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Navigating Transference and Countertransference

Section 1: Introduction

References: 1, 2, 4, 5, 9, 10, 11, 13, 16, 20

While transference and countertransference are concepts that were introduced by Dr. Sigmund Freud over 100 years ago, they remain relevant and complex aspects of therapeutic relationships today. To simply define these concepts, transference occurs when a client projects their feelings about another person onto their therapist, and countertransference is the opposite, where a therapist projects their feelings about another person onto their client (Fritscher, 2023b).

History and Definition of Transference

When Dr. Freud initially discovered transference, he thought it was a form of resistance on behalf of the client and something that interfered with their treatment. When the client projected their feelings onto him, he believed they were covering up unconscious traumatic experiences that were at the core of their symptoms. However, over time, Dr. Freud observed patterns in relationships that clients exhibited in their personal lives, which he found were also reflected in their relationship with him (Arundale & Bellman, 2011; İlkmen & Halfon, 2019). He came to realize that the behaviors a client was projecting onto him were not about him, but instead were how the client's unresolved conflicts and desires were being manifested (Claney, 2024a). In one of his papers, Dr. Freud wrote that therapy was a place where "repressions could be lifted, drives and defenses revealed, and where primitive emotions and fantasies could have their free expression, emphasizing that this process provided an invaluable opportunity for self-exploration, development, and change" (Arundale & Bellman, 2011, p. 17). Dr. Freud "grew to understand that the emotional quality of a patient's feelings toward the analyst (therapist) had value as a means of understanding the patient's neurosis (symptoms), and could be used as a tool" in therapy (Arundale &

Bellman, 2011, p. 16). Dr. Freud proposed that once clients could recognize their unconscious thoughts and feelings and bring them into their consciousness, they could work through the transference process by gaining insight into their relationship patterns and experiencing a different relationship with their therapist, which helped them achieve a positive outcome from therapy (İlkmen & Halfon, 2019).

Following Dr. Freud, clinicians and researchers have built upon the concept of transference, but at its core, it involves how a client relates to their therapist (Arundale & Bellman, 2011). More recently, the definition of transference has been broadened to include not only reenactments of past relationships but also a "new experience influenced by the relationship with the therapist" (Cooper, 1987, as cited in İlkmen & Halfon, 2019, p. 427). Recent studies have shown that transference interpretations are focused on the current relationship between the client and the therapist, linking patterns in it to prior relationships, rather than the primary focus being on the past (İlkmen & Halfon, 2019). Since therapists can cause certain reactions in clients, it is important to recognize that these reactions can either be beneficial or detrimental to the therapeutic process (Madeson, 2021).

History and Definition of Countertransference

A few years after discovering transference, Dr. Freud proposed the concept of countertransference. Similar to his initial view on transference, he looked at the therapist's personal issues and emotional reactions as something that interfered with therapy. He believed that a therapist could experience their client as someone from their past and unconsciously or consciously project their own experiences with that person onto their client. He viewed this as an obstacle, something that a therapist needed to overcome (Arundale & Bellman, 2011;

Gabbard, 2020). In some of his writings, he recommended “emotional coldness” towards clients, while at other times, he encouraged therapists to address their countertransference through self-analysis and receiving therapy of their own. He referred to the process of addressing countertransference as “psychoanalytic purification” (Tansey & Burke, 1989, p. 12). According to Tansey and Burke (1989), Dr. Freud never changed his view on countertransference as he did with the concept of transference. Some of his final writings on the topic continued to refer to countertransference as a hindrance in the therapeutic process, and he continued to encourage therapists to receive treatment, even if it was less frequent than their cadence of therapy when they initially sought support.

Several theorists continued to work on the concept of countertransference after Dr. Freud. Approximately 40 years after he proposed the idea, Dr. Paula Heimann, a psychologist, made significant progress in developing the theory, thereby increasing interest in it. She acknowledged the relationship between the therapist and the client during the therapeutic process, recognizing the two-way nature of the relationship and that both individuals would likely have certain feelings towards one another (Tansey & Burke, 1989). While she argued that countertransference happens on behalf of the therapist, she expanded the concept by proposing that the therapist's “emotional response to the patient is not simply an obstacle or hindrance based on his/her own past, but rather an important tool in understanding the patient’s unconscious world” (Gabbard, 2020, p. 243). Dr. Heimann believed that the feelings the therapist had in response to their client could help them better understand the client’s mind and personality (Arundale & Bellman, 2011). She encouraged the therapist to acknowledge and sustain their feelings, rather than suppress them, and to use them appropriately to help them to better understand their client (Tansey & Burke, 1989).

