Understanding Therapists' Experiences With Countertransference:

A Move Towards Better Training, Supervision, And Practice

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Abstract

Countertransference (CT) is a prominent concept in the counselling literature and is commonly defined as the reactions therapists have to their clients, resulting from their own unresolved conflicts and vulnerabilities (Gelso & Hayes, 2007). According to Friedman and Gelso (2000), while some CT reactions are perceived as positive, they still shift focus to therapists' concerns rather than those of their clients. This can be perceived as defeating the purpose of therapy. This study revealed therapists' experiences with CT to help pave a path towards more ethical and client oriented treatment by shedding light on potential changes that can be made to counselling practice and education. Thematic analyses (TA) by Braun and Clarke (2012) was used to analyze data from interviews with four participants. In seeking to understand how CT is conceptualized by therapists, the contexts within which CT reactions occur, and how therapists deal with their CT, five themes emerged from the data. These included: (a) defining characteristics of CT, (b) CT triggers, (c) reactions to CT, (d) methods of dealing with CT, and (e) impact of CT on therapy. Reflection on said themes may inspire counsellors to handle their CT in ways that have proven effective to others and may help them feel less alone in their CT experiences, allowing for more productive response.

Keywords: Countertransference, transference, psychotherapy, counselling

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CHAPTER I

INTRODUCTION

Counselling and psychotherapy aim to help clients enhance their lives. For this reason, therapists and counsellors are encouraged to develop empathy and understanding of clients (e.g., Elliott, Bohart, Watson, & Greenberg, 2011; Rogers, 1961) and facilitate clients' self-knowledge and growth (Canadian Counselling and Psychotherapy Association, n.d.). However, for therapists to effectively help clients and provide adequate treatment, they must also be psychologically healthy. Yet, many therapists face personal problems that can negatively impact therapy when left unattended (e.g., Alves de Oliveira & Vandenberghe, 2009; Kooperman, 2013). While therapists are trained and expected to understand the client-therapist dyad and their own internal processes (i.e., have self-awareness; Donati & Watts, 2005; Pieterse, Lee, Ritmeester, & Collins, 2013; Whiston & Coker, 2000), their personal problems can increase their susceptibility to experiencing countertransference (CT).

In the literature, CT is generally known as the reactions therapists have to their clients, resulting from their own unresolved conflicts and vulnerabilities (Gelso & Hayes, 2007). Though definitions of CT have varied over time and will be further explained when reviewing the literature, it can be noted that there is a general disagreement regarding whether CT is beneficial or harmful to therapy. Firstly, CT is largely linked to psychodynamic practice, where it is regarded as a tool and utilized in treatment (Cabaniss et al., 2011). For example, as Cabaniss and colleagues (2011) mention, therapists can use CT to understand their own feelings and avoid acting on them. They can also attend to their CT to learn when and how to intervene during

treatment. Recently, CT has also been noted to be helpful and of significance in cognitive-behavioural therapy (CBT) and schema therapy (see Prasko et al., 2010; Vyskocilova, Prasko, Slepecky, & Kotianova, 2015). As mentioned by Prasko and colleagues (2010), within CBT, CT can inform therapists' understanding of the treatment process and clients' internal experiences. Thus, as Machado and colleagues (2014) mention, CT can act as a form of non-verbal communication and can encourage therapists' self-analysis. These conceptualizations of CT are indicative of the growing importance of CT in diverse psychotherapeutic modalities.

In contrast, some research findings demonstrate that CT can influence both clinicians' ability to intervene during treatment and their perceptions of clients (e.g., viewing clients as more ill, more helpless, less adequate; Knaus et al., 2016; Liebman & Burnette, 2013; Schlesinger & Wolitzky, 2002). In a systematic review, Machado and colleagues (2014) highlight that CT was regarded as positive when it involved therapists having positive feelings towards the client, such as closeness, well-being, and respect, and it was regarded as negative when feelings of distancing, such as anger and overload, were involved. As such, it seems that while many therapists utilize CT as a tool in treatment, CT can be either be perceived as constructive or damaging to therapy. This makes clear the complexity of CT and raises additional questions, such as: When do CT reactions occur? When specifically are they constructive or damaging, given the context of therapy? And most importantly, how can they be handled effectively?

Current Study

This study focused on addressing these questions by assessing therapists' understanding of CT, highlighting when therapists are susceptible to experiencing diverse CT reactions and exploring how therapists generally deal with CT. These questions were addressed by conducting semi-structured interviews with four mental health professionals, each of whom had at least 5

years of experience practicing psychotherapy. The reason for selecting participants that were experienced in psychotherapy was to explore their experienced understanding of CT, which understandably grows over time. It was also noted that one's likelihood of experiencing CT also increases over time and being able to share one's own retrospective accounts of CT would provide depth to the study.

The overall goal of the study was to pave a path towards more ethical and client-oriented psychotherapy practice by linking therapists' CT accounts to potential changes that can be made in counselling training, supervision, and within psychotherapy sessions. It was also considered that readers of the current study could learn from the experiences of other practitioners and make connections to their own practice. The present study may offer insight into how therapists define and understand CT and has the potential to help counsellors in training get a grasp on what CT is, so they do not find themselves blindsided when beginning to see clients. Similarly, this study may shed light on when therapists are most susceptible to experiencing CT. This has the potential to help novice therapists prepare for clinical practice by allowing them to understand when to be on the look out for CT, based on what experienced clinicians in the field have encountered. It can also aid experienced therapists, as even they can gain from learning when they may be likely to experience CT. Lastly, considering how therapists deal with CT may help shed light on helpful CT management techniques and the perceived impact CT has on treatment.

To present my research findings, I have divided this thesis into five chapters. This first chapter briefly discussed the nature of psychotherapy, the role of CT in psychotherapy, the way CT is viewed in the clinical literature, and what the current study seeks to address. The second chapter is a literature review, which explores the various historical definitions and understandings of CT, explains the tripartite model in which CT is situated, summarizes

therapists' experiences with CT as noted in the literature, differentiates between the different types of CT that exist, explores the therapeutic impact of CT and how it is managed, draws a connection between CT and the Safe and Effective Use of Self in psychotherapy, highlights the gaps in the clinical literature, and presents the research questions that guide the current study. The third chapter discusses the study's methodology, including the conceptual framework utilized, the participant recruitment and selection processes, the development of the methodological instrument employed, the data collection and data analysis procedures, and the credibility, dependability, trustworthiness, and transferability of the study's results. The fourth chapter is devoted to presenting the results of the study, including the main themes discovered and verbatim examples from participants that provide support to these themes. The fifth chapter discusses these results in more detail and situates them in the existing clinical literature. The chapter also provides a conclusion to the study by highlighting its delimitations and contributions and the potential for future research in CT.

CHAPTER II

LITERATURE REVIEW

This section is meant to summarize the current literature on CT by exploring both its conceptual definition and existing empirical findings. The chapter will begin by defining the related concept, *transference*, and will then discuss the various definitions of CT that have emerged over time. Secondly, the tripartite model will be discussed, as it consists of the transference-countertransference configuration and two related concepts: the working alliance and the real relationship. Thirdly, empirical findings regarding therapists' experiences with CT will be discussed. The section will review the difference between CT origins, triggers, and manifestations to provide a deeper understanding of the concept. Fourthly, the different types of CT noted in the literature will be reviewed. Fifthly, the therapeutic impact of CT will be discussed to illustrate how therapists can help or harm treatment based on how they handle their CT. Sixthly, the literature on CT management will be explored, including common reactions therapists may have to CT, as well as noteworthy suggestions to best manage CT. Seventhly, the chapter will touch on therapist self-disclosure, which can be considered a therapeutic intervention or management strategy when related to CT. Eighthly, the chapter will review what is known as the Safe and Effective Use of Self (SEUS) in psychotherapy as defined by the College of Registered Psychotherapists of Ontario (CRPO). This will help highlight similarities between SEUS and CT and give reason for future research on the concept. Lastly, the chapter will conclude by acknowledging the literary gap and how it links to the current study's research questions.

Transference

Countertransference (CT) is a significant concept in the psychotherapy literature. It was historically regarded as a counterpart to transference (see Epstein & Feiner 1979; Heimann, 1950). As such, it is important to understand what is meant by transference in order to have an adequate understanding of CT. Transference is a classic psychoanalytic concept that was coined by Sigmund Freud (Breuer & Freud, 1893-1895/1955). Transference was considered to be the displacement or transfer of unconscious ideas from the client's past onto the physician, resulting from a "false connection" between the two (Breuer & Freud, 1893-1895/1955, p. 302). It was also noted that the compulsion or illusion of the client, part of the transference, "melted away with the conclusion of the analysis" (Breuer & Freud, 1893-1895/1955, p. 304). In later psychoanalytic treatment, central goals involved methods of actively working with the client's transference, such as activating and interpreting it (Freud, 1937; Gelso & Carter, 1994). This type of work was believed to be necessary for clients to gain an insight or understanding of their concerns (Goldstein, 2000; Ziegler, 2002).

Gelso and Carter (1985) suggest that transference is common to all relationships, including those that fall outside of the therapeutic realm. It has also recently been shown that transference can stem from relationships subsequent to childhood (e.g., Brumbaugh & Fraley, 2006), contrary to what was once believed. Moreover, transference has been theorized to occur in all therapies and not just those oriented in psychoanalytic theory (Gelso, 2014; Gelso & Carter, 1998). Fittingly, in a review, Gelso and Bhatia (2012) found support of transference manifestation in non-psychoanalytic therapies, including cognitive, behaviour, and cognitive-behavioural therapy. Thus, it is recognized that transference feelings are projected from one

relationship onto another and generally, but not exclusively, from personal relationships onto one's relationship with their therapist (Levy, 2009; Levy & Scala, 2012).

Countertransference

If feelings can be projected from clients onto their therapists, the reverse is also possible. In the literature, this is referred to as CT (see Fauth, 2006; Gelso & Hayes, 2007; Hayes, Gelso, & Hummel, 2011). The way CT has been defined has evolved over time. Gelso and Hayes (2007) synthesized the literature and concluded that there were four main existing definitions of CT: the *classical*, the *totalistic*, the *complementary*, and the *relational* definition. The classical definition originated with Sigmund Freud (1910/1959) and consists of the therapist's unconscious reactions to the transference of the client. To Freud (1910/1959), CT was a by-product of the client's transference that was to be overcome; otherwise, it would sacrifice the therapist's ability to perform psychoanalysis. Thus, according to the classical definition, not only does CT have little value, but it is also a hindrance that can drive the therapist to act anti-therapeutically (Epstein & Feiner, 1979; Gelso & Hayes, 2007). Following this, the totalistic definition emerged in the 1950s (Heimann, 1950; Little, as cited in Gelso & Hayes, 2007). Within this definition, all attitudes and feelings the therapist has for the client are regarded as CT (Epstein & Feiner, 1979; Heimann, 1950). According to this view, CT is beneficial and can be utilized in treatment, as it can promote an understanding of clients and their internal worlds and help therapists gauge how others might react to their clients and how their client may affect others (Gelso & Hayes, 2007). Thirdly, within the complementary definition, Epstein and Feiner (1979) refer to CT as a naturally occurring counterpart to the client's transference or relational style. In respect to the complementary definition, therapist and client are both perceived to be sparking reactions in the other (Gelso & Hayes, 2007). Lastly, through the lens of the relational

definition, CT is perceived as being co-constructed by both the therapist's and the client's dynamics (Gelso, 2004, 2007). Some of these dynamics include the client's transference and the therapist's unresolved conflicts, needs, and personality factors.

While these four definitions have contributed immensely to the literature, Gelso and Hayes (2007) suggest an integrative definition of CT. This seems to have become the favoured definition today (e.g., Hayes et al., 2011; Hofsess & Tracey, 2010). Gelso and Hayes (2007) suggest that CT occurs when the therapist's unresolved past or present conflicts and vulnerabilities influence the therapist's reactions towards a client (e.g., thoughts, feelings, behaviours, bodily sensations). It is also recognized that these reactions can be triggered by the client's behaviours or the therapeutic situation. This integrative definition is supported by research findings. For instance, Rosenberger and Hayes (2002) found that a client's mention of information resembling a therapist's unresolved issues might impact the therapist's avoidance behaviour and feelings of expertise and trustworthiness. According to Gelso and Hayes (2007), therapists may also be unaware of their CT, indicating that it can be unconscious at times.

In addition, the topic of CT has increasingly gained recognition and validation since it re-emerged in the 1950s after Freud's initial conceptualization of it (Hayes et al., 2011). In a qualitative study that consisted of examining 127 interviews with psychologists succeeding psychotherapy sessions, evidence of CT was found in 80% of the documented sessions (Hayes et al., 1998). In another study, therapists who were interviewed on their perceptions and experiences of transference collectively reported several cases of CT, some of which involved feeling overly responsible for the client's improvement, identifying with the client, and avoiding the client's negative reactions (Gelso, Hill, Mohr, Rochlen, & Zack, 1999). Moreover, Hofsess and Tracey (2010) found support for the existence of a prototype of CT by surveying

experienced psychologists on the matter. These studies, along with others (e.g., Peabody & Gelso, 1982), demonstrate the evident existence and frequency of CT in therapy and draw attention to the potential impact of CT on the work of therapists with clients.

The Tripartite Model

The therapeutic relationship can be defined as, "the feelings and attitudes that counselling participants have toward one another, and the manner in which these are expressed" (Gelso & Carter, 1985, p. 159). According to the tripartite model (see Gelso & Samstag, 2008), this relationship can be broken down into three separate components: 1) a transference-countertransference configuration, 2) a working alliance, and 3) a real relationship. These components remain common to all psychotherapy relationships, irrespective of therapists' theoretical orientations, and are significant among diverse schools of psychotherapy (Gelso, 2014; Gelso & Samstag 2008). In addition, while the components differ in what they entail, they exist simultaneously and interact with one another during treatment (Gelso, 2011). As such, although transference and CT have been defined, it is important to understand both the real relationship and the working alliance to grasp how all three together can impact therapy.

The real relationship. The real relationship has not always been well defined, and many clinicians have had an incomplete understanding of the concept until recently (Gelso, 2011). Still, the historical significance of what is now called the real relationship can be well noted through its existence in counselling theories and practice (Gelso, 2011; Gelso & Carter, 1985). According to Gelso and Carter (1994), "the real relationship refers to that dimension of the total relationship that is essentially nontransferential, and is thus relatively independent of transference" (p. 297). The real relationship consists of genuineness and realism between client and therapist (see Greenson, 1967, 1971). Based primarily on the work of Greenson (1967,

1971), Gelso (2011) goes further to describe that "genuineness may be viewed as being authentic or who one truly is as opposed to being fake," (p. 13) and that realism "is experiencing and perceiving the other in ways that befit the other rather than in ways that fit what the perceiver wishes for, needs or fears" (p. 13). When explicit, examples of the real relationship can involve immediacy or self-disclosure by the therapist (Gelso, 2011). Still, there exists a non-explicit or concealed component of the real relationship, consisting of genuine self-expression and a realistic perception of the other. In addition, as therapy progresses and client and therapist learn more about the other, the real relationship becomes increasingly apparent in therapy (Gelso & Carter, 1994). The real relationship impacts both the therapeutic process and the therapeutic outcome.

As mentioned briefly above, the real relationship is often painted as the opposite of the transference relationship within the clinical literature (Gelso, 2011). Gelso (2011) defines the real relationship as "the transference-free element in the [psychotherapy] relationship" (p.12) and Gelso and Carter (1994) refer to the real relationship as being "relatively independent of transference" (p. 297). In fact, transference and CT have also been referred to as the unreal relationship (e.g., Gelso & Carter, 1985). This is because transference refers to the process by which the client's past relational experiences and psychological structures impact their experience or perception of the therapist (Gelso & Hayes, 1998). As such, this type of perception can be alleged as a flawed or distorted perception of the other, unlike a perception that is based upon the real relationship. Still, Greenson (1967, 1971) supposes that, to varying degrees, clients experience their transference genuinely and sincerely; yet, the transference is unrealistic and based in fantasy. Hence, there is only really a difference between realism and transference, rather than between transference and both elements of the real relationship. Transference/CT and the

real relationship also interact in many ways. For instance, when clients or therapists have perceptions of the other that are transference based, those perceptions that are grounded in reality become less prominent in therapy (Gelso & Carter, 1994). Similarly, when transference and CT perceptions are understood and resolved, there exists a capacity for the real relationship to be enhanced (Gelso & Carter, 1985, 1994). In a sense then, resolving or managing transference and CT can benefit therapy by enhancing the real relationship.

The working alliance. The working alliance, also known as the therapeutic alliance, has been defined as "the alignment or joining of the reasonable self or ego of the client and the therapist's analyzing or 'therapizing' self or ego for the purpose of the work" (Gelso & Carter 1994, p. 297). Based on this definition, the working alliance can also be described more simply as the relationship within which therapist and client work together to create change. The working alliance has been theorized to include three main factors: 1) an agreement on the goals of therapy, 2) an allocation of tasks to both therapist and client in order to meet therapeutic goals (e.g., empathic understanding or interpretation by the therapist), and 3) the development of an emotional bond between client and therapist (Bordin, 1979). The importance of the concept has been noted frequently in the psychotherapy literature. For instance, Gelso and Carter (1994) suggest that the working alliance is imperative for the progression of therapy, and Bordin (1979) suggests that it is directly related to the effectiveness of therapy and the change experienced by the client. Correspondingly, it is a well-known predictor of the results achieved through therapy (see Crits-Cristoph, Gibbons, & Hearon, 2006). This is best represented by a meta-analysis of 79 previous studies, in which the researchers found a consistently moderate relationship between the working alliance and the therapeutic outcome (Martin, Garske, & Davis, 2000).

The working alliance is also related to the two other components in the tripartite model: the real relationship and the transference/CT. According to Gelso and Carter (1994), these two components impact the working alliance, just as the working alliance impacts them. The working alliance and the real relationship are especially closely related (see Gelso, 2014). For instance, it is the real relationship, rather than transference or CT, which has been theorized to have a primary role in the manifestation of the working alliance (Gelso & Samstag, 2008; Greenson, 1967). Correspondingly, Gelso and Carter (1994) suggest that the strength of the alliance is reliant on the positive quality of the real relationship. Still, there is also a relationship that exists between the working alliance and the client's transference and the therapist's CT. Gelso and Carter (1994) suggest that the type of transference the client has can impact the strength of the therapeutic alliance (e.g., a positive transference can lead to an improved alliance). The working alliance also increases the client's ability to become aware of their transference and express it. Therapists' CT is noted to have a similar relationship to the working alliance as transference does. However, therapists have the added job of monitoring their CT so it can be used for the purpose of therapy and so they can prevent it from negatively impacting the working alliance (Gelso & Carter, 1994). Moreover, studies confirm an association between CT and the working alliance. Machado and colleagues (2015) found that high levels of CT related to the therapist's emotional distance were associated with lower levels of the therapeutic alliance, and Ligiéro and Gelso (2002) found a negative relationship between negative CT behaviour and the quality of the working alliance. This is unfortunate, as based on previous findings (e.g., Martin et al., 2000; Tryon & Winograd, 2011), a collaborative relationship may be key to change.

