytic findings. *Psychotherapy*, *55*, 496–512.

Hofsess, C. D. & Tracey, T. J. (2010). Countertransference as a prototype: The development of a measure. *Journal of Counseling Psychology*, *57*, 52–67.

Leahy, R. (2007). Schematic match in the therapeutic relationship: A social cognitive model. In P. Gilbert and R. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 229–254). New York, NY: Routledge.