Around the same time, a psychiatrist, Dr. D.W. Winnicott, aligned with Dr. Heimann. He noted the following about countertransference:

> *"Therapists often react to patients in the same way that others do. Certain patients can be so contemptuous that everyone with whom they come into contact, including the therapist, may respond with negative or even hateful feelings. He made the point that this hateful reaction had much less to do with the therapist's own personal past or intrapsychic conflicts. Rather, it reflected the patient's behavioral strategies and the need to evoke specific reactions in others" (Gabbard, 2020, p. 243).*

While the theory of countertransference has evolved since the work of Dr. Heimann and Dr. Winnicott, many mental health professionals today hold the belief that countertransference is a valuable tool for gathering information about a client; however, they must be mindful that their own subjectivity can also be involved when they experience a client's behavior (Gabbard, 2020). Gabbard (2020) states that there has been a movement in the mental health field to understand countertransference as a "jointly created phenomenon" that involves both the mental health professional and the client, rather than viewing it as something that is brought into the therapeutic relationship solely by the mental health professional (p. 243). In fact, in the definition of countertransference from the American Psychological Association (2018), it is noted to "serve as a source of insight into the patient's effect on other people" (para. 1), which acknowledges the two-way nature of this concept. However, the mental health professional is the person in the relationship who is responsible for countertransference; they need to be aware of it, monitor it closely, address it appropriately, and seek support and supervision when needed, so that they are staying neutral and using it productively in the therapeutic process (American Psychological Association, 2018; Fritscher, 2023a).

As the concepts of transference and countertransference continue to evolve, they also remain relevant today. Mental health professionals need to be able to recognize and understand these concepts to better understand themselves and

their clients' underlying motivations and patterns. This course delves in-depth into the ideas of transference and countertransference. The risk factors, causes, signs, types, and impact on the therapeutic process are thoroughly reviewed. Strategies for managing transference and countertransference are outlined. Ethical considerations are also mentioned.

Notably, the term "therapist" is used most frequently throughout the course. The term "mental health professional" is used interchangeably with “therapist.” Both terms refer to individuals from various professional disciplines who engage in clinical work with clients, including psychologists, therapists, counselors, marriage and family therapists, and social workers. The terms “client” and “patient” are also used interchangeably.

Section 1 Key Terms

Transference occurs when people transfer experiences and expectations they have learned from interactions with others to new people they meet. Transference typically occurs unconsciously and can have a negative impact on psychological functioning until it is addressed.

Countertransference occurs when mental health professionals transfer their experiences and expectations to a client and react emotionally. While this often happens unconsciously, being able to recognize and examine these feelings can help the therapeutic process (Bender & Messner, 2022).

Section 2: Understanding Transference and Countertransference

References: 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19

Now that the history of transference and countertransference is outlined and the concepts are defined, gaining a deeper understanding of both concepts is crucial for clinical practice, not only for understanding clients but also for understanding ourselves as mental health professionals. This section reviews the risk factors, causes, signs, types of transference and countertransference, and the impact on the therapeutic process.

Transference

According to Deibel (2024), transference often occurs early in the therapeutic process, when the client begins getting to know their therapist. The client's attitude towards the therapist is more closely related to their physical, emotional, and cognitive experiences than to any characteristics of the therapist. Another way to think about it is that transference is more about the client's internal experience than it is about the therapist themself. The client's internal experience and external reactions to the therapist are "related to what the patient consciously and unconsciously expects from the therapist, and these expectations reflect their experience with important people in their life" (Prasko et al., 2022, p. 2131). However, the client projects (or transfers) their experiences and expectations onto the therapist (Prasko et al., 2022). According to Claney (2024a), "the therapist becomes a stand-in for someone in the client's life" (para. 1).

Madeson (2021) states that "transference usually happens because of behavioral patterns created within a childhood relationship" (para. 16). Bender and Messner (2022) write that transference is "preconceived attitudes or expectations toward a person based on one's experience in prior relationships" (p. 447). Both of these statements connect transference to aspects of a person's past, whether it be relationships, experiences, unresolved emotions, or an inability to trust others. It is essential to note that, while there is a connection to the past, recent studies

have demonstrated that transference interpretations are now more centered on the current relationship between the client and the therapist. Patterns in this relationship are linked to prior experiences, rather than the past being the primary focus of the transference process (İlkmen & Halfon, 2019).