Therapists' Experiences with Countertransference

In order to adequately understand CT in therapy, it is important to understand how clinicians themselves experience it. Hayes and colleagues (1998) conducted a qualitative study using data collected from interviews with experienced psychologists and discovered three overarching categories of CT from the data. These categories consisted of CT origins, triggers, and manifestations, highlighting the breadth of CT experienced by clinicians as well as topics clinicians may find noteworthy to discuss. One of these categories, CT manifestations or reactions, is commonly discussed in the literature (e.g., Cartwright, Rhodes, King, Shires, 2014; Gelso et al., 1999; Hayes et al., 1998). For example, by examining interviews with clinicians, it has been found that some common CT manifestations include clinicians feeling excessively responsible in treatment, identifying with the client, experiencing negative reactions towards the client (e.g., frustration, anger), experiencing positive feelings towards the client, requiring admiration from the client, engaging in avoidance (e.g., distancing oneself from the client, avoiding negative reactions from the client, feeling bored or disappointed), being nurturing, as well as manifestations relevant to treatment planning (e.g., a desire to be more directive in sessions, feeling uncertain about treatment; Gelso et al., 1999; Hayes et al, 1998).

Although CT manifestations are important to be aware of, it is equally important to understand what causes these manifestations for clinicians to begin with. This varies, as CT stems from the individual clinicians' unresolved conflicts or vulnerabilities (Gelso & Hayes, 2007). However, some common origins or areas of unresolved conflict for clinicians are family concerns, their needs and values, issues arising from their clinical role, and cultural concerns (Hayes et al., 1998). Common events that trigger these unresolved conflicts are the topics clients bring to sessions, comparing the client with others, deviating from the regular therapeutic

structure, emotions, and clinicians' perception of the client. In their study, Hayes and colleagues (1998) also found a link between areas of unresolved conflict, events that trigger the unresolved conflict, and the manifestations or reactions produced. As an example, the researchers found that psychologists experienced manifestations, such as feelings of anxiety, upon experiencing negative perceptions of the client. Similarly, in a qualitative study that examined data from questionnaires completed by clinical psychology trainees, the dominant CT theme was trainees' desire to protect or take care of the client (Cartwright et al., 2014). According to the researchers, this reaction seemed to be triggered by trainees' perceptions of clients as being sad, under distress, traumatized, or having a hard time getting through problems perceived as debilitating.

Types of Countertransference

In addition to understanding the origins, triggers, and manifestations of CT, it is important to understand the types of CT manifestations discussed in the literature and the labels given to them. As such, Cabaniss and colleagues (2011) differentiate between two types of CT: concordant CT where therapists identify with the client and complementary CT where therapists identify with someone in the client's life. These are both perceived as positive, as they give insight into the client's life. Additionally, Tishby and Wiseman (2014) recently established a typology of CT by conducting interviews with therapists. Five types of CT reactions related to therapists' relationship with their parents and their relationship with clients were identified. These include: 1) therapists transferring a wish they had for their parents onto their clients, 2) therapists perceiving clients' responses in the same way they perceived their parents' responses, 3) therapists responding to clients similarly to how they responded to their parents, 4) therapists re-enacting their parents' negative responses with their clients, and 5) therapists attempting to correct their parents' negative responses by responding differently to clients. While this is an

example of how therapists' internal conflicts can impact therapy, Tishby and Wiseman (2014) mention these reactions can either have a positive or a negative impact on therapy, depending on whether the therapist is aware of them and how the therapist manages them.

Friedman and Gelso (2000) also developed a measure to assess CT behaviours in counselling sessions, as perceived by supervisors. The researchers requested supervisors to rate their supervisee's behaviours in counselling sessions and ultimately found support for two types of CT behaviours: positive CT and negative CT. They found that negative CT behaviours involve therapists' disapproval of clients or a lack of affirmation in sessions (e.g., "[treating] the client in a punitive manner in the session"; Friedman & Gelso, 2000, p. 1228). Conversely, positive CT behaviours consist of therapists being excessively supportive or familiar with their clients (e.g., "[befriending] the client in the session," "inappropriately [apologizing] to the client during the session;" Friedman & Gelso, 2000, p. 1228). Regardless of the labels given to CT, the researchers suggest that engaging in CT behaviours involves the avoidance of client concerns.

Furthermore, therapists' erotic feelings towards their clients have also been discussed in the literature (e.g., Rabin, 2003; Tylim, 2017) and can classify as a type of CT. Therapists' feelings of love and sexual desire for their clients have been historically noted (see Tylim, 2017). While Freud was a big advocate for respecting sexual boundaries in treatment, many other well-known therapists were not, and many violated these boundaries (e.g., Breuer, Ferenczi; Tylim, 2017). In addition, in a study conducted by Pope, Keith-Spiegel and Tabachnick (1986), it was shown that 87% of the 575 participating therapists reported sexual attraction to clients and that 104 participants had considered becoming sexually involved with a client. Similarly, in a more recent study, it was found that 95 of 122 (77.9%) counselling psychologists reported they had been attracted to a client (Giovazolias & Davis, 2001). This demonstrates the regularity of

therapists' erotic feelings for clients. Sexual boundary violations were also noted in the study conducted by Pope and colleagues (1986), as some participants (6.5%) had engaged in sexual intimacies with clients. Tylim (2017) suggests that sexual boundary violations are the result of therapists' inability to contain or reflect on their CT, and Rabin (2003) highlights that some therapists have described their attempts to cope with their sexual CT feelings for clients through revelation or disclosure to clients (e.g., Davies, 1994, 1998; Gorkin, 1987). However, many perceive this practice as dangerous (Rabin, 2003), and Gorkin (1987) notes that his own disclosures were detrimental to therapy.

Therapeutic Impact of Countertransference

According to the clinical literature, therapists' awareness of CT can significantly benefit treatment in many ways. Schlesinger and Wolitzky (2002) found that clinicians who participated in a self-analytic exercise presented more empathy and positive feelings for their client. Researchers of another study found that excellent therapists were rated more positively than other therapists on qualities speculated to be significant in managing CT (Van Wagoner, Gelso, Hayes, & Diemer, 1991). As such, excellent therapists were evaluated as being more insightful about their feelings and more capable of feeling empathy for clients. These are important findings, as many theoretical orientations recognize empathy as an essential component of psychotherapy (e.g., humanistic, psychodynamic; Jenkins, 2001). Empathy has been theorized to help clients recognize and exercise their agency (Jenkins, 2001) and has empirically been shown to predict therapeutic outcome (Elliott et al., 2011). Awareness of CT can also help clinicians work through their CT feelings to prevent them from negatively impacting treatment. In a qualitative study, therapists discussed that imagining conversations with clients between sessions helps them become aware of negative CT, manage their feelings without harming treatment, and

manage their anxiety (Arnd-Caddigan, 2013). The researcher advises that imagined conversations are helpful in the therapy process.

However, CT can also be nontherapeutic or damaging under some circumstances. For example, in the same study mentioned earlier, Schlesinger and Wolitzky (2002) found that clinician's conflict with their own hostility was linked to their ability to intervene with the aggression presented by clients in therapy. Clinicians who had less conflict with their own hostility acknowledged clients' hostility issues as more noteworthy. In addition, Linn-Walton and Pardasani (2014) conducted a pilot study that highlighted the impact of negative CT reactions on therapy. The researchers found that therapists often reacted to clients they disliked by referring them to a different therapist, inducing fear in them, refraining from responding with empathy, and placing blame on the client for their own dislike. These were all considered negative methods of coping. Factors that contributed to therapists' dislike included clients questioning the therapist's ability or expertise, a perceived lack of client progress, feeling unsafe with the client, and the type of client (e.g., teenagers, narcissistic individuals). Furthermore, one study found a link between therapists' evaluations of clients as eliciting negative stress (e.g. therapist feels threatened, therapist experiences an inability to manage reactions to clients) and negative feelings and behaviours directed at clients, such as distancing and hesitancy (Fauth & Hayes, 2006). There has also been a significant amount of literature on negative CT responses to clients with personality disorders. The clinical literature indicates that clinicians generally view this demographic as more ill, more helpless, and less adequate and can be less empathetic towards them (e.g., Knaus et al., 2016; Liebman & Burnette, 2013). Inevitably, such CT manifestations impact clients (e.g., reinforce clients' self-critical feelings, cause clients to

withdraw from treatment; Aviram, Brodsky, & Stanley, 2006; Liebman & Burnette, 2013), highlighting the need for CT management.

Management of Countertransference

The importance of therapists managing their CT is a common theme throughout the literature (e.g., Gelso & Silberberg, 2016; Pérez-Rojas et al., 2017). CT management broadly involves confronting and understanding one's CT reactions (Gelso & Silberberg, 2016). Some scholars have discussed how clinicians typically react to their CT. For example, Epstein and Feiner (1979) discussed four different working orientations for CT. First, they discussed that some therapists would only undergo self-analysis when problems arose in therapy (e.g., problems concentrating, emotional concerns). Secondly, some therapists sought to understand how the client contributed to the therapist's emotional state only when it was impacting the therapist's efforts. Thirdly, some therapists used CT as a tool to understand the client in the present moment and to shape clinical interventions. Fourthly, some therapists held that CT should constantly be examined, as it invades the client's unconscious processes. Other scholars have discussed what CT management should look like. For instance, Gelso (2014) suggests, "The therapist's job is to monitor his/her internal reactions, understand them in relation to his/her unresolved conflicts and the patient's material and person, and prevent them from intruding negatively into the therapeutic relationship" (p. 125). Hayes (1995) summarizes methods of CT management as found in the literature, including taping and reviewing sessions, aiming to meet needs outside of work, developing self-awareness, obtaining supervision, and receiving one's own psychotherapy. Some of these methods involve disclosing CT to others. However, Kottler and Uhlemann (1994, as cited in Guest & Carlson, 2019) note that practitioners may have trouble admitting that they have experienced negative feelings for a client or negative CT, because they

perceive this to oppose their role as a helper. This demonstrates that engaging in CT management may be more difficult for practitioners than meets the eye, as it can be complicated by an identity struggle.

Methods to measure therapists' management of CT have also been established. One such method is the Countertransference Factors Inventory (Hayes, Gelso, Van Wagoner, & Diemer, 1991), which centers on five qualities therapists should have to effectively manage their CT. These include empathy, self-insight, anxiety management, self-integration, and conceptualizing skills. More recently, Pérez-Rojas and colleagues (2017) built upon the Countertransference Factors Inventory by developing the Countertransference Management Scale to measure management of CT during the therapy session. In their study, the researchers found two factors that encompassed the five qualities of CT management highlighted above: 1) "understanding self and client," and 2) "self-integration and regulation." "Understanding self and client" involves the therapist's self-awareness of his or her own processes, the therapist's understanding of the client's processes, and an ability to understand the dynamics and interactions between both. Secondly, the "'Self-Integration and Regulation' subscale [reflects] a sense of the therapist, within the psychotherapy session, as integrated, composed, aware of boundaries, and able to manage anxiety" (p. 16). As such, the clinical literature promotes an active involvement in CT management.

Mindfulness practices in countertransference management. Some literature also highlights the potential role of mindfulness in CT management. According to Bishop and colleagues (2004), mindfulness can be defined as a "self-regulation of attention so that it is maintained on immediate experience" and an "orientation towards one's experiences in the present moment… that is characterized by curiosity, openness, and acceptance" (p. 232). The

benefits of mindfulness are far reaching. Bishop and colleagues (2004) detail that through acceptance, a component of mindfulness, one's emotional distress can become less intimidating and unpleasant. Siegel (2007) notes, based on reviewing the literature, that mindfulness plays a role in emotional regulation, moral reasoning, empathy, and attention. These benefits make clear the potential role of mindfulness in managing CT. Guest and Carlson (2019) further summarize that mindfulness can aid practitioners in practicing non-judgment and openness towards clients who are more difficult to work with and with whom they may otherwise encounter negative CT. There is also empirical support for the potential benefit of mindfulness in CT management. For instance, one study found that meditation, from which the development of mindfulness can ensue, was linked to CT management qualities in therapist trainees (Fatter & Hayes, 2013). As mentioned previously, negative CT experiences may be hard for practitioners to admit to (Kottler & Uhlemann, 1994 as cited in Guest & Carlson, 2019). Therefore, practicing mindfulness may also help practitioners become more accepting towards themselves, which, in turn, may help therapists seek help with their CT when needed.

Countertransference disclosures. Historically, CT was something to be realized by the therapist and used as a source of insight into the client's internal word, and it was often frowned upon for therapists to communicate their CT to clients (Heimann, 1950). However, this view changed over time, with some therapists dealing with their CT by disclosing its content to clients. This is called therapist self-disclosure, which can generally be defined as, "therapist statements that reveal something personal about therapists" (Hill & Knox, 2001, p. 413). The literature differentiates between two types of therapist self-disclosure: those involving therapists' verbal disclosures about their personal lives outside the context of therapy (Hill, Knox & Pinto-Coelho, 2018) and those that consist of here-and-now revelations by therapists about their

feelings or reactions to a client (McCarthy & Betz, 1978). The former is referred to as non-immediate disclosure and the latter as immediate or self-involving self-disclosure (see Audet, 2011). Therapists' self-disclosure is a significant topic in the psychotherapy literature, as a majority of therapists engage in this intervention (see Henretty & Levitt, 2010) and many scholars perceive such disclosures as unavoidable (e.g., Aran, 2016; Davis, 2002; Renik, 1995; Singer, 1977). While some perceive that CT disclosures, in particular, are beneficial for clients (e.g., Aran, 2016; Maroda, 1999), it appears that the beneficial impact of CT disclosures may be contingent upon other conditions. For example, in one study, participants viewed therapists who disclosed resolved CT issues (i.e., personal issues that bore similarity to what the client was sharing) as more attractive and trustworthy than those who disclosed unresolved CT issues (Yeh & Hayes, 2011). These therapists were also viewed as more capable of encouraging hope. In another study, participants rated the therapist as less skilful and therapy as more shallow when CT disclosures took place amidst a weak working alliance (Myer & Hayes, 2006). This demonstrates the conditionality of beneficial CT disclosures and shows that disclosures should be carefully considered to ensure safe practice.

Safe and Effective Use of Self

The College of Registered Psychotherapists of Ontario (CRPO, n.d.) have developed a registration competency termed the *safe and effective use of self (SEUS)*, which is defined as "the psychotherapist's self-reflective use of his or her personality, insights, perceptions and judgments in order to optimize interactions with clients in the therapeutic process" ("Safe and Effective Use of Self," para. 1). The CRPO suggests that practicing a SEUS involves therapists being aware of their influence on the clinical process and the effect of power dynamics, taking caution not to impose their personal concerns on the client, engaging in self-disclosure when

appropriate, and being careful to communicate the same to the client verbally and non-vernally (CRPO, 2012). Dewane (2006) adds to this by noting that the use of self can also include the use of one's belief systems, anxiety, and personality (e.g., touch, humour). As well, therapists' use of self is a concept known to multiple theoretical orientations. For instance, person-centered therapists emphasize the notion of therapists being congruent or genuine (Meador & Rogers, 1977; Rogers, 1980), cognitive behavioural therapy trainees are encouraged to use self-exploration to reach training goals (Laireiter & Willutzki, 2003), and psychoanalytic theorists understand the influence that both therapists' and clients' unconscious minds have on the treatment process (Pagano, 2012). Moreover, it has been shown that an inappropriate use of self (e.g., inappropriate use of silence or self-disclosure) can have negative therapeutic impacts (Ackerman, Hilsenroth, & Silverman, 2001). Thus, SEUS is evidently an important concept, and the need for additional research on therapists' self is acknowledged (e.g., Reupert, 2006).

Additional research can relate to CT, as there are evident similarities between the use of self and CT. As CT involves the therapist's emotional, cognitive, and behavioural reactions towards clients (Gelso & Hayes, 2007), the therapist's self is inevitably involved in the CT process. Knowledge and understanding of CT can be used to understand the therapist's own feelings and reactions towards clients. For example, Pérez-Rojas and colleagues' (2017) concept, "understanding self and client," as related to CT management, is about therapists being self-aware of their own processes, as well as the client's processes. This understanding can then be used as a tool to manage CT and can be implemented in practicing a SEUS to enhance therapy. Therefore, put simply, awareness and management of CT can fall under the broad umbrella of practicing a SEUS. According to Pagano (2012), theories on how therapists can effectively utilize CT are still underway. Suitably, more research can aid in their development.

Literature Gap

Though there is frequent mention of CT in the counselling and psychotherapy literature, some CT related topics require further address. Firstly, as there have been many changes to the definition of CT over the years (see Gelso & Hayes, 2007), many therapists may not be aware of the full complexity of CT and how it manifests in treatment. This is concerning, as therapists who are uninformed about CT can harm treatment (Hofsess & Tracey, 2010). This point makes clear the importance of having a clear and relatable definition of CT that practitioners can easily remember. This can allow practitioners to have CT on their radars, so they can catch and address it as it occurs. Secondly, while some literature discusses CT triggers and origins (e.g., Hayes, 1995; Hayes et al., 1998), more studies are needed to gain a comprehensive understanding of how CT manifests based on the context of therapy and the individual therapist's life (e.g., personal problems). Learning when CT commonly occurs can potentially help therapists understand their own triggers and manage them. Thirdly, there is a gap in research that considers therapists' experiences with CT in a change-oriented way. While some literature discusses how CT can be managed theoretically (e.g., Pérez-Rojas et al., 2017), little literature exists on how to apply these research findings to counselling practice, training, and supervision. Learning CT management tools that other therapists have successfully implemented may aid novice therapists in dealing with CT without compromising treatment. As such, the current study sought to address the following research questions: 1) How is CT conceptualized by therapists? 2) Within what contexts do CT reactions occur? and 3) How do therapists deal with their CT?

