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Therapist Perspectives on Countertransference: Qualitative Data in Search of a Theory

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A consensual qualitative research strategy was used to examine data from 127 interviews conducted with 8 psychologists immediately following their sessions of brief therapy with 8 clients. Analyses revealed 3 domains relevant to countertransference: origins (including categories of family issues, needs and values, therapy specific issues, and cultural issues), triggers (including categories of content of client material, therapist comparing client with others, change in therapy structure or procedures, therapist assessing progress of therapy, therapist perception of client, and emotions), and manifestations (including categories of approach, avoidance, negative feelings, and treatment planning). The frequency of categories within and across cases was classified, and relationships among categories from the 3 domains were detected, generating hypotheses for future empirical research. Implications for practice, training, and continued research are discussed.

The clinician's use of the self as a therapeutic instrument can be influenced greatly by countertransference. On the one hand, countertransference may cause therapists to act defensively in accordance with their own needs, perceive clients in distorted fashion, and exhibit poor clinical judgment. On the other hand, the insight that may be gleaned from countertransference can deepen therapists' awareness of relationship dynamics and provide valuable information about the course of treatment (Gelso & Carter, 1994; Gorkin, 1987; Singer & Luborsky, 1977; Tauber, 1954).

Freud (1910/1959) first introduced the term *countertransference* to refer to the analyst's unconscious and defensive reactions to the patient's transference. Because he viewed countertransference as having uniformly adverse effects on therapy, Freud was "almost inclined to insist that [the analyst] shall recognize this counter-transference in himself and overcome it" (pp. 144–145). Subsequent writers broadened Freud's classical definition of countertransference to refer to all of a therapist's reactions to a client, whether those reactions were conscious or unconscious, in response to transference or to other phenomena (e.g., Fromm-Reichman, 1950; Heimann, 1950, 1960; Little, 1951, 1960). Accompanying this totalistic definition was the perspective that countertransference was not necessarily detrimental to therapy. For example, Little (1951) wrote, "If we can make the right use of counter-transference may we not find that we have yet another extremely valuable, if not indispensable, tool?" (p. 33). A third, as yet unnamed, perspective has emerged in defining countertransference. This perspective distinguishes the extent to which therapist reactions are grounded in the reality of the therapeutic relationship, defining countertransference as irrational reactions emanating from unresolved issues within the therapist (Blanck & Blanck, 1979; Gelso & Carter, 1985, 1994; Langs, 1974). This view of countertransference retains Freud's notion that countertransference is conflict-based while not limiting countertransference strictly to unconscious reactions or to those solely in response to the client's transference. We favor this conceptualization of countertransference because it is both less limiting than Freud's classical view and more useful than the totalistic definition of countertransference.

Present understanding of countertransference is based primarily on clinical writings (e.g., Atwood & Stolorow, 1993; Epstein & Feiner, 1979; Mitchell, 1988) and analogue research (e.g., Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1991, 1993; Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Analogue research on countertransference has followed the general paradigm of testing hypotheses under laboratory conditions that approximate therapy. Analogue

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studies have yielded support for numerous and varied hypotheses, such as: Male therapists withdraw when they are anxious (Hayes & Gelso, 1991; Yulis & Kiesler, 1968); therapist homophobia predicts avoidance behavior with gay and lesbian clients (Gelso et al., 1995; Hayes & Gelso, 1993); therapist awareness of countertransference feelings, in conjunction with adherence to theoretical framework, yields decreased countertransference behavior (Latts & Gelso, 1995; Robbins & Jolkovski, 1987); and therapist gender moderates the effects of countertransference (Gelso et al., 1995; Hayes & Gelso, 1991; Latts & Gelso, 1995; Lecours, Bouchard, & Normandin, 1995).

Because little naturalistic research has been conducted on countertransference (see Cutler, 1958; Hayes, Riker, & Ingram, 1997; McClure & Hodge, 1987 for exceptions), analogue researchers have tended to hypothesize about and examine factors believed to relate to countertransference without having those hypotheses deeply informed by data from field studies. Whereas laboratory analogue research has been helpful, and perhaps necessary, to advancing the measurement of countertransference, the current body of analogue research consists of a disparate set of studies examining largely unrelated hypotheses. The findings from these studies are difficult to integrate in any meaningful way, and they fall short of generating a clinically valuable theory of countertransference.