Risk Factors for Transference

When a client is especially vulnerable, they may be at a higher risk of transference. For example, if the client feels a lack of self-esteem or self-control (Fritscher, 2024b). Some therapists have also speculated that transference is more common in the telehealth setting, as some "issues and fantasies that might not come up in a shared environment may be more easily accessed" in this setting (Sayers, 2021, p. 228). This commonality could be attributed to clients feeling safer and uninhibited in their home environment, at a distance from the therapist (Sayers, 2021).

Causes of Transference

Clients can react to different aspects of the therapist as a person, which is part of what causes transference. They can respond to the therapist's appearance, style, tone of voice, mannerisms, personality traits, and behaviors. They may also react to how often the therapist agrees or disagrees with them. Additionally, if the therapist is challenging to read, meaning they do not act naturally, share anything about themselves, or show any emotions, strong transference can arise, especially if the client has known people who also exhibit these behaviors (Deibel, 2024).

Signs of Transference

There are sure signs that a client may be experiencing transference in the therapeutic relationship. Some signs followed by examples include:

- Strong emotional reactions when compared to the topic that is being discussed.
    - A therapist asks a client about their week, and the client responds by lashing out with anger about why they are being asked the question.
- Inappropriate emotional responses.
    - Laughing when talking about a heavy topic, such as trauma or the death of a loved one.
- Directing emotions or misplacing them on the therapist.
    - A client says that a therapist's comment hurts their feelings, when the issue is actually that the client is sensitive to the comment because it is something hurtful that one of their parents often says to them (Deibel, 2024; Madeson, 2021).
- Repeating patterns in relationships.
    - A client who tends to push people away in their personal life often repeats this behavior with their therapist.
- Making and expressing assumptions about the therapist's thoughts, feelings, and values.
    - A client breaks their sobriety and comments to their therapist that they know they are disappointed in them.
- Feelings towards the therapist shift suddenly.
    - The therapist and client typically maintain a good rapport in sessions, but the client suddenly becomes irritated with the therapist (Claney, 2024a).

- Commenting on the therapist's personality traits, behaviors, style, or appearance.
    - A client tells the therapist that they resemble their mother (Prasko et al., 2022).
- Being preoccupied with the therapist.
    - The client often thinks about the therapist outside of sessions (Deibel, 2024).

According to Prasko et al. (2022), there are also apparent manifestations of transference, including:

- Sudden change in expression, posture, or eye contact (looking away or giving admiring glances)
- Transitioning to a new topic quickly
- Avoiding important issues, stalling, or pausing when speaking
- Not expressing automatic thoughts
- Clenching fists
- Tapping feet

When the therapist asks the client about what they are thinking or experiencing, the client will often brush it off or say it does not matter, which is a critical reaction to pay attention to, as it provides insight into the client's personal past and present relationships (Prasko et al., 2022).

Types of Transference

The three main categories of transference are as follows:

- Positive transference happens when a client projects the enjoyable aspects of a relationship onto the therapist. It can mean that the client sees the therapist as empathetic and caring. It can be a beneficial part of the therapeutic process.
- Negative transference occurs when a client projects undesirable or harmful feelings that they had in a personal relationship onto the therapist. This may sound detrimental to the therapeutic process. However, if the therapist is skilled in recognizing and acknowledging it, the negative transference can become a core aspect of helping the client identify and work through it.
- Sexualized transference happens when a client feels attracted to their therapist (Madeson, 2021).

Within these categories, there are different types of transference, which include:

- Paternal transference is when a client sees qualities of a father figure in their therapist, such as being protective, authoritative, and influential. Depending on the relationship between the client and their father, this may lead the client to experience either positive or negative feelings towards their therapist. For example, if the client's father often criticized or expressed disappointment in them, the client may perceive their therapist as doing something similar in certain situations that arise during therapy. The client may also try to seek approval from their therapist.
- Similarly, maternal transference happens when a client sees qualities of a mother figure in their therapist, such as being loving, nurturing, and influential. If the client had a mother with this type of personality, these qualities could generate trust; however, if the client's mother did not

possess these qualities, it could lead to negative feelings. For example, if the client's mother was loving, the client will likely view their therapist as a source of comfort in their life. However, if the client's mother was critical or overbearing, the client may see the therapist in this light in certain situations.