CHAPTER III

METHODOLOGY

A qualitative research design was employed in the present study. Data collection consisted of conducting semi-structured interviews with four experienced mental health professionals. This research design was selected for two key reasons. Firstly, qualitative research designs, and specifically interviews, allow researchers to understand participants' lived experiences rather than to test hypotheses (Seidman, 2006). Within this study, the aim was to obtain rich, detailed narratives from participants to gain a thorough understanding of their CT experiences and stories to ultimately find key themes among them. Themes were construed to represent the main topics and ideas participants discussed in their interviews. There was no hypothesis to be tested; instead, genuine curiosity about therapists' CT experiences guided the study and information emerged organically through interviews. Secondly, qualitative interviews allow participants to have a voice. Participants are afforded the chance to provide detailed opinions and narratives of their life to contribute to the research and ultimately to society. Within this study, interviewees were given the opportunity to state what was of importance to them, regarding CT, without much limitation. While a semi-structured interview protocol was used as a guideline, participants answered some questions more thoroughly than others, indicating areas of importance to them. In these cases, probes were used to allow participants to continue speaking about what mattered. A thematic analysis methodology was selected for use in the present study, as it allowed the researcher to neatly summarize key themes in a large quantity of data by following a structured step-by-step procedure (see Braun & Clarke, 2006).

Conceptual Framework

Constructivism. Constructivism is based on the premise that "humans actively create and construe their personal realities" (Mahoney & Lyddon, 1988, p. 200). As there are several such realities, all are considered to be equally valid (Ponterotto, 2005; Schwandt, 1994). While the aim of this study was to find themes pertaining to therapists' experiences with CT to gain a better understanding of it within the psychotherapy context, it was noted that all therapists would have their own experiences, as based on their theoretical orientation, life history, and personal beliefs. As such, it was expected that therapists' experiences with CT would also vary. For example, psychodynamic therapists would possibly perceive CT differently than therapists of other theoretical orientations since, within psychodynamic therapy, CT is actively utilized within treatment (e.g., Shedler, 2010). Since experiences with CT were considered to be subjective and specific to each individual psychotherapist, based on their training, a constructivist approach was used in this study. Verbal accounts of therapists' experiences with CT were obtained while considering that how therapists perceive and respond to their CT would be contingent on their specific view of the world and the type of therapy they used in practice. All therapists' experiences with CT were viewed as valid and treated similarly.

This study was also aimed at participants' self-discovery. According to Ponterotto (2005), "the constructivist position espouses a hermeneutical approach, which maintains that meaning is hidden and must be brought to the surface through deep reflection (see Schwandt, 2000; Sciarra, 1999)" (p. 129). Interactions between researcher and participant can help prompt these reflections (Ponterotto, 2005). In this study, these reflections were elicited through dialogue where the researcher asked the participant questions about their experiences with CT in order to gain a thorough understanding of their reality, leading to participant self-awareness and

meaning-making. In other words, as in constructivist paradigms, the participant and researcher co-constructed meaning and research findings (Ponterotto, 2005; Schwandt, 1994). Moreover, constructivist, qualitative researchers understand that empirical data reflect areas of importance for participants (e.g., Mills et al., 2006). In this study, areas of importance, or themes, uncovered what was significant to the group of therapists chosen for the study. These themes shed light on how CT is conceptualized and understood by participants, how participants came to experience CT, and how participants reacted to their CT experience.

Pan-theoretical. I also conducted this study with a pan-theoretical framework in mind, within which all psychotherapy theories were considered relevant and important. A pan-theoretical framework was relevant to the current study for two reasons. First, it was relevant, because the study consisted of interviews with therapists of diverse theoretical backgrounds. As such, the aim was to elicit responses, which not only allowed the researcher to understand the experiences of the individual therapist but also the collective experiences of therapists. This collective understanding was viewed as "pan-theoretical," as it was fed by several theoretical perspectives. Secondly, this framework was relevant to the current study, as research suggests that a large number of therapists today identify as integrationist or eclectic in their practice (e.g., Hollanders & Mcleod, 1999; Norcross, Kapiak & Santoro, 2005). As well, there are many diverse theoretical models that are employed in contemporary psychotherapy (e.g., psychodynamic, cognitive, client-centered). As such, it was supposed that the study's findings could be applied to the training and practice of the current and future generations of therapists, who would appreciate that results were not grounded in one theory alone and could instead reflect the therapeutic preference of many. For example, using a pan-theoretical framework helped better answer the question, "how is CT conceptualized by therapists?" in a way that was

reflective of diverse theoretical orientations. Information produced by the study, in combination with data that might emerge from future research, can lead to the formation of a definition that integrates the experiences and knowledge of therapists of varying theoretical backgrounds and can thus be considered a pan-theoretical definition for use in counselling education.

Semi-Structured Interviews

Upon reviewing a variety of qualitative methods, including the structured interview, semi-structured interview, and unstructured interview, it became clear that the semi-structured interview would best elicit data pertinent to the focus of the present study. Structured interviews are generally suited to quantitative data collection, and unstructured interviews consist of eliciting general information and asking questions that are developed over time (DiCicco-Bloom & Crabtree, 2006; Rubin & Rubin, 2005). Because the present study was founded on answering specific research questions, unstructured interviews were ruled out for use. Structured interviews were ruled out, because the researcher wanted to elicit detailed accounts from participants, which captured their unique experiences, rather than brief answers to predetermined questions. As noted by Kallio, Pietila, Johnson, and Kangasniemi (2016, background section, para. 1), semi-structured interviews are advantageous in that they "[enable] the interviewer to improvise follow-up questions based on participants' responses (Hardon et al. 2004, Rubin & Rubin 2005, Polit & Beck 2010)." As probes or follow-up questions would allow the researcher to collect more thorough data, semi-structured interviews were considered the ideal data collection method.

Development of Interview Protocol

The interview protocol (see Appendix A) consisted of questions meant to address all three of the study's research questions. Interview questions were inspired by the clinical

literature on CT, specifically the existing definitions of CT, methods of managing CT, and factors that contribute to the susceptibility of experiencing CT. They were also inspired by what is not found in the literature, so as to fill the literary gap. Questions one and two were meant to address therapists' general understanding of CT. Question one was specifically meant to address whether any of the definitions noted by Gelso and Hayes (2007; i.e., the classical, totalistic, complementary, relational, or integrative definition) were employed by the study's participants. This question was important, as it helped evaluate whether contemporary therapists had a distinctive understanding of CT, which may or may not lend support to existing definitions. Question two was included to gain an understanding of how participants' own experiences of CT contributed to their understanding of the concept. I was interested in noting links between one's definitional understanding of CT and the experiences that might have shaped this understanding. This question was also included to address the gap in literature that informs of therapists' qualitative, lived experiences of CT. Question three was motivated by literature that suggests the importance of therapists becoming aware of their CT (e.g., Schlesinger & Wolitzky, 2002; Tishby & Wiseman, 2014). As such, with question three, I sought to understand how therapists have been made aware of their CT. Question four was meant to address why a participant believed their experience was CT. I meant to assess what the defining factors were which made the experience CT.

Questions five to eight were meant to address whether or not participants had positive or negative experiences with CT and how CT might have impacted therapy. These questions were formed in response to literature, which essentially disagrees on whether CT is harmful to therapy or helpful. While some literature highlights the negative impacts of CT (e.g., Linn-Walton and Pardasani, 2014; Schlesinger and Wolitzky, 2002), other literature speaks of how CT can be

clinically utilized (e.g., Cabaniss et al., 2011). Question nine was strategically added to the interview protocol in the case that a participant felt uncomfortable disclosing their own CT experience; they could then share the experience of a colleague instead. As there is common mention of the importance of CT management in the literature (e.g., Gelso & Silberberg, 2016; Pérez-Rojas et al., 2017), questions 10 to 13 were designed to identify what therapists specifically do to manage their CT. Question 11, which addresses one's participation in supervision, is inspired by literature that highlights the role of supervision in working through or managing one's CT (Blasini-Méndez, 2019; Grinberg, 1997; Hayes, 1995). As such, question 11 would inform of helpful ways to manage CT. Question 12 was informed by definitions of CT (e.g., Epstein & Feiner, 1979; Freud, 1910/1959; Heimann, 1950), as well as clinical literature on CT (e.g., Cabaniss et al., 2011; Knaus et al., 2016; Liebman & Burnette, 2013; Schlesinger & Wolitzky, 2002), that display opposing view points on its utility. It was believed that some understandings could foster shame or guilt in therapists regarding their experience of CT, as the literature notes that practitioners may have difficulty admitting negative feelings for clients, including negative CT, as they conflict with their self view of being helpers (Kottler & Uhlemann, 1994 as cited in Guest & Carlson, 2019). As such, I was interested in learning how participants felt and what they thought of their CT experience. This was considered to be especially important, as having negative feelings towards oneself for experiencing CT might act as a roadblock to seeking the help needed to appropriately deal with CT.

Questions 14 to 18 were meant to address the contexts within which CT reactions occurred. They were developed in response to literature that revealed common origins and triggers that led to therapists CT experiences (Hayes et al., 1998); I sought to understand whether the study's participants had experienced similar triggers. These questions were also inspired by

literature that sheds light on the importance of therapists' self-care and psychological well being (e.g. Ayala, Ellis, Grudev, & Cole, 2017; Killian, 2008; Shannon, Simmelink-McCleary, Im, Becher, & Crook-Lyon, 2014), as these factors were speculated to impact the experience of CT. Therefore, learning the contexts that breed CT in participants had the potential to shed light on whether these experiences were linked to self-care or a lack thereof.

Moreover, as mentioned previously, each question included in the interview protocol corresponded directly to a research question. Questions one to nine were developed to address the study's first research question, "how is CT conceptualized by therapists?" Questions 10 to 13 were developed to answer the study's second research question, "within what contexts do CT reactions occur?" Lastly, questions 14 to 18 were formed to address the third research question, "how do therapists deal with their CT?"

A demographic questionnaire was also created for the study. Participants were asked their age, gender identity, area of residence, educational qualifications, the regulatory body they were part of, how long they had been a member of this regulatory body, how long they had been practicing counselling or psychotherapy, and their theoretical orientation (e.g., psychodynamic, client-centered, cognitive). It was believed that learning clinicians' age and the length of time they had practiced psychotherapy would allow the researcher to understand when clinicians were trained and what definitions of CT they may have learned during that time. Whether participants still practiced psychotherapy was considered noteworthy, because clinicians who no longer practiced could have a different understanding of CT than practicing clinicians for a variety of reasons, including their level of interest in the clinical literature and the availability of time to process CT experiences. Participants' theoretical orientations were believed to be extremely important, primarily because the study was meant to have a pan-theoretical framework. As such,

it was important to have a record of the diverse theoretical orientations represented in the study. Further, it was believed that learning participants' theoretical orientations would allow for a better understanding of the participants view of CT, as clinicians of diverse theoretical orientations can have differing views and opinions of CT (e.g., CT as pertinent to psychotherapy, CT as unimportant). The rest of the demographic information was collected to help the researcher gain an understanding of the participant's life experiences and views, in order to better understand the material discussed during the semi-structured interview.

One pilot test of the interview protocol was conducted on a student in the Master's of Arts in Counselling Psychology program to ensure that data collected would answer the study's research questions. Data collected did indeed answer the three research questions and also provided the researcher with practice on how best to administer the interview protocol.

Participant Recruitment

Participants were recruited using three techniques: 1) distributing flyers to accessible counselling clinics in Ottawa, Quebec, Toronto, and surrounding areas (see Appendix B and C), 2) sending detailed emails to graduates of the University of Ottawa's counselling psychology program (see Appendix D), and 3) word of mouth. The first step in distributing flyers to accessible counselling clinics was to send an email to the manager of the counselling clinic to inquire if they were willing to advertise a recruitment poster for my research study. A recruitment poster was attached to the email. The manager, if willing to advertise the recruitment poster, was advised to either print copies of the poster provided or request that the researcher mail them paper copies. Secondly, a request was made of the Counselling Psychology Coordinator to disseminate emails to graduates of the University of Ottawa's Counselling Psychology program. A copy of the recruitment letter was emailed to the coordinator for

distribution via the listserv. The third recruitment technique, word of mouth, was used to recruit participants who were known to individuals that the principal researcher knew. For example, if a member on the thesis advisory committee knew of a qualifying candidate who would be interested in the study, they could advise the candidate to contact the principal researcher directly if interested in the study. All these methods were successful in recruiting participants.

Participant Selection

A purposeful sampling technique was used in the current study to increase the probability of finding participants who had substantial information to share (Patton, 2002). It was required that participants had practiced psychotherapy for at least 5 years and had experienced CT in order to ensure they had general knowledge about CT and what it encompassed. Having practiced for 5 years also helped ensure that all participants abided by similar codes of ethics and professional practice standards. Thus, they would be able to understand the ethical implications of diverse CT manifestations and make informed decisions about what information to disclose during the interview. It was also required that participants be of diverse theoretical backgrounds, as the study followed a pan-theoretical conceptual framework and was meant to be representative of the large number of therapists today who identify as being integrationist or eclectic in their practice. This would ensure that therapists' collective experiences would represent a pan-theoretical understanding of CT, as each participant would contribute their own theoretical perspective. This was upheld by sending flyers to counselling clinics that specialized in diverse therapeutic approaches and by making a point to recruit few participants of the same theoretical background. It was planned that exceptions would be made for individuals who identified as eclectic or integrationist in their practice, because these individuals would represent a mix of theoretical backgrounds. Individuals were advised in advance, through the recruitment poster and

letter, that priority would be given to clinicians of varying theoretical backgrounds to ensure diversity within the study. Additional criteria included residing within Canada and having the ability to communicate in the English language, in order to respectively control for cultural impacts on psychotherapy practice and ensure that information could be communicated effectively between researcher and participants. Participants who met all criteria were recruited on a first come, first serve basis, as detailed on the recruitment poster and letter.

Data Collection Procedure

Before data collection was initiated, approval to conduct the study was granted by the University of Ottawa's Research Ethics Board. To begin data collection, an initial meeting was scheduled with candidates who were interested in becoming participants of the study. This meeting was scheduled via email once a potential participant sent me an email indicating their interest in participating in the study. The initial meeting took place over the phone and lasted approximately 10-15 minutes. The focus of this meeting was to: screen the potential participant to ensure they met the study's inclusion criteria, discuss the purpose of the study in greater detail, and answer any questions the potential participant had. Individuals that remained interested in participating in the study, and met inclusion criteria, became participants in the study. The participant was then asked for their availability, so a second meeting could be scheduled. If a participant was unable to provide their availability during this initial meeting, they were asked to email it to me as soon as possible. Once the participant's availability was received, a few different times were proposed for the second meeting and the participant was able to select their preference. At this point, the participant was also asked about whether they preferred to be interviewed over the phone or in person. If geographical distance allowed for the interview to take place in person, the participant was asked whether they preferred to be interviewed in their

own office space, to allow for greater convenience to them, or in an office at the University of Ottawa's Community Counselling Clinic.

Though expected to last 45 to 60 minutes, the second meeting lasted slightly longer than anticipated. It took place shortly after the initial meeting, to ensure the participant remained interested in the study. A consent form (see Appendix E) was emailed to the participant at least 24 hours in advance, so they were able to review it before the meeting. At the beginning of the meeting, the participant and researcher went through the consent form together step-by-step, in order to ensure that all information was understood by the participant and to provide the participant with an opportunity to ask any questions they had. Anonymity and confidentiality, data collection and storage, and compensation were discussed with the participant. The participant was also informed that the researcher would ultimately use the data collected to write a research report that would be shared with the public. They were informed that direct quotations of participants might be used in this report but that identifying information would not be included and all real names would be removed. The participant was informed that they could withdraw from the study at any time without any negative consequence. The consent form also contained the contact information of my thesis supervisor, the institutional ethics board, and myself. This information was included so that participants would know to contact the appropriate body to ask questions about the study or address concerns. A debriefing form (see Appendix F) was also attached to the consent form as an appendix and was mentioned to participants. It contained services the participant could access if the interview caused them any discomfort. After discussing informed consent, participants were given a chance to ask any questions they had and were provided with thorough answers. If the second meeting took place over the phone, the participant was asked to provide verbal consent. The verbal consent of the participant was

audio-recorded. If the second meeting took place in person, both the participant and I signed the consent form in person. The participant and I both kept a copy of the signed consent form. If the audio recorder was not already switched on to obtain verbal consent, it was switched on at this point to begin the audio recording of the meeting. The participant was then asked to provide demographic information.

The rest of the meeting followed the semi-structured interview protocol focused on the participant's experiences with, and perceptions of, CT during therapy sessions. While the semi-structured interview protocol contained predetermined questions, new questions were asked as they came to mind and the participant was probed for further information about an experience or topic when it was of relevance or seemed important to them. Basic notes were taken during the interview to keep record of what caught my attention. Upon completion of the interview, the audio recorder was turned off and the participant was given a chance to debrief. They were invited to talk off record about their experience as an interviewee and were invited to ask any questions they had. Participants were also reminded of the debriefing form that had been attached to the consent form as an appendix and were invited to contact me by email if they required additional information on available services. The participant was thanked for their time and contribution to the research.

Data Analysis Procedure

Thematic analysis is a qualitative research method that can be used to systematically uncover meaning in a dataset by ultimately identifying themes and making sense of them so as to answer a specific research question (Braun & Clarke, 2012). This research method was implemented in the current study, as it provided a systemic way to analyze data by outlining six steps to be followed (see Braun & Clarke, 2012). These steps will be explained further below.

Once participant interviews were completed, I transcribed recordings of the interviews, which became the data. I subsequently analyzed the data using an inductive approach, where ideas and meanings were identified from the data (Braun & Clark, 2012; Thorne, 2000). As per the first step of thematic analysis, I became familiar with the data and made basic notes to begin the process of questioning the meaning behind the data (Braun & Clarke, 2012). To do this, I reviewed the interview transcript with the goal of better understanding participants' experiences with CT. I made note of thoughts and ideas I had while reviewing the transcript, such as what the participant may have been trying to convey, statements that were of interest, and how the participant seemed to define or think about CT. I also made note of passages I did not completely understand. I reviewed these again later.

Secondly, I created preliminary codes to organize, interpret, and label the data (Braun & Clarke, 2012). Codes were labelled according to the participants own language and meaning (i.e., semantic) and the researchers interpretations (i.e., latent). I used the codes to summarize what the participant may have been trying to say in few words. Sometimes, participants clearly and concisely conveyed their experiences, opinions, feelings, or thoughts. In some of these cases, semantic coding was used. One such code was labelled, "CT gives colour to the therapist's work." The majority of the time, however, I made interpretations about what the participant was trying to convey. I tried to understand the meaning behind their words. In these cases, latent coding was used. As an example, one code was labelled, "CT informs of what is happening for client outside of therapy," which was an interpretation of what one participant stated. Codes were generated for each transcript in order of completion. This allowed the researcher to build on the prior transcript by catching and noting codes that seemed to arise frequently within the dataset.