The current study was an attempt to augment the analogue methodology that has predominated countertransference research and move into the field to produce an empirically based, clinically informed theory of countertransference. Our research questions were guided by a theoretical model postulated by Hayes (1995). Drawing from the clinical literature, Hayes proposed an essentially structural theory of countertransference that emphasized five factors: origins, triggers, manifestations, effects, and management factors.

Origins refer to therapists' areas of unresolved intrapsychic conflict. By virtue of their humanness, all therapists possess issues that are unresolved to various degrees. Clinical writings suggest that a therapist's unresolved conflicts can enhance identification with and understanding of a client (Gorkin, 1987; Tauber, 1954) or they may interfere greatly with the therapy process (e.g., via distorted perceptions or defensive reactions; see Cutler, 1958; Singer & Luborsky, 1977).

Triggers are therapy events that touch on or elicit the therapist's unresolved issues. A therapist's origins may be provoked by the client's discussion of a particular topic or by other client behaviors, such as interrupting the therapist or showing up late for a session. The triggers most frequently investigated in previous countertransference research involve clients' presenting problems (e.g., rape, HIV infection, same-sex relationship difficulties; see Gelso et al., 1995; Hayes & Gelso, 1993; Latts & Gelso, 1995) and clients' presenting styles (e.g., hostile, seductive, dependent; Hayes & Gelso, 1991; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Research on these two types of triggers has yielded equivocal findings.

Manifestations are therapist behaviors, thoughts, or feelings that result from the provocation of the therapist's unresolved issues. The clinical and empirical literature indicate that countertransference reactions can assume myriad forms, both internal and external. Internally, countertransference often manifests itself in three forms: anxiety (Cohen, 1952; Gelso et al., 1995; Hayes & Gelso, 1991, 1993; Sharkin & Gelso, 1993; Sullivan, 1954; Yulis & Kiesler, 1968), misperceptions of the frequency with which the client discussed certain topics (Cutler, 1958; Gelso et al., 1995; Hayes & Gelso, 1993; Singer, Sincoff, & Kolligan, 1989), and feelings of liking or antipathy for the client (Fiedler, 1951; McClure & Hodge, 1987). Behaviorally, countertransference may be displayed by withdrawing from or otherwise avoiding the client (Bandura, Lipsher, & Miller, 1960; Hayes & Gelso, 1991, 1993; Yulis & Kiesler, 1968), becoming overinvolved with the client (Gelso et al., 1995), or exhibiting nonverbal behaviors that may be peripheral cues of countertransference (Sherman, 1965).

Effects are the ways in which countertransference manifestations promote or hinder therapy process and outcome. Most writers have viewed countertransference as an impediment, rather than an asset, to therapy, and so the bulk of scholarly attention has focused on the negative effects of countertransference. As a self-serving, or ego-oriented, response to the client, countertransference can be construed as an attempt by the therapist to meet his or her own needs instead of the client's needs (Cutler, 1958). Because therapy is geared ideally toward meeting the client's needs, countertransference may be envisioned as standing in direct opposition to the fundamental aim of therapy. Along these lines, in their review of research on countertransference, Singer and Luborsky (1977) concluded that "uncontrolled countertransference has an adverse effect on therapy outcome. Not only does it have a markedly detrimental influence on the therapist's techniques and interventions, but it also interferes with the optimal understanding of the patient" (p. 449). Singer and Luborsky's conclusion has been bolstered by subsequent research (Hayes et al., 1997; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Strupp, 1980a, 1980b). However, countertransference also may lead to positive effects, such as deepened insight. As stated succinctly by Jacobs (1993, p. 7), "The inner experiences of the analyst often provide a valuable pathway to understanding the inner experiences of the patient." Furthermore, judiciously sharing these "inner experiences" with a client may strengthen the working alliance and enhance the work (Little, 1951).