- Sibling transference often occurs when a person lacks a relationship with one or both parents and instead has a sibling who may have filled one or both of these roles. It can also occur when parents are present, and the client has a typical type of relationship with their sibling, one that is either characterized by camaraderie and closeness or, on the other end of the spectrum, is marked by jealousy and rivalry. Regardless, the dynamics of the relationship between the client and their sibling can also play out in the relationship between the client and their therapist.
- Non-familial transference, also known as idealized transference, can occur when the client perceives qualities in their therapist that are similar to those of someone they have idealized in their life, such as a teacher, clergy member, or mentor. The client may have put this person on a pedestal and can end up doing the same thing to their therapist, seeking specific types of validation or guidance from them.
- Sexualized transference happens when a client feels a romantic and/or sexual attraction to their therapist, and they project these feelings onto them. The client may feel an attraction based on the therapist's physical appearance or personality characteristics, which often means the client has deep issues related to intimacy and sexual relationships (Claney, 2024a; Madeson, 2021).

The Impact of Transference on the Therapeutic Process

As noted above, transference is a powerful tool for therapists to gain a deeper understanding of their clients. By recognizing, observing, and interpreting the signs and manifestations of a client's transference when certain things are discussed in sessions, the therapist "can gain insight into the client's relational patterns and unresolved issues" (Claney, 2024a, para. 3). This insight leads the therapist to help the client uncover, acknowledge, and work through their patterns and issues. As long as the client is willing to engage in therapeutic work, recognizing and exploring their transference will enable them to have healthier relationships and a greater overall sense of well-being in the future (Claney, 2024a).

Claney (2024a) also notes that transference plays a significant role in the therapeutic relationship between the therapist and client. She states, "When managed effectively, transference can strengthen the therapeutic alliance by deepening trust and emotional connection. Clients who feel understood and supported in their transference experiences are more likely to engage fully in the therapeutic process" (para. 5).

If a client fails to address their transference, it is possible they will not achieve a satisfactory outcome from therapy. The client may feel uncomfortable, embarrassed, or stressed in therapy sessions, which can lead them to hold back in the therapeutic work they need to do. They may regress or withdraw from therapy. The relationship with the therapist can also be negatively impacted (Fritscher, 2024b).

Countertransference

Unlike transference, countertransference can happen at any point during the therapeutic relationship. Currently, it is widely recognized by many mental health

professionals as an inevitable aspect of their work (Phillips, 2022). Some studies have shown that over 80% of therapists assessed by their colleagues have reported experiencing countertransference in their careers (Khanipour & Yarahmadi, 2024). Because therapists are human, they can be triggered by their clients and experience a range of emotions (Phillips, 2022).

Another difference from transference is that the therapist's reaction to the client can be influenced by their "past experiences, personal biases, or unresolved conflicts. They can also be in direct response to a dynamic with the client, informing the therapist of what it is like to be in a relationship with the client" (Claney, 2024b, para. 2).

Risk Factors for Countertransference

In an analysis done by Khanipour & Yarahmadi (2024), studies have shown that risk factors for countertransference can be grouped into the following three categories:

- Therapist-related risk factors, including their amount of training, self-awareness, and mentalizing capacity, which is the ability to "understand both one's own and other people's behavior in terms of mental states, such as desires, feelings, and beliefs" (Free et al., 2024, p. 87). Risk factors also include the therapist's ability to recognize emotions, adhere to the treatment plan, and display empathy. If the therapist is female and/or has trait anxiety, they are at a higher risk for countertransference. They are also at a higher risk of countertransference if the content of the client's issues is relatable on a personal level, if they compare clients, and if they change the treatment plan (Khanipour & Yarahmadi, 2024).
- Patient-related risk factors include attachment style and mental health diagnoses, such as a personality disorder, substance use disorder, suicidal

thoughts, and a history of sexual trauma. Additionally, the client's nature comes into play, meaning that if they are seductive or aggressive, rather than neutral, the therapist may be more likely to experience countertransference in their relationship.

- Culture-related risk factors, including the amount that the therapist and the patient are culturally aligned (Khanipour & Yarahmadi, 2024).