Thirdly, I found patterns within the data set and identified subthemes to link codes together (Braun & Clarke, 2012). To do this, I reviewed my codes and began clustering those that fit together to represent a broader idea or topic. The subthemes formed did not only represent participants' shared experiences; rather, they represented a main topic from one or more of the interviews, accounting for diversity between participants. Fourthly, I reviewed subthemes to improve quality and ensure they fit within the dataset as a whole, by broadening subthemes to include new codes and refining them to discard old codes (Braun & Clarke, 2012). During this stage, some subthemes were also removed and others added until I felt satisfied that all codes fit well within a subtheme. I ended up with 21 subthemes. I then grouped together subthemes that could collectively represent an even broader topic, leading to the formation of five overarching themes. Fifthly, I labeled these five themes and defined them, so they would be better understood by others (Braun & Clarke, 2012). The naming process took some time, as I wanted to label themes in a way that best represented the data. For example, one theme was initially called, "What to do With CT." The label was later changed to, "Methods of Dealing with CT." Sixthly, I produced this present report to explain and share my data.

Trustworthiness

An important part of all research, quantitative and qualitative alike, is its trustworthiness (Krefting, 1991). As such, this study too addressed trustworthiness criteria. Aspects of trustworthiness within a qualitative research design include its credibility, transferability, dependability, and confirmability (Guba, 1981).

Credibility. The credibility of a research study is reliant on the premise that individuals experience a multitude of realities (Guba, 1981) and that there are several such interpretations of these realities (Riege, 2003). As such, findings and interpretations should be checked to ensure

they are representative of participants' experiences and appropriately reflect their realities. Credibility can be established through the use of member checks, where the researcher tests empirical data and interpretations by sharing it with the research participants, and through peer debriefing, which involves sharing one's ideas and thinking with a group of peers who can ask questions aimed at discovery (Guba, 1981). In this study, member checking occurred by sharing transcripts with research participants and making changes when necessary. Peer debriefing occurred by sharing my insights with my research supervisor during meetings while allowing for questions.

Transferability. Transferability is concerned with the ability to transfer a study's hypothesis from its current context to another similar context (Guba, 1981), such that readers can relate the research narrative to their own lives (Tracy, 2010). Transferability can be increased by conducting purposive sampling and obtaining detailed descriptions from participants (Guba, 1981). Purposive sampling was used in this study by conducting interviews with individuals who were most likely to have an adequate understanding of CT, in order to gather plentiful, important information on the concept (Guba, 1981). Based on the inclusion criteria of the present study, participants interviewed were experienced in providing psychotherapy and had previously experienced CT, which helped ensure that they understood the concept. In order to obtain detailed descriptions from participants, the semi-structured interview protocol used in the present study consisted primarily of open-ended questions. I also probed for further information and asked follow-up questions when appropriate.

Dependability. Dependability has to do with the consistency, stability, and credibility of a research study (Guba, 1981; Riege, 2003). Within qualitative research, however, it is acknowledged that some degree of variance between participants is real and does not simply

result from errors within the study (Guba, 1981). To ensure dependability, researchers should 1) outline the steps and details involved in conducting a study so it can be replicated in the future (Shenton, 2004), 2) ensure a match between research questions and the study's design (Reige, 2003), and 3) incorporate an auditing process (Guba, 1981). The steps involved in the present study have been, and will continue to be, described in great detail throughout this report to allow for some consistency between the present study and future research. The reasoning behind using the specific research design (e.g., qualitative research design, semi-structured interview protocol, thematic analysis) has also been explained thoroughly in this report. The use of an audit trail (i.e., a record of all steps taken in the study and possession of relevant documentation; Guba, 1981) was also incorporated. Documentation included a record of all steps taken, interview notes, copies of correspondences between participant and researcher or note thereof, and notes created during data analysis. A dependability audit was also conducted by an individual with the expertise to determine whether acceptable practice had taken place within the study (Guba, 1981). During this process, documentation and interview transcripts were reviewed by my thesis supervisor.

Confirmability. Confirmability is concerned with whether reasonable conclusions are being drawn from the data (Riege, 2003) and can be established by having a confirmability audit (i.e. ensuring consistency between data and interpretations; Guba, 1981). In addition, it has been noted that practicing reflexivity can also allow for confirmability within the study (Guba, 1981), as it allows researchers to take responsibility for how they impact the research and interpretations drawn (Berger, 2015).

In the present study, initial codes were formed immediately after the first interview was transcribed, so the codes could be reviewed by an auditor early on to ensure that analytic

procedures were being followed appropriately. Changes to the process were made accordingly. For example, upon initial review, it was noted by the thesis supervisor that the researcher was generating subthemes rather than codes. As such, the first interview was re-coded to meet analysis standards. The rest of the interviews were also coded immediately following transcription and were audited in order of completion. During this phase, the thesis supervisor reviewed the codes formed and ensured they were representative of what participants were detailing in their interviews. The thesis supervisor suggested adding and/or removing some codes and, as such, changes were made. Once codes were generated for each interview and reviewed during audit, the researcher began generating subthemes and themes that encompassed the various codes formed. These were also reviewed by the thesis supervisor. To allow for reflexivity in the study, I engaged in reflexive journaling following interviews and kept note of assumptions made during data analysis. In addition, I made note of my understanding and biases of CT (see Appendix G) to allow readers to understand how I may have influenced the data.

Purpose of the Study

The purpose of the study was to understand CT through therapists' retrospective accounts by learning about how therapists define and conceptualize CT, when specifically CT reactions occur, and how therapists manage, handle, and cope with their CT. Semi-structured interviews were conducted with four mental health professionals and subsequently transcribed. Thematic analysis (TA) by Braun and Clarke (2012) was then used to guide data analysis. The following three research questions were selected for the present study:

1. How is CT conceptualized by therapists?
2. Within what contexts do CT reactions occur?
3. How do therapists deal with their CT?

CHAPTER IV

RESULTS

Descriptive Analysis

A total of four participants were interviewed for the present study. The length of interviews ranged from 52 to 68 minutes. A description of each participant is shown in Table 1 (see below), based on demographic information provided by participants prior to the start of the semi-structured interview. Each of the four participants was assigned a pseudonym to ensure complete confidentiality. Three participants identified as female and one identified as male. Their ages ranged from 28 to 54 years. One of the participants resided in Ottawa and three resided in Quebec. All four participants had at least a Master's level education in Counselling Psychology or a related program. Two of the participants, at the time of the interview, had membership with the College of Registered Psychotherapists of Ontario (CRPO), one had registration with the Order of Psychologists of Quebec (OPQ), and one had registration with the College of Psychologists of Ontario (CPO). They had been members of these regulatory bodies for a range of 2 to 10 years. They had been practicing counselling and psychotherapy for 5 to 25 years and all were in practice during the time of the interviews. Three participants were either integrationist or eclectic in their theoretical approach, as they were inclined to use more than one theory of counselling or psychotherapy when working with clients. One participant identified as structurally integrative in their theoretical orientation, designing conceptualizations and interventions based on what a client presented during therapy. The second identified as eclectic but indicated an inclination towards using client-centered, somatic experiencing, and acceptance and commitment therapy theories. The third identified their theoretical orientation as narrative and systemic. The fourth participant stated their theoretical orientation as being third-wave

cognitive therapy, primarily acceptance and commitment therapy. All participants fully met the inclusion criteria required for this study.

Table 1

Participant Demographic Information

Participants	Nancy	Leah	Ria	Peter
Gender	F	F	F	M
Age	34	28	37	54
Area of Residence	Ottawa	Quebec	Quebec	Quebec
Degree	M.Ed. Couns.	M.Ed. Couns.	M.A. Couns.	Ph.D
Registration with Regulatory Body	CRPO	OPQ	CRPO	CPO
Years Registered	4	2	5	10
Years of Experience	9	5	7	25
Currently Practicing?	Yes	Yes	Yes	Yes
Identified Theoretical Orientation	Eclectic. Client Centered, ACT & Somatic Experiencing	Narrative & Systemic	Structurally Integrative	Third-wave cognitive. ACT

Data analysis revealed a total of five overarching themes, each of which contained a series of subthemes. The following themes were identified: (a) defining characteristics of CT, (b) CT triggers, (c) reactions to CT, (d) methods of dealing with CT, and (e) impact of CT on therapy. A complete list of all themes and subthemes can be found in Table 2, which is located at the end of this chapter. A detailed description of each theme, including the subthemes that each theme is comprised of, will be provided below. One or more verbatim examples will also be

provided for each subtheme to offer greater clarity on the meaning of the subtheme and support the development of the subtheme.

Defining Characteristics of Countertransference (5 Subthemes)

The following five subthemes emerged from the data surrounding how therapists defined and conceptualized CT. While definitions and conceptualizations varied, therapist responses could be divided into five subthemes, each of which provided a further account of the varying perceptions of CT among participants. Each of the subthemes will be explained individually and in detail below.

1. It is normal to experience countertransference. Whilst describing their understanding of CT, participants discussed how the experience of CT in psychotherapy is both normal and part of being human, allowing for a compassionate understanding of one's CT experiences. They also indicated that it is essential and often inevitable. The following account from Leah highlights that CT is expected when one chooses to become a therapist and does not indicate any wrongdoing on the part of the therapist.

> Um I feel like okay about it. I think it's a normal part of… Um I think it's a normal and expected part of being a therapist and kind of comes with the territory. Like, like every [counsellor]… So I have never felt like I'm doing something wrong because I have CT. I think I always just thought I'm human and that's why I have CT. [Leah]

Similarly, the following statement from Peter highlights that CT is both part of being human and part of being a therapist.

> Well, in relation to talking about stuff that comes up… Like, you know, like CT is not… I guess I've come to [the understanding] that it's [there] because I'm a human being. And if you're a human being in this line of work you're going to have CT. [Peter]

Moreover, some participants mentioned that CT is a focus of psychotherapy. In the following statements, Ria details how her experiences with CT caused her to reflect on it and

eventually come to see how it plays a principal role in therapy. She also described the importance of using it clinically, due to its central role.

> And I'd say those are… That's one of my experiences that like really led me to reflect on like, what is this thing that's happening, right?... Inside of me. And how can I use it? And is it eventually to come to the conclusion that that's the whole point of therapy? [Ria]

She also commented on her desire to become a mentor who can help practitioners understand CT better due to its importance.

> I want to become one of the mentors that I was lucky enough to have in my career. I think that uh having more supervisors uh be able to help clinicians hone in on what this is, understand it, where's it come from for them, and how to use it clinically is like … This is why we're here. This is why we're doing this psychotherapy stuff to begin with. It's the whole purpose. [Ria]

While participants discussed feeling shamed by colleagues for experiencing CT and initially feeling guilty for their experience due to self-imposed expectations and beliefs, all four participants seemed to agree that it is 100% normal and part of the therapeutic process. They also indicated that advice they would give to individuals experiencing CT is that it is normal and okay to have this experience.

2. Signs that alert therapists to countertransference. During interviews, participants discussed emotions, thinking patterns, and experiences that occurred in and out of sessions that alerted them to their experiences of CT. Some signs discussed included having negative emotions towards clients, reacting unusually to a certain client, feeling emotions which the client should be feeling, thinking about clients past termination, selectively noticing issues in clients that relate to the therapist's own life, and feeling responsible for the client's emotional experience. The following statement made by Ria sheds light on how she recognized that she was experiencing CT when she began feeling emotions that would have been more typical for the client to feel in a given situation.

> And I was in the room with her. I was… I felt like I was feeling like that mirroring, that, that empathic response to the effects that she was having but that she was cutting herself off from. I was feeling those feelings. And it was disorientating because she was so disconnected from them and I was feeling them like in my body. [Ria]

Further, participants commented on how they knew they were experiencing CT when their own personal processes entered into therapy. Nancy shed light on how her awareness of her own history helped her understand that what she was feeling in her relationship with a client had to do with her own need to rescue people. Moreover, Ria helped explain how a client can remind the therapist of someone in their own life, causing the therapist to project onto the client their personal feelings about this person.

Moreover, some participants discussed how, when experiencing CT, they would often notice in the client what was going on in their own life. For instance, Peter discussed that he would catch himself saying to clients what could have easily been said to him by a therapist.

> There would be words that would come out of my mouth that were sort of aimed at addressing something that was not working in me, [something] in the client's life, dysfunctional whatever you want to, to call it. And I could have easily sat in the client's chair and have a therapist say this to me. Like I can't believe this is coming out of my mouth because I'm doing the same thing, sort of thing. So it's almost, it's almost been a little surreal when I hear myself say things and then I, in that moment, look at my own life and say, "Holy crap I, you know, I'm doing the same thing. [Peter]

3. Countertransference is multidimensional. Participants in the study collectively demonstrated a multidimensional understanding of what CT is. They indicated that there are different ways of understanding and conceptualizing CT depending on the individual therapist and the unique client experience, revealing that there is not one right way.

> Because in reality… Like in our field, there is no truth [laugh]. Like it kind of… Your question kind of brings me to that space: Is it CT, is it something else, is it… So I don't know. I can't like… It's not something I can confirm if it's CT or not. But what I know is I don't have that experience with all of my clients. [Ria]

In agreement with her understanding of CT as highlighted above, Ria discussed how she would sometimes question her mentors' definitions of CT to see if these definitions resonated for her.

> Uh and then trying to understand, "Do I actually agree with how they're conceptualizing CT or not?" Like I tried to like individuate myself [laugh] from my mentors in that way and be like, "Do I agree? Do I not agree?" Uh and then uh really trying to make space for it and stop shaming myself. [Ria]

Moreover, Nancy discussed that CT is not simply based on one's behaviour; instead, one's feelings can count as CT irrespective of the therapist's behavioural reaction to them.

> Um but I would say… You know, let's say you might uh… As a therapist, you might be feeling it and, and taking great care not to have it impact things. But I think if you're feeling it or noticing it, that counts as CT even if maybe you are trying to prevent it from derailing you. [Nancy]

Additionally, Ria raised awareness of how therapists and clients do not produce CT on their own; instead, they co-construct CT based on how their individual dynamics (e.g., personality, history) interact.

> It's like always going to be a mix between your own personality, uh your own history of relationships, uh and the clients. Um there'll be kind of an intertwined co-construction of something with the client in that space. [Ria]

Peter also discussed that CT stems from both therapist and client. Specifically, he mentioned that CT is a therapist's response to a client's material. He also added that the response stems from the therapist's attachment issues.

> Well, it starts with a… some kind of response in the therapist to the client, to material the client is presenting in the session, to the person of the client, to any aspect of the client experience. So the therapist's response to that. Um but I think what I… In particular related to CT, the way I conceptualize it is it's, it's not just any response. It's a response that's really routed in the therapist's own uh attachment issues. And, and uh really uh personal issues, issues part of their attachment issues from a psychological perspective. [Peter]

4. Perceived effectiveness of countertransference is context-specific. Interviews highlighted tension in participants' understanding of the effectiveness of CT, as participants

commented both on its potential utility in therapy and the ways in which it harms therapy. Participant accounts further demonstrated that the perceived effectiveness of CT depends on the context of therapy. In the following statement, Leah suggests that specific feelings, such as disgust or anger towards a client, can signify that the client should receive care from someone else.

> I think when, when I have an attraction or, or like clear anger and disgust for a client, it's been an indicator for me that um they were not going to be therapeutically useful for them, so it's time to transfer them to another clinician. So in that way, the fact that I have this CT is telling me there's something going on and they need better care than what I can give them because I, I can't work with them. [Leah]

On the other hand, Nancy discussed how CT positively impacted her work with clients who reminded her of someone she knew.

> You know, I would say it [makes me] appreciate clients and, and um be extra patient with them um because they reminded me of someone. For example um… Although um… So I guess it gives some sort of colour [laugh], colour to my, my work um in different ways. [Nancy]

During his interview, Peter stated that, to him, CT feels like a challenge to the work of therapy. If he had a choice, he would choose for CT not to be present. He highlighted that his perception of CT can partially be attributed to his theoretical approach to psychotherapy.

> In light of the way I describe it, I think that if I could live the rest of my professional career without any CT, I would be happy about that. So it feels like it's a challenge to the work. I mean, that said, I also recognize that at the same time there are some therapists who can use this to their advantage because their… You know, it's, it's more central to their approach. Uh that's fine. I work ACT. In the behavioural therapy, CT is not part of the um, the framework. [Peter]

As seen in the various participant statements shared above, the specific context of therapy can dictate whether the CT experienced is understood as positive or negative in nature, thereby influencing its perceived clinical effectiveness.

5. Therapist experiences of countertransference change over time. Participant accounts revealed that their experiences of CT changed over time. Such experiences included their perceived competence, level of shame, and openness to discussing CT. In the following statement, Nancy suggests that her competence regarding CT has been subject to change, as she initially had more difficulty identifying it.

> You win some you lose some. Uh I do think that the more um experienced I become, the more easily I catch it. And I would also say there have been… I think early on for sure there have been times that I've only caught it after the fact or when someone was pointing it out to me or asking me challenging questions to say, to get me to look at what happened…So I don't think that I've been equally competent about it the whole time. [Nancy]

In the statements below, Ria made mention of how shame ensued from some of her past CT experiences, due to expectations and ideas of how a therapist should be. She discussed how over time she learned to make sense of her CT feelings and their therapeutic significance, which allowed for her to feel far less shame for experiencing them. This learning that occurred over time also speaks to Ria's change or increase in perceived competence, as she found more helpful ways of understanding and using her CT feelings. Ria began by sharing her confusion and shame in regards to CT.

> So there were quite a few, like 2, 3 years in there, where I felt really lost. Like I had all this um… All these experiences and all this information about my therapeutic relationship with my client that I didn't quite know what to do with, or where to put, or even didn't know how to feel okay about it. I felt a lot of shame around it. [Ria]

Ria explained these feelings further and also shared her newfound understanding of CT.

> What it looks like now. Um so my experience of it is, there's a lot less shame than there used to be…Um I'd say that sometimes… Like there are few emotions that I feel uh guilt about. Like if I have… If I have, let's say, strong feelings of disgust for someone that um has a narcissistic personality structure, which is a common CT experience… Uh like feelings like that I'll have a hard time tolerating um because I feel a lot of guilt for… It kind of goes against my own kind of uh understanding of whom I'm supposed to be as a therapist. I've never experienced those things towards a client and all that. So that's the first reaction that I'll, that I'll get. But I worked a lot on trying to understand why I would

> have that reaction, what it's there for, right? And how I can use it in therapy, right? If I'm feeling disgust… Usually we feel disgust when something is toxic for us. And if we don't… And if we don't feel disgust, we might take in something that's not good for us. [Ria]

Moreover, at the end of his interview, Peter mentioned that he likely would not have been able to have the same type of conversation around CT earlier in his career due to the vulnerability it involves.