Management factors are therapist behaviors and characteristics that help therapists regulate and productively use their countertransference reactions. On the one hand, management factors may decrease the likelihood of deleterious countertransference behavior. Alternatively, such factors may help therapists effectively use their countertransference reactions after they have occurred. Among the behaviors believed to facilitate countertransference management are being in therapy, using supervision, reflecting on sessions (and tapes of sessions when possible), and meeting one's needs as fully as possible outside of work (Hayes, 1995). Therapist characteristics that have been found to aid in managing countertransference are self-insight, anxiety man-

agement, conceptual skills, self-integration, and empathy (Hayes, Gelso, Van Wagoner, & Diemer, 1991; Hayes et al., 1997; Latts & Gelso, 1995; Robbins & Jolkovski, 1987; Van Wagoner, Gelso, Hayes, & Diemer, 1991).

Consistent with Hayes' model, the purpose of this study was to explore the causes of countertransference in terms of therapists' unresolved issues (i.e., origins) and the specific events in therapy that provoke therapists' issues (i.e., triggers). We also wanted to investigate what happened as a result of countertransference being elicited (i.e., manifestations). Finally, we were interested in the effects of countertransference on therapy process and outcome and in knowing what helped therapists manage their countertransference reactions. We believed that answers to these questions would provide a framework by which therapists could better understand and make therapeutic use of their countertransference reactions to clients. In addition, we thought that such a framework might also prove beneficial to supervisors and educators in helping trainees to examine countertransference issues.

To fulfill the purposes of our study, we employed the consensual qualitative research (CQR) strategy developed by Hill, Thompson, and Williams (1997; see also Hill et al., 1996; Rhodes, Hill, Thompson, & Elliott, 1994). The primary features of CQR are a reliance on words rather than numbers to describe phenomena, intensive study of a small number of cases, the context of the entire case providing a basis for understanding parts of the phenomena, and inductive reasoning. Procedurally, CQR entails partialling interview or questionnaire responses into domains (i.e., topic areas), constructing core ideas (i.e., brief summaries) for all the material within each domain for every case, and developing categories that describe themes in the core ideas within domains across cases. CQR involves a primary team of three to five judges who use a consensus method of agreement so that a variety of viewpoints are given equal consideration. One or two auditors review the consensus judgments made by the primary team, who then engage in a continual process of revisiting the raw data to ensure that their interpretations and conclusions are consistent with the data.

Method

Data Set

Data for the present study were obtained from Hill's (1989) eight case studies conducted in 1984–85. Each case involved 12–20 sessions of therapy, and 127 sessions were conducted overall. To examine data pertaining to countertransference, we inspected transcripts of interviews that were conducted with the therapists immediately after each session. Whereas various findings from these eight case studies have been reported elsewhere (Hill, 1989; Hill, Helms, Spiegel, & Tichenor, 1988; Hill, Helms, Tichenor, et al., 1988; Hill, Mahalik, & Thompson, 1989; Thompson, Hill, & Mahalik, 1991), the data pertaining to countertransference have not been examined previously.

Participants

Therapy dyads. The therapists were 8 psychologists (4 women, 4 men) ranging in age from 34 to 78 years (M = 46.4, SD = 13.5) with 5 to 42 years of postdoctoral experience (M = 18.5, SD = 10.9). Six of the therapists were White and two were Black. The therapists were invited to participate in the study after having been identified by peers as expert clinicians. Thus, this was a highly seasoned group of therapists considered by their colleagues to be very competent clinicians. The clients were 8 women, ranging in age from 32 to 60 years (M = 42.4, SD = 9.4), who responded to newspaper announcements offering free individual psychotherapy for women older than 25 who had relationship and self-esteem problems and who did not have a history of drug or alcohol abuse. Six of the clients were White, one was of Middle Eastern descent, and one was Chinese American. The 8 clients all had elevated Depression and Psychasthenia scores on the Minnesota Multiphasic Personality Inventory.

Interviewers. The interviewers were 3 female counseling psychologists in their mid-thirties and 1 female doctoral student in counseling psychology in her mid-twenties. One interviewer was assigned to each case, with substitutions occurring occasionally because of scheduling conflicts. The fourth author of the present study was an interviewer.