Some therapists have also speculated that countertransference occurs less frequently in the telehealth setting, as the therapist can be protected by the screen and physical distance from the client (Sayers, 2021).

Causes of Countertransference

As noted above, countertransference can be triggered by aspects of the therapist's own experiences that are evoked by the client, such as unresolved conflicts. Countertransference may also be a response to the client's transference (Claney, 2024b). Additionally, the client can evoke certain feelings in the therapist based on various aspects of the therapeutic process, such as the content being discussed in the session or the client's appearance or personality, which can result in countertransference (Claney, 2024b; Phillips, 2022).

Signs of Countertransference

There are sure signs that a therapist may be experiencing countertransference in the therapeutic relationship. Some signs followed by examples include:

- Inappropriate or strong emotional responses.
    - The therapist displays a strong sense of dislike or excessive positive feelings towards the client for no apparent reason.
- Being preoccupied with the client.

    - The therapist is overly emotional about the client's situation and is preoccupied with them between sessions. They may even daydream about them (Fritscher, 2023a).

- Feeling overly invested in a client.
    - The therapist is worried about the client's life and the implications of their decisions outside of sessions.
- Maintaining boundaries becomes difficult.
    - The therapist starts to blur professional boundaries by talking about themself more than the client during sessions. They can feel an urge to self-disclose at a level that makes the client uncomfortable.
- Avoiding thoughts about a client.
    - The therapist needs to seek supervision about a client's treatment plan, but is avoiding thinking about them and their situation.
- Changing a typical therapeutic style (Claney, 2024b).
    - In sessions, the therapist is usually engaged, focused, and warm, but suddenly they seem disengaged, scattered, and insensitive.
    - The therapist may start to end sessions early or extend them. They may also feel dread or excitement in anticipation of a session, which can lead to a change in their style (Hegblom et al., 2025).

Types of Countertransference

There are four different types of countertransference:

- Subjective countertransference "involves feelings that are rooted in the therapist's own issues and have little to do with the patient" (Keenan, 2024,

para. 5). The emotions related to the client are often connected to unresolved issues in the therapist's life. Feelings towards the client can vary from anger and irritability to love and care. The client awakens feelings and problems in the therapist's life through their therapeutic work. They can be related to something from the therapist's past or to something the therapist is currently experiencing in their personal life. Regardless, these feelings are considered a distraction in the therapeutic process and can impact the therapist's ability to engage their client in treatment effectively. Subjective countertransference is considered harmful if it goes unnoticed by the therapist (Fritscher, 2023a; Keenan, 2024).

- Objective countertransference also involves the therapist's emotions that "arise in response to the client's maladaptive behaviors and characteristics" (Beltrani, n.d., para 8). Objective countertransference is different from subjective countertransference because it is not rooted in the therapist's unresolved issues. The therapist's emotional reactions are directly related to the client's maladaptive behaviors and patterns that are shared and observed during therapy (Beltrani, n.d.). According to Beltrani (n.d.), "the therapist's emotional reactions to the client's maladaptive behaviors can serve as valuable cues, shedding light on the challenges the client is facing. It can inform treatment strategies and interventions, allowing the therapist to tailor their approach to address the client's specific needs" (para. 8).
    - According to Keenan (2024), a therapist can experience both subjective and objective countertransference when working with a client. He states that it is essential for a therapist to "know how to distinguish their own feelings from the feelings that belong to the patient" (Keenan, 2024, para. 9). He suggests that one way to make this differentiation is for the therapist to pay attention to how long their feelings last. The therapist is likely experiencing objective

countertransference if their emotional reactions to a client subside quickly after the session ends. Subjective countertransference can occur when the therapist experiences emotions related to the client for an extended period after a session (Keenan, 2024).

- Positive countertransference happens when the therapist is overly supportive of their client, trying too hard to be friends with them, and disclosing too much information about themself. It can harm the therapeutic process as it can lead to boundary issues and favoritism (Claney, 2024b; Fritscher, 2023a).
- Negative countertransference occurs when the therapist responds negatively to the client's uncomfortable feelings expressed during therapy. The therapist may reject, punish, or be critical of their client, all of which can harm the therapeutic process (Fritscher, 2023a).