> It's a, it's a vulnerable place. And, you know, I probably wouldn't have been able to have conversation like we had, you know, 10 years ago. And, you know, there's probably lots of other therapists who couldn't have this kind of conversation. It's very, very tricky and vulnerable terrain because it requires… Like you really have to like permit yourself to open up and, in doing so, really like permit yourself to be vulnerable to, to oneself. [Peter]

Countertransference Triggers (3 Subthemes)

The interview data highlighted triggers to CT experienced by therapists. This theme included three subthemes: therapist-specific experiences that trigger CT, client-specific elements that trigger CT, and client-therapist interactions that trigger CT. Each subtheme, which will be discussed further below, provided perspective on how CT is triggered by a variety of factors, as well as a combination of factors, rather than just the therapist's personal processes, the topic or material brought forth in psychotherapy, or the client themself.

1. Therapist-specific experiences that trigger countertransference. The data informed of how the therapist's own personal life experiences can trigger CT when working with clients. This data revealed that stressful life events can be a precursor to developing CT. In the following statement, Ria talks about how a major life event, which created a period of instability in her life, impacted her level of availability for clients. During her interview, she went on to discuss that, during this time, there were some topics she could not address with clients, as they were too sensitive.

> What does one do when your life is just, feels like it's falling apart? Like your whole [identity]… Like everything in my life was about to change drastically… Where I was going to live, my relationship with my son. Uh I was going to have like shared custody where I was used to seeing him everyday and then I would see him half the time. And then uh I'm in the middle of a degree, financially unstable. And now I'm going to be, supposed to be, financially… Like everything was affected by this… So I called my supervisor and I'm like, "I can't be available to clients. Like what am I supposed to do?" [Ria]

Similarly, during his interview, Peter mentioned that when his marriage ended, he met with fewer clients. To some degree, he stayed away from practicing therapy.

Moreover, during her interview, Leah talked about how experiencing the loss of someone in her life, and consequentially having to go through a family systems adjustment, impacted her interactions with clients. As a result of her experience, she found herself less present in sessions when her memory of loss was triggered.

> There were many times where I had to remind myself to stay present um because my client was sharing something that resonated with my personal experience. I was finding myself disengaging from the session either self protectively or just because my mind was going off. [Leah]

2. Client-specific elements that trigger countertransference. Similar to the above mentioned subtheme, data also highlighted how the client's behaviour, personality, or content brought to sessions, sparked CT. Ria discussed how one of her clients reacted strongly to her and attempted to switch roles with her during sessions, thereby attempting to influence power dynamics. This caused Ria to act out of her CT in some ways. However, Ria only realized what was going on between her and the client after-the-fact.

> So anyway um this client came in and he came up as grandiose, narcissistic personality structure. Um and it was very much that kind of that manifestation in therapy. Like very idealized me and devalued me within like maybe ten times in 5 minutes in a session or… Like the very extreme responses to me. And there was this uh… He… The way he tried to… My understanding is he was trying to switch roles with me in certain moments where he saw me… I think in certain moments, he felt he looked up to me and that was hard on his self-esteem. Um so he tried to switch and have me look up to him… And now I understand better that that's what was happening. And if I had understood that that's

> what was happening in those moments, I would have done things differently. But I didn't. Like that escaped me in those moments. [Ria]

In her interview, Leah discussed how a client's relapse, after a period of recovery, caused her to feel a sense of pressure to get him back to a state of recovery. She discussed how this specific client situation caused her to feel more responsible for this client than she usually did for others.

> And also the fact that he had, he had a history of substance abuse and a lot of uh risky behaviours and suicide attempts. And then he had gotten to a place where he was doing so well.... And then he was given to me at a point where he had relapsed. So I think I sensed… I, I felt an extra sense of responsibility because he had done so well, because I wanted to perpetuate that, because I felt like he, you know, had made so much progress. I wanted to help him get to that place so that was extra responsibility because he was already involved in the system for so many years. [Leah]

This intense life experience (i.e., relapse) evoked CT in Leah. Similarly, Ria mentioned that some clientele she had, who had intense life experiences themselves, evoked intense CT in her. As an example, some of these clients had experienced complex trauma or been diagnosed with a personality disorder.

Moreover, during his interview, Peter discussed his experience with a client who showed scepticism regarding therapy. Peter felt a sense of responsibility to prove to the client that therapy could work for him. While the client's scepticism did not fade, Peter did not want to confront the client about his disinterest in attending sessions. He wanted instead to protect himself.

> He was very sceptical. He was kind of pushed towards therapy by his wife. But he was, he was kind of… I don't know if she put an ultimatum but there was sort of that feeling about it: Like, "You need help and our marriage is falling apart." So he ended up with me. But he was… He was sceptical and, and I felt like I needed to, you know, like show him this could be… This could work. Like I couldn't face down… I never faced down the scepticism by him, is a good way to put it. And the feeling there is like… Well I don't know. It's not a feeling so much. But it's um, yeah. Like not really wanting to put in the [open], put right in front of the two of us, that he did not want to be here, that he's not

> here for himself, that, you know… And not… And kind of like protecting him from that like as a way to protect me, I guess. [Peter]

3. Client-therapist interactions that trigger countertransference. Not surprisingly, data revealed that CT can also stem from the way clients and therapists come together and interact. Specifically, the data showed that when client and therapist are either very similar or very different in certain ways, CT can ensue. For instance, Ria discussed how a value conflict with a client influenced her to experience CT, which manifested in feelings of disgust for the client.

> Cause I felt so much disgust for the values evoked by [this person]… And therefore, I felt so much disgust for my client who admired these values. [Ria]

The following statement made by Leah demonstrates that having similarities to a client's life can also influence the emergence of CT in the therapist. In this particular example, Leah found that having a similarity to a client's loved one caused her to feel a sense of loss and grief.

> [The client's loved one and I] share a name and we share um a lot of similar features… We look quite similar. The client's experience of her [loved one] and really remembering of her [loved one] in session has initiated feelings of loss and grief in me and some kind of like mirroring her [loved one's] presence. Um so I would say that, that is kind of a transference and CT experience for both of us. [Leah]

As a result of this similarity, Leah experienced a shift in her perceived role.

> It made me feel like I had a role to play for her, that I could provide something to her, that I could heal in some way or, or contain or, or treat more because I have, I bare similarities to a person that she's lost. [Leah]

Leah indicated that she became less of a therapist and more of an attachment figure to the client.

> So it kind of took me out of my therapist mind and feeling and put me into a more personal, a more attached, a more uh familial feeling towards her. [Leah]

Reactions to Countertransference (6 Subthemes)

The data shed light on a wide range of reactions participants had to CT. Some of the data focused on emotional reactions participants had when interacting with clients. Other portions of

the data made mention of behavioural reactions participants had, some of which were purposeful and others that were impulsive. The seven subthemes, pertaining to the CT reactions participants had, will be discussed in more detail below.

1. Positive countertransference feelings can cause loss of objectivity. This subtheme focused on the positive and warm feelings therapists experience towards their clients and/or the positive reactions that ensue from these feelings. Though the nature of these feelings and reactions seem blameless, they can cause a loss of objectivity in therapy. In the succeeding statement, Leah reveals that her ability to enjoy time spent with a client and her feelings of sadness at the end of sessions cause her to run over time with the client.

> Um and, you know, she's probably one of the only sessions… Well probably one of the only clients I run over time with um because I enjoy spending that time with her. Not only for her well being but also for me. I think it's been like healing. Um and so I think I feel sad when it's over. [Leah]

On the other hand, Nancy discussed how she over-empathized with a client's sense of helplessness, which, in turn, impeded on her perceived ability to help him. She terminated therapy with him, as she felt overwhelmed and believed she could not help any further.

> Um I would say there was definitely um a client where… Oh my god, it was terrible. Umm we became really stuck in a pattern where he felt helpless and I felt helpless and, and, and it was this giant helplessness fest every session. And I would try to challenge him and then he would prove to me that he is in fact helpless and I can't possibly, possibly help him in any way. [Nancy]

Nancy felt like empathizing with the client, without addressing what was happening in therapy, pulled her into feeling helpless too.

> He really was feeling helpless and terrible… And my empathizing with him in an unchecked way got there… You know, pulled me into that. [Nancy]

Moreover, in the statement below, Peter shared that when clients attribute positive therapy outcomes to him, he sometimes indulges in their praise.

> But when, when clients feel like they've been, they've benefited a lot from therapy and they're inclined to kind of see it in me, that I had something, or a lot, to do with this. And I'm sort of gobbling up their praise. [Peter]

He mentioned that the praise feels pleasurable. He also shared that one client he had this experience with gave him a gift at the end of treatment, which he accepted.

2. Negative feelings about countertransference. The data that made up this subtheme revealed that, upon experiencing CT, participants often reacted to their CT by feeling shameful, guilty, embarrassed, or being hard on themselves. They sometimes also felt helpless, confused, and stuck. The former statement by Nancy, for instance, demonstrated the sense of stuckness she felt in sessions with the client who focused on his helplessness. Similarly, during her interview, Ria shared that, as a novice therapist, she saw a client whose life circumstances could not necessarily be changed by psychotherapy.

> I had a client come in. She was in a really difficult situation. One of those scenarios where it was like a custody battle. Like really messy, like legal custody battle. I just… It was going to be a long drawn out process. She didn't know what the result was going to be. Very stressful. And there wasn't much she can do to change what was happening in her life externally, right? [Ria]

As a result, Ria had to accept that there was not much she could do other than empathize with the client. Still, she experienced a sense of helplessness in the therapeutic relationship.

> And this client was perfect to have at that point in my training because I was like, I can't do… I can't do anything really but empathize and kind of just be like, yeah… And I felt a lot of hopelessness and helplessness with her… And I just like sat in that with her over and over and over again. [Ria]

Participants also often felt negatively about how they handled their CT. For instance, Nancy reviewed her experience with a client whom she initiated termination with upon feeling overwhelmed. She stated that she does not feel proud about this moment in her career.

> And then I ended up initiating terminating with him in a really abrupt way that was not at all fitting for how long we worked together. And that I think is CT unchecked. Like this is not… This is not a proud moment um, you know, to be talking about. But I know it

> happened where we got locked into this pattern. And instead of addressing it or figuring it out, I got overwhelmed and basically said, you know, paraphrasing, "I can't help you, I'm referring you, go." [Nancy]

Nancy also indicated she feels some shame, embarrassment, and guilt regarding the way she handled the situation.

> Yeah, there is a bit of shame and embarrassment and a touch of guilt for how this person might feel I have treated them, that they may have perceived this as, as um being treated badly by me. Um not in a… Not in a bad way as abusive or harmful but, but, you know, I'm sure they weren't happy about how, how it went down. [Nancy]

Moreover, Leah shed light on a couple of occasions where she blurred boundaries with clients. In one of these cases, she responded to an email outside of work hours while on vacation. She detailed that while this did not have much of an impact on her client, it impacted her severely when her client responded to her email with "volatile" information. She indicated a desire to have handled the situation differently.

> For both situations it was blurring the boundaries where the work actually required more of a boundary. Especially when working with um youth who um have no attachment figures. I think I had to be more careful for having some more severe boundaries. In, in both situations I didn't. And that was, I think, harmful on both ends. I should have modeled something differently. And it, it hurt me as a, as a person, not as a clinician, um to, to do that. [Leah]

3. Avoiding/dismissing countertransference. The data contained in this subtheme revealed the ways in which participants dismissed or avoided CT experiences or chose not to address them. This subtheme does not indicate any perceived wrongdoing on the therapist's part; instead, it sheds light on when CT was dismissed, even when participants had good reason for dismissing it, and how participants retrospectively perceive their reaction. In the following statement, Ria sheds lights on why she sometimes chooses not to address CT.

> Like I'd say that sometimes I put the analysis of CT aside in the sense that either I'm not detecting it consciously or I know it's there and I'm choosing not to address it, either because it's not time yet or they're not ready yet. I don't understand it yet enough to bring it into the relationship or that's not what they're coming to therapy for. [Ria]

During her interview, Ria also described a situation during which she ignored the request of a client with whom she experienced CT without consciously realizing what she was doing. The client had requested something of her and, while she stated she would have usually done something like this for other clients, she continuously forgot about this client's request, though constantly reminded by him.

> And actually I would acknowledge it. Like, "Yeah I'll [do it]" and I would never [do it]. It just like… After session with him I would just be like… I… It wouldn't even cross my mind to go [do this] even though I generally had the intention of doing it while I was in session with him. [Ria]

Furthermore, as mentioned prior, Nancy stated that, when overwhelmed by the therapeutic encounter she had with a client, she initiated an abrupt termination rather than addressing the situation. Similarly, Leah mentioned feeling disgusted with one of her clients, as he was inappropriate, vulgar, and made passive sexual comments. She initially tried using her CT feelings to aid in therapy, which she believes was therapeutically useful. However, when he continued to be inappropriate and aggressive, she asked him not to return to therapy.

4. Straying from the normative therapy experience. Data revealed that participants often reacted to their CT by straying from the typical expectations of psychotherapy. For instance, Nancy discussed how her CT experience with a client contributed to her and the client straying from the larger goals of therapy.

> I would let the conversation go to certain topics that um maybe seemed off topic. And at the same time, it was important. Like um that talking about um friends, um friends drama. We talked about friends drama and um boy drama and um accomplishments um that they weren't… You know, those things weren't necessarily part of our goals. [Nancy]

Nancy detailed that the focus of therapy became day-to-day concerns, which was not what the client had initially sought therapy for.

> You know, she came for grief counselling and we talked about um, you know, small achievements or who said what. So um small things that I'm not sure were necessarily um… I could have redirected those and could have said, "Okay well which one should we focus on? Um what are you here for?" But it became part of the process for her to just get these little tidbits of support around other things where she didn't have a person to go to. Or to, you know, show me her new [hairstyle] or um show me a new song she likes. Things like that. [Nancy]

Additionally, Leah shared her experience with a client whom she believes she developed too strong of an attachment to. Leah discussed how she felt pressure to model a secure attachment for the client while therapy was on-going, due to the client's life circumstances. When termination came along, Leah, who felt as though their work together was left unfinished, shared some of her personal feelings with the client. Leah also mentioned that she still thinks about the client to date.

> And I, I don't know if I felt the need to… I don't know why I did, but I shared how grateful I was to have worked with her, to have met her, to have witnessed so many of her strengths. Um and then we both got very emotional and um… And she asked me for a hug at the end and I obviously obliged. Um and I… That was um at least a year ago and I continue to think about it and think about her so… [Leah]

Furthermore, during his interview, Peter discussed an experience he had with a client early in his career. During one session with the client, Peter seemed to step out of his role as a therapist and reacted to the client as though he were her parent.

> And she started to cry in this second session. I forget what she was talking about. But I remember this. I remember she's feeling like… She's crying, there's some sort of distress that's coming out. And I reached out, and I, I just lightly sort of touched her knee. Just, you know, this kind of like, like a parent would do to a child or something like that. I see… I look back on that now and think it comes from… And I, I remember being like really… You know, I'm like… All kinds of emotions there like coursing through me at this time. Um and somewhere in there I'm…. In that mix of feelings that I'm having is this like feeling like I'm like a parent to her who needs to like soothe her and I do it in a physical way by touching her. [Peter]

5. Focusing on the therapist. Sometimes, as a result of CT, participants focused on their own needs, life experiences, personal processes, and wants during therapy. This subtheme is not

meant to convey that participants were harmful in putting their own needs first. Instead, this subtheme is meant to highlight situations in which therapists thought of their own well-being before that of the client. In some of these situations, therapists acted in ways that were well thought out and displayed a sense of self-compassion. However, in other situations, participants, often without realizing it, let their own personal processes impact psychotherapy. In the statement that follows, Leah shared that sometimes in therapy she not only focuses on what clients say that resemble her own life, but she also guides assessments in this way.

> Uh there are definitely times where um I am paying more attention to things that resemble my life. It's happened for the most part when it comes to siblings…Um the moment that I hear someone say that they have sisters, it resonates my experience. Um and I guess that I'm paying more attention. Not only paying more attention but I'm guiding my assessments sometimes to look at: how could siblings be a support system for you, how can you make use of them, how can they protect you against, you against your parents? I use the sibling system um probably more than a parent system just because I have a strong sibling support system. So that's something that I pay attention to more. Um and I definitely lead my conversations more because of my lived experience. [Leah]

In this case, Leah focused on what related to her own life experience rather than that of the client. Similarly, Ria discussed an experience she had with a client who brought up a sensitive topic in therapy. When the client started moving on from the sensitive topic, Ria moved on with her rather than giving her the opportunity to discuss the topic more in depth.

> I gave it space and when she was ready to… When she started moving on, I moved on with her. I didn't stop and kind of really dive deep into what that means for her and her understanding of [it] and all of those things, right? Um I wasn't able to give her that space in that moment. [Ria]

In her interview, Ria also made mention of advice that she once received from a supervisor when she was going through a rough time in her personal life and did not know if she could see clients. Her supervisor told her that she did not have to be 100% okay to see clients; she could be at 65% instead. She indicated to Ria that it was okay not to explore certain topics with clients, as whatever she did discuss with a client in therapy would eventually help the client.

Ria stated that this was a liberating piece of advice and raised the point that even therapists have dynamic lives and go through both good and bad times. In this case, by focusing on her own needs, Ria was able to continue seeing clients.

6. Being intentional in using countertransference. This subtheme highlighted situations in which participants were cautious and calculated in using their CT with clients. For example, during her interview, Ria indicated that she is cautious of how and when she discloses her feelings during sessions. In the following statement, she elaborated that she is careful about this, as the use of CT humanizes the therapist and can take away from space needed by clients for their own internal experiences.

> The, the act of using CT will evoke … It'll, it'll create a shift in the client's transference, right? It'll make me appear as um a person with her own internal experiences in that moment for the client, which a lot of the time is a good thing but sometimes they need me to be more in the background so they can use, take that space. [Ria]

In the following statement, Nancy too discussed that she is careful and somewhat hesitant about addressing CT with clients during therapy sessions due the potential impact it can have on the client. She mentioned that addressing CT could make the client feel uncomfortable, which in turn causes her to feel uncomfortable.

> I'm usually a little bit nervous doing it because, because it involves… It usually involves some amount of self-discourse also um of what, what I'm seeing or what I think is happening. And also it's potentially uncomfortable for the client and I don't love making people feel uncomfortable. [Nancy]

Methods of Dealing With Countertransference (5 Subthemes)

Data from the study highlighted methods of dealing with CT commonly utilized by participants. Interview data indicated that, upon experiencing CT, participants often reflected on it individually and discussed it with others. This allowed them to understand it better and thus

deal with it more effectively. Participants often also dealt with their CT by using it clinically in sessions. The five subthemes this theme is comprised of are discussed in detail below.