Judges and auditor. The 6 authors (4 women and 2 men) served as the judges and auditor for the current study. Four were counseling psychologists, and 2 were advanced doctoral students at an American Psychological Association accredited counseling psychology program. The 6 authors possessed 3 to 22 years of clinical experience. The first, second, third, fifth, and sixth authors all served as members of the primary research team at different points in the study. The fourth author provided audits on the findings of the primary research team. All of the authors, except the fourth author, were unfamiliar with the identity of the psychotherapy participants and with the content of the psychotherapy sessions, except what was revealed through postsession interview data. In terms of theoretical orientation, the first author described himself as humanistic, interpersonal, and feminist; the second author was humanistic and feminist; the third author was feminist and existential; the fourth author was humanistic, interpersonal, and psychodynamic; the fifth author was psychodynamic with existential leanings; and the sixth author was humanistic.

Bracketing biases. Each researcher recorded her or his biases and expectations at the outset of the study. In so doing, we attempted to minimize the influence of our biases on the data analysis. This procedure, known as *bracketing,* is common to qualitative research (Rennie, Phillips, & Quartaro, 1988). At the same time, we wanted to acknowledge our familiarity with the countertransference literature and let our work be informed, but not unduly influenced, by our understanding of this construct.

In terms of familiarity with the literature, the first author had published several studies in the area of countertransference and was very familiar with research and theoretical writings on countertransference. The second, third, fourth, and fifth authors possessed moderate knowledge of the countertransference literature, and the sixth author had little familiarity with writings on countertransference prior to the study.

The authors' views varied concerning the effects of countertransference on therapy process and outcome. The first four authors believed that countertransference is a potential source of insight into the therapy relationship, and that if recognized and handled appropriately, countertransference could be utilized to deepen the therapeutic relationship. However, they also believed that the closer clients' issues are to therapists' own unresolved personal conflicts, the less able therapists are to help clients. Furthermore, they maintained that when countertransference is not managed effectively, it will negatively influence therapy. The fifth and sixth authors believed that countertransference often goes undetected because it is primarily unconscious and because of the professional myth that "good" therapists do not struggle with countertransfer-

ence management; consequently, they held that countertransference usually has an adverse impact on therapy.

The authors noted several additional expectations and potential biases prior to examining the data. The first author viewed countertransference as pervasive, pantheoretical, and capable of being detected by therapists who stay inwardly attuned during therapy and reflect upon sessions afterward. The second author was skeptical about therapists' ability to recognize and accurately report their own countertransference, as were the fifth and sixth authors. The third author considered countertransference to be both common and underreported across therapists of varying theoretical orientations. The fourth author adhered strongly to the "wounded healer" notion that all therapists struggle with their own issues that affect their capacity to be objective with clients.

Procedures

Interviewers observed psychotherapy sessions and then conducted semistructured interviews with therapists immediately afterward. The purpose of these interviews was to gather information about therapists' general strategies and impressions of the session, including how they had been helpful, mistakes they had made, and what they had found meaningful. Interviewers followed a protocol consisting of 14 open-ended questions, one of which inquired about therapists' feelings toward their clients and the influence of countertransference on those feelings. Countertransference was defined for the study as therapist reactions that therapists identified as originating from areas of unresolved intrapsychic conflict. Interviewers also sometimes asked questions about issues they noticed from watching the therapists' sessions (e.g., commenting on a particular therapist behavior and inquiring about its roots or intended effects). All interviews were audiotaped and then transcribed verbatim.

Procedures for Analyzing Data

Identifying sections of interviews pertaining to countertransference. All 127 transcripts were read independently in their entirety by two members of the primary research team to identify sections of interviews that pertained to countertransference. When therapists discussed their personal reactions to the client, these responses were studied only if therapists identified the reactions as emanating from unresolved intrapsychic conflict. For example, we did not study one therapist's reactions that she attributed to premenstrual syndrome because this did not fit our working definition of countertransference (i.e., the reactions did not stem from intrapsychic conflict). We also did not study therapists' reactions to being involved in the research project. Three members of the primary research team discussed each identified section of an interview until consensus was obtained about whether it pertained to countertransference.

Audit. The auditor examined the consensus version of the sections of interviews pertaining to countertransference, and she then made suggestions that were considered by the primary research team. If the primary research team reached consensus agreement that an auditor's suggestion should be incorporated, revisions were made accordingly. This process was repeated until the auditor suggested no further revisions. The auditing procedure was employed for each subsequent step of the research process that is described below (determining domains, abstracting core ideas, cross-analysis, and charting the data).