The Impact of Countertransference on the Therapeutic Process

Countertransference can impact the therapeutic process in both positive and negative ways. Some of the positive impacts include the therapist gaining a better understanding of their client’s experiences and gaining more insights into their relationship patterns, as well as developing greater empathy for them. These things can help guide the client toward more profound and meaningful changes in their life (Claney, 2024b). Some studies have shown that countertransference can help therapists feel more connected to their clients, leading to a more positive therapeutic relationship. When used appropriately, countertransference can also lead to better outcomes from therapy, including clients reporting an improvement in their symptoms (Fritscher, 2023a).

Some of the negative aspects of countertransference include less clarity in professional boundaries, interventions that are biased or ineffective, and possible harm to the therapeutic relationship (Claney, 2024b).

A client may pick up on countertransference if they notice their therapist becoming overly emotional about certain situations, sharing too much personal information, or continually focusing on specific topics during therapy sessions. The client may decide to discuss these behaviors with their therapist, which can present challenges for the therapist to address.

However, it is beneficial for the therapeutic relationship for the therapist and client to discuss it openly, and for the therapist to implement strategies to address it (Claney, 2024b). Khanipour & Yarahmadi (2024) state that if the therapist decides to neglect their countertransference, they can "significantly impair the effectiveness of therapeutic methods" (p. 304). This neglect can violate aspects of their profession's code of ethics.

Section 2 Reflection Question

Have you experienced transference from a client? If so, what type(s)? What signs did you notice? What was the impact on the therapeutic process?

What is your experience with countertransference? Did any of the types resonate with you?

If you have experienced countertransference, what signs did you notice? What was the impact on the therapeutic process?

Section 3: Managing Transference and Countertransference

References: 6, 9, 15

Mental health professionals can take specific steps to manage transference in the therapeutic relationship. Countertransference can be handled by the therapist implementing various strategies in their life and clinical practice.

Transference

The therapist is the person in the relationship who is responsible for managing transference. A therapist needs to possess a specific skill set and sensitivity in addition to maintaining professional boundaries to manage it effectively. While transference can be challenging for both the therapist and the client, it is an essential part of the therapeutic process, allowing the client to undergo healing and growth.

The first step in managing transference is recognizing it. The signs outlined in the previous section can help therapists recognize transference. In addition to being aware of the signs, the therapist also needs to be mindful of their own emotional responses.

Once it has been identified that transference is occurring, the next step is to explore its underlying cause. By engaging in this exploration, the client gains an understanding of their projection onto the therapist, including who they are thinking of from their past, and the reason the projection is occurring. This understanding enables the client to uncover their past emotions and unresolved conflicts, providing self-awareness and insight into their current behaviors and patterns.

The final step is to help the client change. Gaining awareness and addressing issues opens the client up to different, healthier ways of engaging with others in relationships. The client can implement these changes in both the therapeutic relationship and other personal relationships. The therapist can remain available to the client, providing opportunities for reflection, processing, and emotional support throughout sessions. Ongoing support from a therapist can be beneficial in helping clients make lasting changes in their lives.

There may be challenges throughout the process of addressing transference and implementing changes. The client may be resistant or defensive at times. They may feel embarrassed about what they are uncovering in their therapeutic work. They may also need space or a break from doing this work due to its intensity. The therapist can address these challenges by presenting with empathy and patience, validating the client's feelings, normalizing the process, and encouraging the client to stay open in their communication. The therapist also needs to maintain their professional boundaries and avoid becoming too entangled in the client's projections or giving inappropriate responses (Claney, 2024a).

Countertransference

Similar to transference, the therapist is the person in the relationship who is also responsible for managing countertransference. Knowing how to manage it effectively is essential for being an ethical and practical mental health professional.

The first strategy for managing countertransference is self-awareness. Engaging in regular self-monitoring through reflection and processing can help therapists understand their emotional reactions to their clients. Another strategy is to attend their own personal therapy sessions. Just as their clients participate in individual

work during sessions, therapists can also engage in this practice to gain insight into their own emotional experiences and relationship patterns.

Supervision and consultation with colleagues is another strategy for managing countertransference. Other people in the mental health profession can help therapists discuss their cases and explore their emotional reactions. They can also discuss professional boundaries and strategies for maintaining them. In addition to discussion, therapists can use process notes as a way to track their emotional responses throughout the therapeutic process and review them in supervision. Role-playing is another helpful tool to use in supervision. Individual clinical supervision or focused group supervision are options.