1. Clinical use of countertransference. This subtheme highlights situations in which participants used CT clinically within sessions to either aid psychotherapy or prevent harm to psychotherapy. For instance, in the following statement, Nancy describes the value of using CT clinically with clients by pointing out patterns that she notices.

> I'm going to say it's almost always helpful to name a pattern to a client, to say I'm noticing, you know… I'm noticing we, whatever. I'm noticing we always change the subject when we get to talking about school. I'm noticing that we seem to get locked into arguments. Or I'm noticing whatever. Just share what you're noticing with the client. Um and ask the client if they're noticing it. And ask the client what it means to them. Um or, or you might, might share with the client how you're feeling about what's happening. And ask the client what it's like for them to hear that or what it means to them to hear that. Um so talk about the process with the client is how I would sum it up. [Nancy]

Moreover, during his interview, Peter described how he learned to empathize better with a client after realizing he was experiencing CT. Peter initially felt intimidated by the client's presentation in therapy. When he realized that he was experiencing CT, he began to understand the client presented that way because he was feeling vulnerable.

> So when that comes up, [when] that prickly uh kind of cynical and really condescending presentation shows up, I feel like, yeah, I can see where he's coming from better which is a place of really feeling vulnerable. And, and we actually got to that point. We've gotten there in our work where we can name it as such. When he's feeling uh cynical and prickly and stuff like that and he's acting that way, it actually shows that he's feeling insecure, unsettled, feeling vulnerable, stuff like that. So, so it has helped me. And when I see him that way, well it's a lot easier to like be beside him when he's, [what I call], prickly. [Peter]

Similarly, Ria indicated that she used her own experience and CT to empathize with a client who was going through a rough time. She sat with the client in her feelings and used her tears therapeutically to empathize with the client. Ria indicated that she felt like the client needed to be validated to feel empowered, and she mentioned that her efforts benefited the client.

> Um but the first step of just sitting with her and sharing… Like using that experience that I had and just being like, "Wow you must be feeling so helpless and so hopeless," right? "And so sad that you're in this situation, that you have to fight with your […]" Sometimes I would even allow myself to tear up just a little bit, right? Just very authentic, right? Just be… Really experience it. And um eventually she like… It's like she needed to sit in that and really be like just completely and thoroughly validated in that to kind of balance into a more empowered state, which happened. [Ria]

At another point in her interview, Ria mentioned that while clients tell her their stories, she is attentive to her free associations, such as images, physical sensations, thoughts, and beliefs that emerge. She discussed that she questions what emerges and asks herself whether it is relevant to her own personal processes. If it has to do with her own personal processes, as well as the client's own processes, she finds a way to bring it into the relationship. She stated the following example to demonstrate how she uses what emerges from her free associations in sessions.

> Usually I'll just say, "I have this image that's coming to mind for me. It might be relevant. It might not be relevant. But does it resonate with you in any way?" Uh I'll be direct like that. Uh but usually what I'll do is if I'm having some kind of experience, I look for it in their own experience, in their own words… Um and then I reflect that back: "Is it possible that this is happening for you right now here or in that context?" [Ria]

2. Self-reflection. Participants in the study often dealt with CT by engaging in self-reflection. Participants indicated that they engaged in self-reflection during, after, and/or before therapy sessions. For instance, in the following statement, Leah mentioned that she sometimes lets her clients know that she needs a few seconds of silence to think during sessions.

> Um I've probably said in session um like, "I'm just going to like take a couple seconds here and just think and, you know, uh like just think in silence" Um and like, "I… You know, I welcome you to do the same." And I've probably taken like a breather in session and kind of a few seconds to collect myself. Um when that's happened um I just basically take charge. And I think that feeling can manifest in a session itself. [Leah]

Similarly, during her interview, Ria discussed that she takes time before or after a therapy session to reflect on her internal experiences regarding the client with whom the session has or will occur. She then uses her internal experiences to better understand the client's processes.

> Um anytime you're with a client or before an appointment or after an appointment, you kind of check in and see like, "Okay what are my thoughts and what are my feelings and what are my bodily sensations around the experience, the interpersonal experience with this client?" So if I start feeling something come, like a shift in my body for some reason in session, then I'll stop and I'll kind of try and figure out what might be happening either between us or inside of them uh and inside of me, of course, to see what, what could have been a shift inside of them and what's going on inside of them. They go somewhere in their head or they're lost in an image or a place or, or whatever. [Ria]

During his interview, Peter described how he managed to reflect and think during an emotionally charged experience he had with a client. The client became emotionally distressed near the end of a therapy session and Peter was unable to help her settle down. Peter then noticed that he felt a need to rescue the client and was able to talk himself down. This helped him deal with the situation in a more effective way.

> Well, well what happened was that I came around to uh, to realize in myself that, "Well what she's experiencing right now, she's experienced at least, you know, 5000 times outside my office and this is one more instance of it. It's not dangerous in and of itself, the feelings that are coming up." And I needed to step back and let her leave even while she's uh deregulated. [Peter]

3. Supervision. Participants often used supervision as a way to deal with their CT. This subtheme was meant to highlight therapists' decision to seek out supervision and explain how supervision helped them. Participants indicated that supervision can help in normalizing therapists' experiences and can help therapists figure out their next steps in treatment and become aware of their CT. Leah discussed during her interview that supervision helped normalize her CT experience. She stated the following when asked how supervision helped her.

> I think it's the moments where they go, "I feel the exact same way," um, you know, "this happened to me countless times," um like, I, you know, "I dread having this client come in on Wednesdays" or whatever it is. It's, it's sharing that. And they say it in kind of such

> a like, "This is just another day" kind of way. That makes you feel like this is completely normal and you are absolutely right to bring it up because it's a shared experience. Most of the times that you said it's the most helpful, it's not necessarily the advice that they [give] or what they did for themselves, because that doesn't necessarily apply um to like a case specifically. It's just the like "Me too" and, you know, "This is normal" feeling. [Leah]

She also shared her belief that supervision is a safe space to talk about anything, including CT.

> Um I think just because I've had really good supervision experiences in the past, it's modeled for me that it's a hundred percent a safe space and you can share anything. And I had a lot of conversations with previous supervisors about CT and just like clients and all that stuff that I kind of share without any hesitation. [Leah]

Likewise, during his interview, Peter spoke of his experience as a supervisor. He mentioned that a topic commonly discussed in his supervision meetings is CT. He also mentioned that his supervisees feel safe discussing CT with him.

> Well, I mean this happens a lot because I supervise several therapists in the community. And a lot, a lot of our work is around processing CT. And in some ways it's been some really intense things. Um and I really enjoy… I really enjoy that work. So I approach it like, open this up and really dig into the experiences in a, in a client. And I think… My supervisees tell me this: that they feel very safe in navigating this terrain. They don't, you know, they don't feel judged or that they've done something wrong and that this is all in the perspective like of doing better at therapy. [Peter]

Furthermore, during her interview, Ria shared that after feeling shamed whilst disclosing her CT experiences to mentors or supervisors, she began to question whether she agreed with her mentors' conceptualizations of CT. She then decided to select mentors who shared similar values to her.

> I, I selected uh mentors that had the same values as I do around CT… And that like helped me grow immensely, exponentially. Where anything… 'Cause, 'cause I mentioned, "I had a shaming experience around my CT and I need you to help me, as my mentor, figure out when that's happening and how it's… And, and take that block away." [Ria]

Ria continued to share that her selected mentors were able to help her better understand her CT. Now, she has internalized these mentors and their teachings.

Moreover, while participants used supervision to deal with CT, they mentioned that sometimes these attempts were unfulfilling. For instance, Leah stated that she once discussed that she was attracted to a client during peer supervision. She indicated that she was responded to with disgust and judgment, making the experience negative for her.

4. Consultation. Participants in the study, in addition to seeking out supervision, consulted with others as a way of managing or dealing with their CT. This subtheme sheds light on the specific individuals that participants chose to speak to about their CT and the importance of these discussions. During her interview, Nancy mentioned a time during which she felt a sense of urgency to help a client of hers, due to her own internal need to rescue people. As such, she decided to consult with a colleague.

> So I went to talk to a colleague because I had um … Yeah I had an intuition or, or well an intuition but also sort of self knowledge that this is an area, that this tends to show up for me…Um and, and I also noticed that I was really stressed out about answering this email. And so this, this stronger than usual emotion made me want to talk to a colleague to say, "Okay before I reply to this, let me examine my steps." [Nancy]

Upon consultation, Nancy recognized that she felt resistant to what her colleague was advising and became aware of her CT.

> Um and then as I was talking to her about this… Um and, and she explained that she would probably first see if the, you know, the client could access other resources first. And then I felt this, "Oh no, but I can't do that." And that made me, that made me sort of notice that there's definitely something going on here that, that's more than just… Yeah. [Nancy]

During her interview, Ria shed light on a different type of consultation: personal therapy. She mentioned that she went to therapy to cope with the shame she felt for experiencing CT. She indicated that this was helpful for her.

> Like uh I went to therapy. I've been in therapy quite a few years but I started with a new therapist that's more psychodynamically oriented as well. And he really helped me walk through like what this is. This experience of disgust, for example, and all of that. And that really helped me. He was really important and… So I'd say the first way of coping, trying

> to cope, was acknowledging how I was feeling in terms of the feedback I was getting from my mentors. [Ria]

Likewise, Peter shared that he sought out personal therapy to help him both personally and professionally. In the following statement, he discussed how personal therapy helped him with his CT.

> Well it's really opened the terrain for me to like think about these experiences in ways that don't frighten me. Because I think in the past I was, I was a lot, I was much more reluctant. And because I felt, I felt shame about it. I never would have told you this story about putting my hand on this client, me 30 years ago [laugh]. If we had this conversation 10 years ago, I don't think I would have. [Peter]

5. Self-care. This subtheme was meant to highlight data that revealed the importance of self-care in effectively handling CT, as indicated by participants in the study. For instance, Nancy mentioned that she previously experienced CT during a time when she was feeling overwhelmed and had a high caseload. She went on to share the reason she finds self-care important when dealing with CT.

> I think for me what, what being um better at self-care does is I am more um able to be grounded and present. And being grounded and present means that I can be more aware of my emotions and my thoughts and my sense of interpersonal process. [Nancy]

Likewise, during her interview, Ria shared that she has previously experienced compassion fatigue. As she felt like she could not be helpful to clients at that time, she decided to take time off work.

> And with all the changes in my life, I have hit a few, a few times over the past 5 years, like points where I felt compassion fatigue, where um that was not. Um that's an experience of CT that's just not helpful, right? Like they need… My clients are coming to me for my mirror neurons. [If] my mirror neurons are not working, then I shouldn't be sitting in this chair [laugh]. So um uh… So it's influenced in that way a few times. I'd say maybe three times in the last 5 years where I just, I took a week off completely from clinical work because it just wasn't possible for me to be there for that person. Uh and I'm really proud of myself for … Like I monitor that very, very closely. [Ria]

Ria indicated that she is proud of herself for taking the breaks she needed to, as there is a lot of pressure to be present for clients when working in the psychotherapy field.

> And I'm proud of myself because I, I take the breaks that I need to. And that's hard, I think. Also like in our field because when we get into private practice, there's a lot of pressure. There's waiting lists and clients want to see you twice a week and it's like intense. People need you. [Ria]

Impact of Countertransference on Therapy (2 Subthemes)

The data collected from participants raised awareness of the differential impacts of CT on clients and therapists. While some situations of CT resulted in therapeutic gains and seemed to benefit the client or therapist, other situations had a negative impact. Discussion of two subthemes pertaining to the impact of CT on therapy can be found below.

1. The differential effects of countertransference on clients. This subtheme speaks to the ways that CT impacts clients, as indicated by participants. Overall, participants perceived CT impacted clients in both helpful and harmful ways depending on the context and how therapists used their CT. During her interview, Nancy indicated that, when addressing CT with a client, the result was usually positive; however, sometimes the client did not understand what she was doing and the intervention had little impact.

> There have been times when it fell flat. Like I've attempted to address it and either the client said, "I don't know what you're talking about" or we addressed it and, and, and it just didn't go anywhere. But it's been mostly positive I… From what I can think of. [Nancy]

During her interview, Leah mentioned that she felt disgust for a client and used it in her session, as she believed the intervention aligned with the client's therapy goals. According to Leah, the client was surprised with her disclosure and appeared disgruntled at how forthcoming she was. However, she believes she may have helped him reach his goal or, at least, helped him understand how he contributed to his presenting problem.

On the other hand, Ria explained her CT experience and behaviour with one of her clients and made note of the perceived negative impact it had. She noticed that, as a result of how she presented towards the client, behaviours the client engaged in signified a potential rupture to the therapeutic relationship. She also indicated that her CT behaviour elicited some covert aggression in the client.

> And then next session the client came in but interestingly the client came […] late. So like we can see that there's, there's something. There's a rupture right there, right? And he was trying to express that in some way, uh either to avoid me or to show some kind of covert aggression to me by like undermining the work that we're doing. [Ria]

2. The differential effects of countertransference on therapists. This subtheme was meant to highlight how CT impacts therapists. This subtheme differs from subthemes that fall under the theme, reactions to CT, because it speaks to how therapists are impacted by CT rather than how they respond to clients, though there is undeniably some overlap. During interviews, some participants discussed the positive impact CT had on them while others discussed the negative impact it had. In one of the statements previously discussed, Leah noted that she sometimes ends sessions late with one of her clients. Further, she discussed that sessions with this client are healing for her. Similarly, Peter mentioned that while he generally finds CT bothersome as it occurs, he is able to retroactively see value in his CT experiences.

> That said, in the aftermath of that, in a conversation like I'm having with you, when I go back and talk about it and, and process it a little more, I can also experience it as kind of um, you know, learning. Like it's, like uh… It has benefits to that. Even while the experiences are kind of difficult, once they pass, I regrouped and I've taken some time to work at it, I think there's value in it. It's just that in the [moment] it's kind of hard. [Peter]

Peter also mentioned that by reviewing his experiences in conversation, he is able to learn more about himself and how he impacts his work.

> Um I learn more about me, I think, is what I can learn. That's what's happened I think. I can see where I show up, me [Peter], in my work more. [Peter]

As mentioned, participants also discussed how CT affected them negatively. In a statement previously discussed, Leah shared that, while experiencing CT, she responded to a client's email when she was away on vacation. She mentioned that this gesture ended up severely impacting her, as the client responded to her email with volatile information. Leah then had to sit with this information for several days before she could return to work. Likewise, Ria highlighted the commonality of burn out and compassion in therapists. She stated that compassion fatigue could be considered an unhelpful CT experience.

> And burn out and compassion fatigue are just like so much a part of what we do. Like we're really at risk for that. We take in a lot of people's things. Like… So I'm always monitoring that. And with all the changes in my life, I have hit, a few, a few times over the past 5 years, like points where I felt compassion fatigue where um that was not... Um that's an experience of CT that's just not helpful, right? [Ria]

To conclude this chapter, the following table provides a brief overview of the aforementioned themes and subthemes that correspond to participants' experiences with, and understanding of, CT.

Table 2

Summary of Themes and Subthemes Regarding Participants' Countertransference Experiences

Themes	**Subthemes**
1. Defining Characteristics of Countertransference	1. It is normal to experience CT 2. Signs that alert therapists to CT 3. CT is multidimensional 4. Perceived effectiveness of CT is context-specific 5. Therapist experiences of CT change over time
2. Countertransference Triggers	1. Therapist-specific experiences that trigger CT 2. Client-specific elements that trigger CT 3. Client-therapist interactions that trigger CT
3. Reactions to Countertransference	1. Positive CT feelings can cause loss of objectivity

	2. Negative feelings about CT 3. Avoiding/dismissing CT 4. Straying from normative therapy experience 5. Focusing on the therapist 6. Being intentional in using CT
4. Methods of Dealing with Countertransference	1. Clinical use of CT 2. Self-reflection 3. Supervision 4. Consultation 5. Self-care
5. Impact of Countertransference of Therapy	1. The differential effects of CT on clients 2. The differential effects of CT on therapists

CHAPTER V

DISCUSSION

This study examined experienced therapists' understandings of CT. Specifically, the study sought to address what participants thought of CT, when they experienced CT, and how they reacted to CT. There was a focus placed on understanding how the participant group, which consisted of therapists of varying theoretical backgrounds with differing life experiences, viewed and defined CT. This understanding was sought in response to literature that makes note of the multiple existing definitions of CT (see Gelso & Hayes, 2007). As well, the study sought to understand how therapists cope with or manage their CT, in light of the clinical literature suggesting the importance of effectively managing such processes to prevent them from impeding on psychotherapy (Gelso, 2014; Hayes, 1995). The study's focus on understanding the contexts within which CT generally occurs for therapists, and understanding whether therapists' CT is contingent upon their specific life experiences, was inspired by literature highlighting the conflicting views on the utility and value of CT in psychotherapy (e.g., Cabaniss et al., 2011; Knaus et al., 2016; Liebman & Burnette, 2013; Schlesinger & Wolitzky, 2002). Once data collection was completed, Thematic Analysis (TA) was used to make sense of the participants' collective understanding of their CT experiences by identifying themes in the data set (Braun & Clarke, 2012).

Five themes and 21 subthemes emerged from the data, shedding light on participants' understanding of what CT is, what might contribute to the development of CT, typical ways of reacting to CT, helpful ways of responding to CT, and the role of CT on the client, treatment, therapist. The researcher's interpretation of some data from the study complemented and supported the existing clinical literature, specifically literature regarding the importance of

managing CT. Other data led to new considerations regarding therapists' understandings of and reactions to CT experiences. In the following section, the data found in the study will be compared to the existing clinical literature. To conclude the section, there will be review of the study's delimitations, contributions, and recommendations for further research.

Summary of Main Results

This study shed light on participants' understanding of CT as a concept. This understanding of CT included perceptions of its normality and commonality among clinical practitioners and the multiple ways of conceptualizing it, both of which were subject to change over participants' careers. In terms of how CT was defined, participant responses alerted to the fact that definitions of CT seem to vary amongst therapists based on their experiences providing therapy and their clinical training. It can be noted, however, that every participant conveyed that CT is shaped both by therapist and client. Whether or not stated blatantly, participants shared their understanding that CT is a co-construction, resulting from the therapist's personal processes (e.g., needs, past experiences, relationships) and clients' (e.g., the presenting problem, client personality, challenging life experiences). Moreover, one's view of the effectiveness of CT not only depended on their experiences with CT but the specific experience they were discussing. Every participant discussed both positively perceived and negatively perceived experiences of CT. This suggested that perceptions of CT as being harmful or helpful were context-specific.