Determining domains. Two members of the primary research team read every section of an interview pertaining to countertransference for each case. They then independently generated overarching categories, or domains, that encompassed all of the data they had read. Three members of the primary research team then discussed these domains until they reached consensus about the numbers and names of domains. Three domains were identified: origins (therapist-identified areas of unresolved intrapsychic conflict), triggers (therapist-identified, therapy-related events that stimulate or activate unresolved intrapsychic conflict), and manifestations (therapist-identified, therapy-related reactions that result from the activation of unresolved intrapsychic conflict). Although we were interested at the outset of the study in countertransference effects and management factors, these domains were not identified in the data and were not studied.

Abstracting core ideas. Three members of the primary research team independently read all the data in a specific domain from each interview and generated labels or short phrases to capture what they considered to be the core ideas contained in the interview data (e.g., therapist's uncertainty about ability to be a good parent). Three members of the primary research team discussed the wording of core ideas until consensus was reached.

Cross-analysis. Three members of the primary research team then conducted a cross-analysis to further classify the core ideas across cases. Individual team members independently examined all the material across cases within a domain and generated categories, and subcategories, that encompassed the data (e.g., family or parenting issues). The team then discussed the categories until they arrived at a consensus version.

To summarize the steps in the data analysis to this point, we identified interview data pertaining to countertransference and determined that the data fit within three large domains (origins, triggers, and manifestations). Each expression of thought in the data was labeled with a short phrase to capture the core idea expressed therein. Then, all of the core ideas within each domain were compared to generate categories and subcategories that would encompass them.

Charting the data. Data were charted so that patterns or relations among domains across cases could be identified by the primary research team. We agreed in advance that pairs of categories from different domains needed to coexist in at least one session in four or more of the eight cases to be identified as a pattern. Patterns were discussed until consensus was attained.

Results

All 8 therapists described countertransference reactions, although not for every session. In fact, data pertaining to countertransference were identified in 80% (101 of 127) of the sessions that therapists conducted. For each case, we classified the frequency of categories as *general* if a category occurred in every session; *typical* if it occurred in at least half, but not all, of the sessions; and *variant* if it occurred in fewer than half, but at least one, of the sessions. Across cases, we classified categories as *general* if a category occurred at least once in all eight cases; *typical* if it occurred at least once in half or more, but not all, of the cases (i.e., four to seven cases); and *variant* if it occurred at least once in fewer than half the cases (Hill et al., 1997). Table 1 contains a summary of findings from the cross-analysis.

Origins

Therapists varied in their ability, willingness, or both to discuss the sources of their countertransference reactions. For example, one therapist identified countertransference

Table 1
Summary of General, Typical, and Variant Categories of Countertransference Origins, Triggers, and Manifestations