One more strategy is continuing education. Therapists can attend professional development courses to enhance their understanding of countertransference and learn how to utilize it effectively. Lastly, therapists can use the coping strategies they typically employ to support themselves in their daily work, such as mindfulness, journaling, or exercise (Claney, 2024b; Fritscher, 2023a; Keenan, 2024).

Section 3 Reflection Question

If you have experienced transference or countertransference, how have you managed it?

Section 4: Ethical Considerations

References: 15

Each mental health profession has its own code of ethics that practitioners are required to adhere to. While each code of ethics has variations based on the

profession, they all include guidelines to respect clients and avoid causing harm to them, to maintain professional boundaries and not engage in any relationships outside of the therapeutic one, and to have professional competence, all of which specifically relate to countertransference. Therapists should not act on any feelings, whether positive or negative, towards clients, as this can harm the therapeutic relationship and blur boundaries (Keenan, 2024).

Section 4 Key Terms

A code of ethics is a set of standards that guide conduct for mental health professionals.

Section 4 Reflection Question

When reviewing your profession's code of ethics, are there standards other than the ones mentioned in this section that stick out to you when considering countertransference?

Section 5: Case Study

William is the chief executive officer of a large, successful private company. Recently, the human resources department has been receiving complaints about William's behavior, primarily that he has been lashing out at female employees in meetings and placing unreasonable demands on female members of his executive leadership team. The board of directors and the human resources department of the company decide that William needs to seek professional counseling to explore and address these behaviors. William receives a referral to a therapist from a friend who is also an executive at a company and has sought counseling in the past.

William contacts the therapist, Karen, and has his first appointment about a week after their initial conversation. Upon starting the session, William comments that Karen has the same mannerisms as his mother. He proceeds to tell her the reason that he is seeking therapy and that he is only doing it to keep his job. He disagrees with the board of directors and human resources about the behavior complaints, but does not want to disclose that information to them. Karen attempts to explore ways to help William, but he seems defensive, and they spend the majority of the first session in silence. This trend continues for the subsequent few sessions, and Karen finds herself feeling an immense amount of dread when she arrives on the day of the week when William's session is scheduled. She also finds herself feeling disengaged during the sessions and ends them early each time.

One day, William arrives at his appointment and tells Karen that his company continues to receive complaints about him and that his job is at further risk of termination. He decides to open up to Karen about why he has been acting out at work. He shares that his mother has had heart problems for a significant part of his life, but the last few months have been challenging as her health has declined. She is currently receiving hospice services at home. Over the subsequent few sessions, Karen learns more about William's relationship with his mother. She learns that William's mother has never really been loving towards him and is overly critical of his every move. William has emotionally distanced himself from his mother, often acting defensively and carelessly in their relationship. However, due to her medical condition, she needs more support from William, though her behavior towards him has not changed. When Karen tries to discuss his mother with William in depth, he lashes out in anger at her, feeling that she is being critical of him. He has also expressed this to Karen several times and has made assumptions about what she thinks of him. Karen feels at a loss on how to help William. Being that she has seen him in sessions for a few months now, and her

negative feelings towards him are increasing, she decides to seek clinical supervision from her mentor about what she should do next.

Section 6: Case Study Review

William is displaying transference towards Karen. His transference is evident from the first session, when he comments on the way Karen reminds him of his mother. William is emotionally vulnerable because of his complicated relationship with his mother. She is now terminally ill and needing support from him, though she has not been supportive of him. Even with her death approaching, she has not changed her behavior toward her son, which is even more upsetting to William. He feels out of control and is triggered by other women in his life, including Karen. William is experiencing maternal transference; he is directing emotions and misplacing them on the therapist as well as others at work, repeating relationship patterns, and making and expressing assumptions about other people.

Karen's mentor helps her process William's transference as well as her own objective countertransference. Through talking with her mentor, Karen realizes that she needs to have an open, honest conversation with William to address his transference and assess his willingness to change gently. Karen and her mentor decide to meet once a week throughout this process, so that Karen has the support that she needs to provide adequate care to William, as long as he is ready and agreeable to doing the therapeutic work. Karen also decides to take a half-day course on transference and countertransference to further develop her skills in this area and make sure she is providing ethical, competent care.

Section 7: Conclusion

Although the concepts of transference and countertransference were proposed over 100 years ago, they remain active components of the therapeutic relationship. When a mental health professional possesses knowledge of both these concepts and the necessary skills to manage them in their clinical work, they are providing ethical, effective, and competent care to their clients.

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