During interviews, participants also discussed multiple reactions they had to CT over their careers. Some of these experiences seemed positive but accounts from participants revealed that even positive CT reactions sometimes influenced a loss of objectivity. Fittingly, and unsurprisingly, participants' stories highlighted the need for therapists to acknowledge their CT and keep it in check by practicing a safe and effective use of self (SEUS). Participants noted the

importance of supervision, self-reflection, personal psychotherapy, and consultation when experiencing CT and mentioned the overall positive role these methods had in their lives. The negative impact of poor supervision was also discussed, pointing to the importance of supervisors being knowledgeable and compassionate in regards to CT. Moreover, participants discussed the impact that CT can have on both clients and therapists. While some of these impacts were perceived as positive in nature, others were perceived as harmful. This again highlighted the importance of being aware of CT and managing it appropriately.

Main Results and Links to the Literature

The normality of experiencing countertransference. This study, first and foremost, shed light on the commonality and normality of CT. Participant accounts not only highlighted the frequency of CT encountered in their own lives but also revealed that other therapists, familiar to participants, commonly experienced CT as well. These therapists were colleagues, supervisors, and supervisees of participants. Each participant detailed at least three occurrences of CT which they themselves experienced and insinuated the existence of multiple others. While a criterion in this study was that participants had experienced CT, resulting in 100% of participants having experienced such, this study's results support existing literature indicative of the high incidence of CT in psychotherapy (Gelso et al., 1999; Hayes et al., 1998; Peabody & Gelso, 1982). Participants discussed CT experiences with clients who reminded them of individuals in their personal lives, clients with whom they experienced closeness, clients with whom they shared similarities, and clients who were highly emotional or indicated distress in sessions. They also experienced CT when encountering hardships in their personal lives (e.g., divorce, increased workload) and when having negative opinions about, or negative feelings towards, clients. Given the wide range of situations detailed that involved CT, it is not unlikely

that participants experienced CT a large proportion of the time spent counselling. These results provide support to a study which found that 80% of sessions examined for the study contained evidence of CT (see Hayes et al., 1998).

Though there is a vast amount of literature on CT, there is little qualitative research that specifically touches on therapists' perceptions of its normality. There is, however, research that examines therapists' CT experiences, intuitively indicating that CT is a normal occurrence in psychotherapy (e.g., Hayes et al., 1998; Hayes, Nelson, & Fauth, 2015). Scholars also note the importance of CT, and understanding CT, in the helping process (e.g., Agass, 2002). In addition, while it is common understanding that psychoanalytic literature notes the centrality of CT in psychotherapy (e.g., Arundale & Bellman, 2011; Cabaniss et al., 2011), CT was not previously regarded as significant in other types of psychotherapy (e.g., behavioural therapies). However, there has evidently been a recent shift according to both the clinical literature and results from the present study. Vyskocilova and colleagues (2015) inform that cognitive behavioural therapists experience CT as automatic thoughts and schemas that result from relationships with clients. They also note that, for schema therapists, schemas and automatic thoughts can shed light on therapists' emotional reactions to clients, including their CT. These conceptualizations of CT are indicative of the growing importance of acknowledging such processes in diverse psychotherapeutic modalities. Fittingly, participants in the present study varied in their theoretical orientations and none identified as being solely psychodynamic in their approach; yet, each participant evidently believed in the existence and significance of CT and disclosed multiple occurrences of it experienced throughout their careers. Therefore, it is clear that CT is present not only in psychoanalysis but in all psychotherapy (Ehrlich, 2001), demonstrating it is both a common and normal occurrence.

The definition of countertransference. This study aimed to elicit data indicative of participants' conceptualizations and definitions of CT. This aim ensued as a result of literature revealing multiple existing definitions of CT (see Gelso & Hayes, 2007). Though participant accounts revealed that CT can be understood in various ways, all participants seemed to agree that CT is based on the interaction of the therapist's and the client's processes. They either indicated that CT is co-constructed or indicated their awareness of how the therapist's CT response is triggered by the client or material brought forth by the client. Participants also provided many examples of how their own personal, often unresolved, issues played a role in their CT (e.g., past attachment issues, loss of a loved one, personal needs). This collective understanding of the participant group lends support to the integrative definition of CT (Gelso & Hayes, 2007), which holds that CT occurs when unresolved conflicts and vulnerabilities of the therapist influence his or her reactions towards a client. This definition also recognizes that the client's behaviours or the therapeutic situation can trigger a CT reaction in the therapist. It is not surprising that participant accounts lend support to this integrative definition, as much of the contemporary literature also seems to reference this definition (e.g., Hayes et al., 2011; Hofsess & Tracey, 2010).

The study also elicited much data related to CT triggers. To elaborate, participant accounts highlighted that CT can be triggered by the client, the therapist, and/or the client-therapist interaction. While some participants' accounts focused primarily on how their own personal issues triggered CT, it seemed that the client played a role. In other words, something about the client (e.g., similar problem as therapist) triggered an existing personal issue of the therapist to come to surface. This supports the notion that it is only when a client triggers a therapist's unresolved conflicts that CT will ensue (Rosenberg & Hayes; 2002). The empirical

literature also emphasizes the evident interaction between therapist and client processes in instigating CT. In a qualitative study conducted by Hayes and colleagues (1998), participant accounts revealed that a client's discussion of material that touched on a therapist's unresolved conflicts triggered CT. Another study found that counsellor anxiety was caused by a combination of counsellors' proneness to and discomfort with anger and the client's own anger (Sharkin & Gelso, 1993), further highlighting the importance of both client and therapist factors in causing CT.

The complexity of countertransference. This study's findings suggest that CT is a complex process and that its clinical effectiveness is context specific. All participants shared their experiences with some of the various emotional and behavioural reactions to CT and referenced the diverse factors that triggered these experiences. The wide range of CT-related thoughts, feelings, and behaviours noted by participants included, but were not limited to, over-empathizing with clients, indulging in clients' praise, feeling stuck and helpless, feeling a sense of pressure to help clients, feeling overly responsible for clients, feeling anxious, and terminating therapy. Some of these CT related feelings and behaviours are noted in the literature. For instance, in one study, Hayes and colleagues (1998) identified "feeling overly responsible or burdened by a client" as a CT manifestation. In addition, Kiesler (2001) mentions therapists' anxiety as a potential CT feeling, and Pen (1990) makes note of the link between CT and termination. Overall, these experiences, noted by participants and the literature, insinuate that CT cannot be neatly categorized due to the diverse nature of CT reactions.

Participants also indicated different levels of therapeutic effectiveness depending on the CT trigger and reaction experienced. In agreement with the literature, when participants had positive feelings towards clients, they indicated increased engagement in psychotherapy (Tanzilli

et al., 2018). For instance, during interviews, participants mentioned that positive feelings towards clients led to higher levels of patience for clients, an ability to meet clients' emotional needs, and an increased amount of time spent in session with clients. Fittingly, participant accounts suggested a connection between negative feelings towards the client and acts of disengagement (e.g., termination, disregarding client's requests). These findings are important, as there exists a relationship between higher levels of therapist disengagement and lower levels of skills needed to conduct psychotherapy with some client groups (i.e., personality disorders, poor relationships; Dahl et al., 2017).

To further highlight the complexity of CT, all participants were able to make note of at least one positive and one negative CT experience. They were also able to reference at least one example of how CT helped therapy and one example of how it caused, or may have caused, harm. The literature echoes this complexity in the perceived effectiveness of CT, as there is mention of the potential utility of CT, as well as the need to appropriately manage CT to avoid harm to therapy (e.g., Cabaniss et al., 2011; Gelso & Carter, 1994; Hayes et al., 2011; Peabody & Gelso, 1982).

Furthermore, this study suggested that even positive feelings towards the client might compromise therapist objectivity. Friedman and Gelso (2000) suggest similar when they indicate that both positive and negative CT can lead to the avoidance of client concerns and an emphasis on therapists' needs. Interestingly, in their study, the researchers describe positive CT as "therapist behaviours that seemed to be inappropriately familiar or overly supportive" (Friedman & Gelso, 2000, p. 1227). Some participants in the study engaged in what can be considered mild forms of positive CT behaviours (e.g., running over time in sessions, accepting gifts). It can be noted that participants did not suggest these behaviours had a negative impact on therapy.

Nonetheless, it is important for therapists to be mindful of their CT behaviours, as therapists' use of clients to meet their own needs can harm clients and therapists alike, producing feelings such as shame and guilt in the therapist (Stewart, 2010).

Safe and effective use of self. Interviews from the study supported the notion of practicing a safe and effective use of self (SEUS), as recommended by the CRPO (n.d.), specifically in regards to CT. For instance, both positive and negative CT behaviours mentioned above serve as examples of therapists' concerns entering and influencing psychotherapy, which validates the need to practice a SEUS. Moreover, in addition to what was mentioned above, participants in the study alerted to incidents during which topics discussed were either chosen or avoided based on the therapist's life and concerns (e.g., attending to specific topics, avoiding specific topics). These incidences are of significance, as the CRPO notes that to practice a SEUS, therapists should be aware of their influence on the clinical process and take steps to protect their clients from this influence (2012). While participants in the study seemed aware of questionable CT related behaviours they engaged in, it should be noted that they demonstrated this awareness while discussing retrospective experiences rather than in the moment with the client, though some mentioned they had become aware during treatment. However, it is possible that these particular instances were discussed due to the topic of the study, the questions asked by the researcher, and the tendency for participants to discuss more meaningful or emotionally loaded experiences.

Furthermore, the CRPO notes that to practice a SEUS, therapists should be cognizant of power dynamics between client and therapist (2012). The study's findings support the importance of this aspect of SEUS, as one participant discussed a CT experience involving power dynamics, where the client attempted to switch roles with her. She realized this after-the-

fact, and was thus unable to prevent her CT from impacting therapy. The CRPO similarly acknowledges that self-disclosure should only be used when appropriate (2012). Participants in the study indicated they self-disclosed to participants with whom they experienced CT. While they did not differentiate between non-immediate and immediate self-disclosures during interviews, results suggest they were referring to immediate self-disclosures (see Audet, 2011). For instance, one participant mentioned that she sometimes points out patterns that she notices in sessions and discloses her feelings about them to clients. She mentioned this intervention is almost always helpful. Another participant discussed a session during which she disclosed her feelings of disgust for a client. While she believed this helped the client understand how he contributed to his presenting problem, she mentioned that he was surprised and disgruntled by her comment. These examples validate that therapists must be cautious about when they use self-disclosure, which has the potential to be beneficial or harmful to clients and therapy.

Countertransference management. Sound management of CT is of importance, as it has the potential to help therapists practice a SEUS by becoming aware of how the therapist's processes are impacting therapy and taking steps to prevent or mitigate this. The literature also specifically notes that acting out of one's CT can cause damage in therapy (Hayes et al., 2011). Participants in the present study mentioned using management strategies such as supervision, self-reflection, personal psychotherapy, and consultation. These strategies for CT management are also mentioned in the literature (e.g., Agass, 2002; Berzoff & Kita, 2010; Hayes, 1995; Schlesinger & Wolitzky, 2002; Yip, 2006).

Participants predominantly shed light on the helpful role of supervision in dealing with their CT. This was expected, as the clinical literature also indicates that therapists view supervision as helpful with CT. For instance, in one study, almost all therapists mentioned that

supervision or consultation helped them cope with CT feelings when working with clients with eating disorders (Franko & Rolfe, 1996). Participants in the present study indicated that supervision mainly helped in normalizing their experiences. Stewart (2010) notes one example of this when she states that discussing how clients are used to meet therapist emotional needs can normalize this 'process.' Stewart (2010) also indicates that supervision can help clinicians actually become aware of their attempts to fulfill their own emotional needs through clients. Similarly, participants in the current study mentioned that supervision could play a role in helping therapists become aware of their CT experience. Moreover, scholars suggest that supervision can help therapists use their 'selves' more effectively in therapy (McTighe, 2011). For example, supervisors can aid therapists in this endeavour by displaying vulnerability and self-awareness and being non-judgmental when being told of their supervisee's CT experience. Supervisors' non-judgement seems to be of particular importance, as participants in the present study mentioned feeling judged in supervision on some occasions and indicated this was unhelpful. As such, it is important for supervisors to be cautious of how they react to supervisees' disclosures of CT.

Another strategy utilized by participants to deal with CT was self-reflection. Participants revealed they took time before, after, and/or during sessions to reflect. According to their accounts, reflection helped them gain a better understanding of clients, perform better in therapy, and handle difficult situations more effectively. A study by Hayes and colleagues (1991) also notes the link between one's ability to reflect on their feelings and CT management. There are also additional CT management strategies cited in the literature. For instance, it is suggested that engaging in self-care activities between client sessions can help lower the intensity of CT experienced (Baehr, 2004, as cited in Hayes et al., 2011). This was reflected in participant

accounts, as they mentioned either taking breaks or seeing fewer clients when needed. Further, McTighe (2011) summarizes that the literature sheds light on the role of personal psychotherapy in averting therapists' unresolved issues from harming therapy and allowing therapists to use their personalities constructively in therapy (Thompson 1988/1956; Wolstein 1988/1959, as cited in McTighe, 2011). Participants in the present study, similarly, mentioned the helpful role of personal psychotherapy in better understanding their CT and feeling less shameful of their experiences. In conclusion, based on participant accounts and the clinical literature, CT management seems to be an important consideration in psychotherapy.

Delimitations

One limitation of this study was the low number of participants recruited. While the researcher attempted to recruit additional participants, these attempts were unsuccessful. As such, having only four participants take part in the present study impacted the transferability of results. To control for this, purposive sampling was utilized, as it has been noted to increase transferability (Guba, 1981). Having limited participation also unmistakably impacted the quantity of data that could be collected, which led to fewer codes and themes being generated. Secondly, the length of time participants had practiced psychotherapy ranged from 5 to 25 years, making it difficult to extrapolate from the findings. The experiences and accounts of a therapist who has practiced psychotherapy for 5 years can be quite different from those of a therapist who has practiced for 25 years. The study, however, did not differentiate and instead examined participants' collective experiences. Thirdly, due to the ethical obligations mental health professionals have, many participants may have felt uncomfortable disclosing their true experiences with CT. This could have led to participants disclosing less during the interview. Nonetheless, this study allowed participants to share what they were comfortable with and what

they believed was of importance, and many participants shared experiences they were ashamed of, as they wanted to contribute to the field through this research. Fourthly, there was a limitation inherent in the definition of CT, which is often perceived as being unconscious and is thus difficult to study. As such, I did not aim to study unconscious phenomenon. Instead, I collected therapists' retrospective accounts of CT, which they had become aware of and were conscious of. This study allowed therapists to reflect on their reactions to clients, make meaning of them, and identify whether these experiences could be classified as CT. This was evidently eye opening to participants, who displayed thoughtfulness during interviews.

Contributions

There is a lack of literature that considers therapists' experiences with CT for the purpose of creating change within the counselling field. This study sought to contribute to counselling literature and practice by collecting data on therapists' understanding of CT, as well as highlighting when therapists were susceptible to experiencing diverse CT reactions and how therapists generally dealt with CT. Results detailing of how the study's participants, who are practicing therapists, understand and define CT were promising and may be helpful to counsellors in training. Rather than simply understanding CT based on how it has historically been defined, specifically in psychoanalytic literature, counsellors in training may gain some understanding of what CT is in psychotherapy today by reading this study. However, it is evident that this study alone cannot contribute to a comprehensive, contemporary definition or conceptualization of CT, because of the limited participation in the study. Still, it demonstrates the need for further research in this area due to the large amount of data elicited regarding this topic. Results from this study that shed light on CT triggers detail of when CT may ensue. This may be helpful to both novice and experienced therapists. It is possible that novice therapists

may be helped by simply knowing when CT may occur, so they can feel prepared for clinical work. On the other hand, experienced therapists can also benefit from these results, as there is always the potential for new CT experiences. Furthermore, this study highlighted ways in which participants dealt with CT. Learning of the constructive ways in which participants dealt with CT may be helpful for novice therapists, who may be nervous about experiencing CT and are confused about what to do upon experiencing it. Some methods of dealing with CT employed by participants were less constructive but can still provide novice therapists with insights that can inform potential strategies for managing CT. These strategies have the potential to be adopted into counsellor training and supervision where applicable, especially as more research in this area becomes available in the future. While CT is complex and context-specific, learning these strategies may provide a guideline to new practitioners, as they are just beginning their careers and are inexperienced in managing CT.

Recommendations for Future Research

As there are limitations to the present study, further research is needed to build upon, and further validate, these results. Future research assessing therapists' definition and understanding of CT have the potential to assist in formulating a comprehensive definition of CT informed by the lived experiences of practicing therapists. It is recommended that researchers also recruit therapists of varying theoretical backgrounds. This will allow for the resulting definition of CT to be clear and relatable to the majority of practitioners today, as the literature suggests that many of today's therapists identify as integrationists (e.g., Hollanders & Mcleod, 1999; Norcross et al., 2005). Future research on how to cope with CT and when CT may ensue can be helpful in contributing to counsellor education. Using results from a larger participant group to inform

counselling curriculum can lead to changes in the preparedness of novice counsellors to deal with CT, as well as more ethical management of CT.

Moreover, as mentioned, participants' experience practicing psychotherapy ranged from 5 to 25 years. Studying groups with narrower ranges of experience (e.g., 5 to 10 years, 10 to 15 years, 15 to 20 years) would be helpful, as results could better represent the experiences of a more refined population. There is also some literature on CT experiences within supervision. While this study did not elicit data on this topic, future research in this area may be informative for supervisors in the counselling field and could potentially benefit their supervisees. Lastly, the study elicited some data on CT self-disclosures. In the future, it would be of value to ask participants how they engage in both immediate and non-immediate self-disclosures in order to allow for differentiation between the two. Thus, while this study can be considered a helpful starting point for research into therapists' experiences with CT, there is a need for future research in order to make greater impact on counselling practice, training, and education.

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Appendix A

Semi-structured Interview Protocol

Understanding Therapists' Experiences with Countertransference: A Move Towards Better Training, Supervision, And Practice
Date: _____ (M/D/Y) Time of Interview: _____ Interviewee #: _____

A. Information for participants
The purpose of this study is to understand countertransference (CT) through therapists' retrospective accounts by learning about: 1) how therapists' define and conceptualize CT, 2) the contexts within which CT experiences occur, and 3) how therapists deal with their CT. The information collected from this study will inform counsellor education and training and will be used to find viable solutions for clinicians who are dealing with CT.