Domain	Category	Frequency in each case								Overall frequency
		1	2	3	4	5	6	7	8	
Origins	Family issues	V	V	V	V	V	T	V	V	General
	(a) Parenting issues	V	V	—	—	—	V	—	V	Typical
	(b) Partner issues	V	—	—	—	—	V	V	V	Typical
	(c) Family of origin issues	V	—	V	V	V	V	—	V	Typical
	Needs and values	T	V	V	T	T	V	V	—	Typical
	(a) Grandiosity and narcissism	V	V	V	—	V	V	V	—	Typical
	(b) Devaluing dependence	V	—	V	V	V	—	—	—	Typical
	(c) Other needs and values	V	V	V	V	V	V	V	—	Typical
	(d) Need to be needed or to help	V	V	—	—	V	—	—	—	Variant
	(e) Need for control	V	—	V	—	V	—	—	—	Variant
	(f) Valuing directness	V	—	—	V	—	—	—	—	Variant
	Therapy-specific issues	V	V	V	—	V	V	V	—	Typical
	(a) Termination issues	V	—	V	—	V	V	V	—	Typical
	(b) Performance issues	V	V	—	—	—	V	—	—	Variant
	Cultural issues	V	—	—	V	—	—	—	—	Variant
	(a) Gender issues	V	—	—	—	—	—	—	—	Variant
	(b) Race issues	—	—	—	V	—	—	—	—	Variant
Triggers	Content of client material	V	V	—	V	V	V	V	V	Typical
	(a) Death	V	—	—	V	—	V	—	V	Typical
	(b) Family of origin	—	V	—	V	V	V	—	V	Typical
	(c) Parenting	—	—	—	—	—	V	—	V	Variant
	(d) Partner issues	—	—	—	—	—	V	V	V	Variant
	Therapist comparing client with others	V	V	V	—	V	V	—	—	Typical
	Change in therapy structure or procedures	V	V	V	V	V	V	V	—	Typical
	(a) Sessions starting late, missed, or rescheduled	V	V	—	V	—	—	V	—	Typical
	(b) Termination	V	V	V	—	V	V	V	—	Typical
	(c) Other changes	—	—	—	V	V	V	V	—	Typical
	Therapist assessing progress of therapy	V	V	V	V	V	—	V	—	Typical
	(a) Progress perceived positively	V	V	V	V	V	—	—	—	Typical
	(b) Progress perceived negatively	V	V	—	—	—	—	V	—	Variant
	Therapist perception of client	V	V	V	T	V	V	V	V	General
	(a) Positive perception of client	V	V	—	T	—	V	V	—	Typical
	(b) Perception of client as dependent	V	—	V	V	V	—	V	V	Typical
	(c) Other negative perception of client	V	V	V	V	V	V	V	—	Typical
	Emotions	V	—	—	—	V	V	V	—	Typical
	(a) Client expressing negative emotion	V	—	—	—	—	V	V	—	Variant
	(b) Therapist's emotional arousal	V	—	—	—	V	V	—	—	Variant
	Other triggers	V	V	V	V	—	V	V	—	Typical
	(a) Client's appearance	V	—	—	V	—	V	V	—	Typical
	(b) Nature of therapy relationship	V	V	V	V	—	—	—	—	Typical
	(c) Idiosyncratic triggers	V	—	V	V	V	V	V	—	Typical
	(d) Transference	V	—	V	V	—	—	—	—	Variant
Manifestations	Approach	V	T	V	T	T	T	V	V	General
	(a) Nurturing	V	V	—	V	V	V	V	V	Typical
	(b) Compassionate understanding	—	V	—	—	V	V	V	V	Typical
	(c) Identification with client	V	—	V	V	V	V	—	V	Typical

Table 1 *(continued)*

Domain	Category	Frequency in each case 1	2	3	4	5	6	7	8	Overall frequency
Manifestations (continued)	(d) Other positive feelings toward client	V	V	—	T	V	V	—	V	Typical
	(e) Relief	—	V	V	—	—	V	V	—	Typical
	(f) Other positive feelings	V	V	V	V	V	V	—	—	Typical
	Avoidance	V	V	V	V	T	V	V	V	General
	(a) Blocked understanding	V	—	V	—	V	V	V	—	Typical
	(b) Boredom or fatigue	V	—	—	—	—	V	V	V	Typical
	(c) Distancing self from client	V	V	V	V	V	V	V	—	Typical
	(d) Blocked exploration	V	V	V	—	V	V	—	—	Typical
	(e) Disappointment with client	—	V	V	—	—	—	—	—	Variant
	Negative feelings	V	V	V	V	T	V	T	V	General
	(a) Anger or frustration	V	V	V	V	V	V	V	—	Typical
	(b) Sadness	—	V	V	—	—	V	V	—	Typical
	(c) Inadequacy	V	V	V	V	V	—	—	—	Typical
	(d) Anxiety or pressure	V	V	V	—	V	V	V	—	Typical
	(e) Feeling overly responsible or burdened	V	V	—	—	V	V	—	—	Typical
	(f) Other negative feelings	—	—	V	—	V	—	V	V	Typical
	(g) Anticipating negative feelings	—	V	V	—	V	—	—	—	Variant
	(h) Guarding against negative feelings or behaviors	—	V	—	V	—	—	V	—	Variant
	Treatment planning	V	V	V	V	V	V	V	—	Typical
	(a) Choosing to be less active or directive	V	—	V	V	—	—	V	—	Typical
	(b) Wanting to be more active or directive	V	V	V	V	V	—	V	—	Typical
	(c) Other thoughts related to treatment	V	V	V	V	—	V	V	—	Typical
	(d) Uncertainty about treatment	V	—	—	—	V	—	V	—	Variant
	(e) Making assumptions about client	V	—	—	—	—	V	—	—	Variant
	Other manifestations	V	—	V	V	—	V	V	—	Typical

Note. For individual cases, the following criteria were used to quantify categories: G = General: category applied to every session; T = Typical: category applied to at least half, but not all of the sessions; V = Variant: category applied to fewer than half, but at least one of the sessions. Across cases, the following criteria were used to quantify categories—General: category applied to at least one session in all eight cases; Typical: category applied to at least one session in four to seven cases; Variant: category applied to at least one session in one to three cases. $N = 8$.

origins in only 4 of 12 postsession interviews, whereas another therapist identified and freely discussed origins in 14 of 17 interviews.

Family issues engendered countertransference in all eight therapists. Furthermore, therapists identified specific issues in each of three subcategories: family of origin, parenting, and partnering. For example, one therapist described his anger toward his mother because of her unwillingness to accept help from him. The therapist experienced similar anger toward his female client who was reticent to let the therapist help her. Another therapist revealed that he never wanted to be a parent because he thought he would be too demanding and overprotective. He saw his work with a client who needed nurturing and support as an opportunity to test his personal myth that he would be an inadequate father. A third therapist, who was about to get married, worked with a client in a troubled marriage. The therapist continually encouraged the client to stay with her husband, admitting in one postsession interview, "Marriage is wonderful. It will all work out fine in the end."

The second category of countertransference origins clustered around therapists' needs (for control, to help, narcissistic and grandiose needs) and values (directness, independence). To be precise, the category of narcissistic and grandiose needs included therapists' needs to be important, powerful, right, and gratified. As an example, one therapist

expressed a continual need to feel powerful in working with a client whom he found to be intimidating.

The third category of origins involved issues particular to the role of therapist. More specifically, countertransference emanated from issues related to termination and therapy performance (e.g., the need to be perceived as competent). Regarding termination, for example, one therapist admitted to having countertransference problems ending his work with clients; consequently, he "pulled back" from his client and avoided exploring her feelings in their final session. Another therapist, who had a need for relationships to end well, interpreted her client's demeanor in their final session as a positive reflection on therapy. This same therapist expressed in her final postsession interview, "Feeling that [the client] had relapsed would have been really very hard for me."

The final category of origins involved cultural issues, with subcategories of gender and race. Although only one therapist identified countertransference issues pertaining to gender, the cross-gender nature of this dyad was frequently problematic for the therapist. His need to be a "strong male" who was in charge was threatened by his female client, whom he perceived to be powerful. Similarly, only one therapist identified countertransference issues emanating from race, although three of the therapy dyads were cross-racial. In the dyad in which countertransference was identified as originating from racial issues, the therapist described countertransference reactions she had on discovering that her client was Asian. Although race may have continued to play a salient role in this therapy relationship, the therapist did not identify race as an origin of countertransference in subsequent sessions.

Triggers

As reflected in Table 1, the *triggers,* or therapy-related events that elicited countertransference, fell into seven categories. The first of the categories, content of client material, included four subcategories: death, family of origin, parenting, and partner issues. An example of how content of client material evoked countertransference occurred when a client's discussion of difficulties with her stepson triggered the therapist's own unresolved feelings toward his stepson. This same client later talked about her father's death, which stimulated the therapist's fears about his mother's impending death.

The second category of triggers, therapist comparing client with others, involved the therapist drawing parallels between the client and assorted individuals, including former clients, the therapist, and the therapist's family members. For instance, one therapist perceived his client as similar to himself in terms of having unresolved issues around control and responsibility. The relationship between this therapist and his client was marked by an ongoing struggle to establish dominance. In the interview following their 12th session, this therapist remarked, "I guess the countertransference part of it is that her showing metaphorically her vulnerability to me is flattering to me. That's obviously a countertransference reaction . . . neither one of us are 100% uncontrolling people . . . I was glad that she's vulnerable, and that's not a proud thing to say."

The third category of triggers, change in therapy structure or procedures, entailed disruptions to the typical sequence of therapy. This included sessions starting late, sessions being missed or rescheduled, termination impending or occurring, and other changes, such as the therapist not having a chance to review case notes before the session.