B. Review consent procedures
Before beginning the interview, we will review the informed consent document and sign the document or obtain verbal consent. Please let me know if you have any questions or concerns. We can address your questions now and as they come up during the interview. You can also feel free to contact me after our meeting today with any additional questions you may have.

C. Collect demographic information
To begin our interview, I am going to ask you some demographic questions that may be relevant to the context of the study.

1. What is your age? _____
2. What is your gender identity? _____
3. Where do you currently reside? _____
4. What are your educational qualifications? _____
5. Are you a member of a regulatory body for professionals who practice counselling or psychotherapy? _____
    a) What is the name of the regulatory body? _____
    b) How long have you been a member? _____
6. How long have you been practicing counselling or psychotherapy? _____
7. Are you currently practicing counselling or psychotherapy? _____
8. What is your theoretical orientation? (E.g., psychodynamic, humanistic, eclectic, etc.) _____

D. Contextual Interview Questions

We will now go through some questions regarding your understanding of CT and your experiences with it. If ever the questions make you feel uncomfortable, please let me know. We can take a break or stop the interview at any time if you wish. This interview will be audio recorded and later transcribed to ensure that data used for the study is accurate. All identifying information will be removed during the transcription stage. You have been provided with a debriefing form that contains services you can access if the interview causes you any discomfort.

1. What is your understanding of CT?

2. What does CT look like in your practice? What is an example of CT that you have encountered?

    a) What makes you say this is CT?

    b) Imagine yourself re-experiencing the situation. How do you feel?

3. How did you become aware that you were experiencing CT?

4. Have you experienced something similar that was not CT?

    a) If so, what makes you think this was not CT?

5. In what ways does CT influence your work?

6. How has CT impacted your work with a client in a positive way? Please provide an example.

7. How has CT helped you understand a client more or empathize better? Please provide an example.

8. How has CT impacted your work with a client in a negative way? Please provide an example.

9. Do you know of any colleagues or therapists who have experienced CT? Please provide an example.

    a) How would you feel if you experienced a similar situation to this person?

10. What did you do when you experienced CT?

    a) What did you do within the session to deal with your CT?

    b) How did your CT experience impact the way you provided therapy to the client?

    c) What did you do outside of therapy to cope with your CT? (E.g. Supervision, personal life, etc.)

11. Have you discussed CT in supervision?
    a) If so, what did you hope to gain from bringing this up supervision?
        i. Did this happen?
        ii. In what ways did supervision help?
        iii. In what ways did supervision not help?
    b) If not, why did you not bring this up in supervision?
12. How does it feel to recognize that you experienced CT?
    a) How does it feel to recognize that you reacted to CT as you did?
        i. What would you do differently next time?
13. If a colleague told you that he or she was experiencing CT, what advice would you give him or her?
    a) What advice would you give your colleague about dealing with CT in the session?
    b) What advice would you give your colleague about dealing with CT outside the session?
14. What was going on in your life when you experienced CT?
    a) How might this [*event or circumstance*] have contributed to your experience of CT?
15. Describe a time when you experienced CT out of the blue?
    a) Looking back at it now, what do you make of this experience? (E.g. why it happened, how it happened, how you felt, etc.)
16. Have you gone through any major life changes during your time as a therapist and how did they impact your experience of CT?
17. Can you tell me about a CT experience that you had with a client that you really liked?
    a) How do you remember feeling in sessions with this client?
    b) Did you do anything different in the session?
    c) What was your overall experience with the client?

18. Can you tell me about a CT experience you had with a client that you disliked or did not like as much as other clients?

    a) How do you remember feeling in the sessions with this client?

    b) Did you do anything different in the session?

    c) What was your overall experience with the client?

Appendix B

Request for Posting

To whom it may concern,

My name is Shainoor Kara and the purpose of this email is to inquire if you can advertise a recruitment poster for a research study at your counselling clinic. I will be the primary researcher in this study, as part of my requirements to complete a Master's degree within the department of Counselling Psychology at the University of Ottawa. My research will be supervised by Dr. Nicola Gazzola.

The purpose of this study is to understand countertransference (CT) through therapists' retrospective accounts by learning about: 1) how therapists define and conceptualize CT, 2) the contexts within which CT experiences occur, and 3) how therapists deal with their CT. The information collected from this study will inform counsellor education and training and will be used to find viable solutions for clinicians who are dealing with CT.

Criteria for participation:

- You reside within Canada
- You are able to communicate in the English language
- You have practiced psychotherapy for a minimum of 5 years
- You have experienced CT

Participants can expect to take part in a 45-60 minute interview conducted either in person or over the phone, during which they will be asked about their understanding of CT and their experiences with it. If participants choose to be interviewed in person, the interview will take place in the participant's office space or in an office at the University of Ottawa's Community Counselling Clinic located in Lamoureux Hall, room 351. The interview will be conducted in the English language. It will be audio recorded and later transcribed to ensure that data used for the study is accurate. Please note that all identifying information will be removed during the transcription stage and that the primary researcher and her thesis supervisor will be the only individuals with access to the data. Participants will be given the option to enter their name in a draw for a chance to win a $25 Chapters gift card as compensation for their participation in the study. Individuals who are interested in participating in the study will be asked to contact the primary researcher. I have attached the recruitment poster to this email. If you are willing to advertise this recruitment poster at your counselling clinic, you can print copies of the poster provided or request that I mail you paper copies.

If you have any questions or concerns about the research being conducted, please feel free to contact my supervisor or me.

I look forward to hearing back from you. Thank you for your time,

Shainoor Kara, MA[Ed] Candidate, Counselling Psychology
University of Ottawa

Appendix C

Recruitment Poster

Understanding Therapists' Experiences with Countertransference: A Move Towards Better Training, Supervision, And Practice

The purpose of this study is to understand countertransference (CT) through therapists' retrospective accounts by learning about: 1) how therapists define and conceptualize CT, 2) the contexts within which CT experiences occur, and 3) how therapists deal with their CT. The information collected from this study will inform counsellor education and training and will be used to find viable solutions for clinicians who are dealing with CT.

Criteria for participation:

- You reside within Canada
- You are able to communicate in the English language
- You have practiced psychotherapy for a minimum of 5 years
- You have experienced CT

Participants can expect to:

- Partake in a 45-60 minute audio-recorded interview conducted in the English language, during which they will be asked about their understanding of CT and their experiences with it.
- Be given the option to enter their name in a draw for a chance to win a $25 Chapters gift card as compensation for their time and contribution to the study.

To ensure complete confidentiality for participants, all identifying information will be removed from the data that is collected. The data will only be accessible to the primary researcher, Shainoor Kara, and her thesis supervisor, Dr. Nicola Gazzola.

If you are interested in participating in the study or would like more information, please email the primary researcher. Please note that participants will be selected on a first-come, first-serve basis depending on whether they meet the inclusion criteria. Priority will be given to clinicians of varying theoretical backgrounds to ensure diversity within the study.

Shainoor Kara Email:	Shainoor Kara Email:	Shainoor Kara Email:	Shainoor Kara Email:	Shainoor Kara Email:	Shainoor Kara Email:	Shainoor Kara Email:	Shainoor Kara Email:	Shainoor Kara Email:	Shainoor Kara Email:

Appendix D

Recruitment Letter

To whom it may concern,

My name is Shainoor Kara and the purpose of this email is to invite you to participate in a study I am conducting, as part of my requirements to complete a Master's degree within the department of Counselling Psychology at the University of Ottawa. My research will be supervised by Dr. Nicola Gazzola.

The purpose of this study is to understand countertransference (CT) through therapists' retrospective accounts by learning about: 1) how therapists define and conceptualize CT, 2) the contexts within which CT experiences occur, and 3) how therapists deal with their CT. The information collected from this study will inform counsellor education and training and will be used to find viable solutions for clinicians who are dealing with CT.

Criteria for participation:

- You reside within Canada
- You are able to communicate in the English language
- You have practiced psychotherapy for a minimum of 5 years
- You have experienced CT

Participants can expect to take part in a 45-60 minute interview conducted either in person or over the phone, during which they will be asked about their understanding of CT and their experiences with it. If participants choose to be interviewed in person, the interview will take place in the participant's office space or in an office at the University of Ottawa's Community Counselling Clinic located in Lamoureux Hall, room 351. The interview will be conducted in the English language. It will be audio recorded and later transcribed to ensure that data used for the study is accurate. Please note that all identifying information will be removed during the transcription stage and that the primary researcher and her thesis supervisor will be the only individuals with access to the data. Participants will be given the option to enter their name in a draw for a chance to win a $25 Chapters gift card as compensation for their contribution to the study.

If you are interested in participating in the study or would like more information, please feel free to contact my supervisor or me. Please note that participants will be selected on a first-come, first-serve basis depending on whether they meet the inclusion criteria. Priority will be given to clinicians of varying theoretical backgrounds to ensure diversity within the study.

Thank you for your time and consideration,

Shainoor Kara, MA[Ed] Candidate, Counselling Psychology
University of Ottawa

Appendix E

Informed Consent Form

Researchers:
Shainoor Kara
MA[Ed] Candidate
Counselling Psychology
University of Ottawa

Dr. Nicola Gazzola
Professor, Thesis supervisor
Counselling Psychology
University of Ottawa

You have been invited to participate in a study called *Understanding Therapists' Experiences With Countertransference: A Move Towards Better Training, Supervision, And Practice.* This research will be conducted by Shainoor Kara as part of her requirements to complete an MA[Ed] degree within the department of Counselling Psychology at the University of Ottawa. The research will be supervised by Dr. Nicola Gazzola.

Purpose of Study
The purpose of this study is to understand countertransference (CT) through therapists' retrospective accounts by learning about: 1) how therapists define and conceptualize CT, 2) the contexts within which CT experiences occur, and 3) how therapists deal with their CT. The information collected from this study will inform counsellor education and training and will be used to find viable solutions for clinicians who are dealing with CT.

Procedures
If you agree to participate in this study, you will be interviewed about your understanding of CT and your experiences with it. The interview will last approximately 45-60 minutes and will be conducted in the English language. This interview will be audio recorded and later transcribed to ensure that data used for the study is accurate. Please note that all identifying information will be removed during the transcription stage. The researcher will also take basic notes during the interview. Once your interview is transcribed, you will be sent a copy of your transcript by email. The document will be encrypted. The password will be given to you once the interview is complete. You will have up to two weeks to make changes to the transcript once it is sent to you. You can add or remove text from your answers, so they better reflect your experiences. Data from the study will ultimately be used to write a research report that will be shared with the public. The direct quotations of participants may be used in the report, as long as they do not include any identifying information.

Potential Risks and Discomforts
There is a possibility of experiencing discomfort when recalling and discussing previous CT experiences during the interview or after its completion. Although there is minimal risk, you can inform the researcher of any discomfort you experience at any time during the interview. You can also inform the researcher if ever you would like to take a break or prefer not to answer a question. At the end of the interview, you will be provided with a debriefing form that contains services you can access if the interview causes you any discomfort.

Potential Benefits of Participation
Participation in this study will help shed light on how therapists understand and cope with CT, as well as which contexts typically breed CT. This information can be shared with counsellors in training, practicing therapists, and supervisors, who can learn CT management strategies to share with others and use themselves for the purpose of providing clients with adequate treatment.

Confidentiality and Anonymity
To ensure complete confidentiality for participants, all identifying information will be removed from the interview transcripts. As well, any information obtained that could compromise the confidentiality of participants will not be shared with anyone other than the primary researcher and the thesis supervisor. To maintain anonymity, all identifying information will be removed from the interview transcripts and each participant will be assigned an interviewee number (e.g. 77-50).

Data Collection and Storage
Data collected for the study will consist of audio recordings and transcripts of interviews, as well as any notes taken by the primary researcher while conducting interviews. Hard copies of data will be stored in the office space of Dr. Nicola Gazzola. Electronic copies of data will be encrypted with a password and stored on the computers of Shainoor Kara and Dr. Nicola Gazzola. The data will only be accessible to Shainoor Kara and Dr. Nicola Gazzola. The data will be preserved for 5 years after the completion of the study, after which it will be destroyed and disposed of.

Compensation
As compensation for your participation in the study, you will be given the option to enter your name in a draw for a chance to win a $25 Chapters gift card. The draw is open to all research participants who enter their name in the draw, regardless of whether they decide to withdraw from further participating in the research project. Once the research project is complete, a name will be randomly selected amongst those who have entered the draw. The primary researcher will inform the person whose name is drawn by email. To win the prize, the person must correctly answer a skill testing question. If the person does not respond within 14 days from the date of the draw, the prize will be awarded to the second name that is randomly selected and so on until the prize has been awarded. The odds of winning a prize will depend on the number of participants recruited for the research study. The prize must be accepted as awarded or forfeited. It cannot be redeemed for cash. Your name that you provide when you enter the draw is collected for the purposes of contacting you if your name is selected in the draw. Your name and the contact information you have provided will be kept confidential and then destroyed once the prizes have been awarded. We reserve the right to cancel the draw or cancel the awarding of the prize if the integrity of the draw or the research or the confidentiality of participants is compromised. The draw is governed by the applicable laws of Canada.

Participation and Withdrawal
Your participation in the study is completely voluntary and can be withdrawn at any time. If you choose to withdraw your participation, your data will not be used in the study, and it will be destroyed and disposed of immediately. At any time during the interview, you may ask questions

of the researcher, refuse to answer any questions, and/or request to take a break. None of these actions will result in any negative consequence.

If you have any questions, you may contact either the researcher or her supervisor. Any questions or complaints about ethical conduct of the research study can be forwarded to the Office of Research Ethics and Integrity at Tabaret Hall, 550 Cumberland Street, Room 154, at ethics@uottawa.ca or at 613-562-5387.

There are two copies of the consent form, one of which is mine to keep.

I, _____, understand all information contained in this form and agree to participate in this study.

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

Appendix F

Debriefing Form

Thank you for participating in this study. We appreciate the time and energy you put into it.

If you have any further questions, please feel free to contact me, Shainoor Kara, by email or my supervisor, Dr. Nicola Gazzola, by email or by telephone. As noted on the Consent Form, any questions or complaints about ethical conduct of the research study can be forwarded to the Office of Research Ethics and Integrity at Tabaret Hall, 550 Cumberland Street, Room 154, at 613-562-5387.

Below are some services you can access in the case that the interview caused you any discomfort:

Distress Centre Ottawa and Region

- Offers 24/7 phone-line services to individuals needing help due to crisis or distress. Further information can be found on the Distress Centre Ottawa and Region website
- Distress Line Telephone: 613-238-3311
- Crisis Line Telephone: 613.722.6914
- Website: https://www.dcottawa.on.ca

The Walk-In Counselling Clinic

- Offers free, single-session counselling services to community members. Counselling sessions last approximately 1.5 hours. The location and times for this service varies and can be found on the Walk-In Counselling Clinic website
- Website: https://walkincounselling.com/

Services for those who reside outside of Ottawa will be forwarded upon request. As such, please feel free to contact me if you require information on additional services available within Canada.

Appendix G

Positionality on CT

I first heard of countertransference (CT) during a training session meant to prepare me to work with clients who had experienced sexual assault. CT, which I did not yet understand, was painted as a harmful phenomenon to be cautious of. The topic immediately peaked my interest, and I began reading up on it soon after returning home from the training session. From the open source documents that I read, I gathered that CT is an unconscious, emotional reaction that a therapist has to a client. I also gathered that CT is about the therapist's own internal processes and that it can be linked to a client's transference. At the time, I did not really even know what transference was. Surprisingly, I had stumbled upon the term CT before the term transference. What I was most curious about was whether or not CT truly was unconscious. I wondered if clinicians consciously noticed when CT was occurring and simply disregarded it, because they did not want to deal with it. After thinking about it for some time, I formed the opinion that CT probably operated on a conscious level. I thought that clinicians would know when a client had triggered them. For instance, they would know if a client reminded them of their mother or had similar past experiences as them. I also did not think of CT as positive or negative. Instead, I viewed it as an inevitable part of therapy, which could lead to therapeutic benefit or harm based on how a clinician chose to deal with it. For example, terminating with a client without explanation if they remind you of someone from your past would likely cause more harm than good. If it were explained well, I thought, then perhaps it would be okay. Still, my opinions were not well informed. I wanted to learn more about CT, specifically what others thought of it, so I decided to select it as my thesis topic.

For the purpose of completing a literature review, I read a large portion of the clinical literature on CT. At this point, I realized that several definitions of CT existed in the literature, far more than I had initially thought. At the time, I did not know which definition resonated with me most, as there was a surplus of information to process. I became curious about what practicing clinicians thought, leading to the formation of one of my research questions (i.e., How is CT conceptualized by therapists?). In September 2018, I began an internship in which my primary role was to provide supervised counselling services to clients. Soon enough, I had my own CT experience, resulting from material brought forth by a client in a session. For the purpose of privacy and confidentiality, I will not provide details on the material that triggered me. I did not realize I had experienced CT until I reflected on the session a few hours after it ended. This experience allowed me to understand how CT can operate on an unconscious level. Clinicians may not always understand that what they are experiencing is CT until after-the-fact. Additionally, through reflecting on the session, I noticed how I had acted differently with my client as a result of the CT. While I did not do anything that can be considered harmful, I certainly did not do my best. The CT feelings I was experiencing made me feel like I had to do something to make up for what I perceived as 'a session gone wrong'. Of course, I perceived this (i.e., the session going wrong) as my own doing and not that of the client. My need to do something manifested as me talking more. I said more and listened less, even when it would have been helpful to do the opposite. My paraphrases also sounded more like interpretations, which I was luckily able to catch and change during the session. After this experience, I began to form a better understanding of CT.

My current beliefs about CT resonate most with the integrative definition of CT coined by Gelso and Hayes (2007), whereby CT occurs when the therapist's unresolved past or present conflicts and vulnerabilities influence the therapist's reactions towards a client. This is the definition of CT that I support, primarily, because this is what I experienced myself. I do not think I reacted to the client's transference as might be suggested by the complementary definition of CT (see Epstein & Feiner, 1979), as I cannot feasibly see how the client's transference had a role in my particular experience. As such, I support the integrative definition. However, I also see value in the Freudian definition of CT, which acknowledges the unconscious nature of CT (Freud, 1910/1959). I believe CT is unconscious until realized, even if it is realized within a few minutes of its manifestation.

My experience also allowed me to form a stronger opinion on the impact that CT can have on therapy. I now believe CT can cause more harm than good. When managed well, I believe therapists can look past their CT to effectively work with a client. However, when it is not managed and kept in check, I believe it can harm both the therapeutic relationship and the therapeutic outcome. I have developed an interest in learning more about how clinicians cope with their CT and how some manage to use it as a tool. I think this can benefit myself and other clinicians who do not quite know how to manage or even address their CT.