The fourth category of triggers involved the therapist's assessment of the progress of therapy. This category included two subcategories: progress perceived positively and progress perceived negatively. For one therapist, the positive progress his client was making tapped into his self-identified narcissism and caused him to delay telling the client about having to reschedule an upcoming session, fearing that his client would lose her "good rhythm." When therapy progress was perceived negatively, therapists had a variety of adverse reactions. One therapist who felt that therapy was not progressing well slipped and called his client by the name of her "passive, incompetent, whining sister."

The fifth category of triggers, the therapist's perception of the client, evoked countertransference in all eight therapists. Positive perceptions of the client caused one therapist not to confront her client about being late for two consecutive sessions. Perceiving the client as dependent was a typical trigger for therapists, one of whom said in a postsession interview, "I think it's a general sensation of not wanting, not feeling comfortable with her being dependent on me, fighting her dependency, pushing her away in that sense. I don't think that's a specific transference; I do that with everybody . . . I just in general tend to push away people's emotional dependency." Other negative perceptions of the client involved views of the client as noncompliant, hysterical, passive-aggressive, and vacant.

Emotional arousal constituted the sixth category of triggers. Client anger, in particular, evoked countertransference reactions, both when it was directed at the therapist and when it was not. For instance, one therapist acknowledged that he had difficulty when other people expressed anger toward him, and when his client did so, he "subtly undercut" the anger by thanking her for sharing her emotions.

The final category of other triggers included four subcategories: client appearance (e.g., wearing a black dress), nature of the therapy relationship (e.g., amount of eroticism between client and therapist), idiosyncratic triggers (e.g., therapist in conflicting roles with client), and transference. In describing how a client's transference tapped her countertransference, one therapist said, "I felt frustrated with her endless denial about looking more at her strengths. I also feel frustrated with the worshipping me that she does and putting all this stuff on me." The interviewer then asked, "How was any of that influenced by your past?" and the therapist responded, "Well, my role models are just primarily clearer and stronger in that you deal with things more directly and it's better to deal with them head on than to postpone, so there's not much value in her doing it that way."

Manifestations

We grouped the manifestations into four categories: approach, avoidance, negative feelings, and treatment planning. *Approach* was defined as therapist behaviors, feelings, or thoughts that decreased the distance between therapist and client. Approach reactions occurred across therapists and encompassed numerous subcategories: nurturing feelings and behavior, compassionate understanding, identifying with the client, relief, and other positive feelings, some of which were directed toward the client. An example of an approach response occurred when a therapist, who worried about his children's safety, empathized deeply with a client when she described fears about not being able to protect her children from harm. The therapist said in the postsession interview, "I understand the fear and the worry and how terrible losing a kid would be for me, you know. And I certainly at times in my life have an ongoing fantasy about the atom bomb being dropped and what would I do and what route would I get out of the city, you know . . . so I have some, I guess mostly just empathy of that situation."

We defined *avoidance* manifestations as therapist behaviors, feelings, or thoughts that increased the distance between therapist and client. All therapists experienced avoidance reactions, which included subcategories of blocked understanding, boredom and fatigue, distancing from the client, blocked exploration, and disappointment with the client. For example, one therapist, who had a need to "look good" professionally, distanced himself emotionally from a client with whom he felt stuck. Another therapist, who had unresolved issues around being childless, said in one postsession interview, "It may be a matter of countertransference that I got a little bit bored about her long-winded tale about the daughter."

The third category of manifestations, *negative feelings*, was defined as therapist emotions that were uncomfortable and that could either increase or decrease the distance between therapist and client. Negative feelings occurred in all therapists, and they included anger or frustration; sadness; inadequacy; anxiety or pressure; feeling overly responsible or burdened; other negative feelings, such as guilt, envy, and pity; anticipating negative feelings; and guarding against negative feelings or behaviors. These negative feelings had an inconsistent effect on the distance between therapist and client. The feelings sometimes drew the therapist closer to the client and sometimes caused the therapist to pull back. For instance, one therapist experienced an empathic sadness while working with a client and described "reaching" for something in the client, and in a later session, "clutching" the client amid the therapist's sadness. In contrast, another therapist felt sadness at the prospect of terminating with a client and avoided exploring the client's painful feelings toward the end of therapy.

The last category of manifestations, *treatment planning*, was defined as therapist decisions, evaluations, and other thoughts related to the therapy process. Treatment planning included five subcategories: choosing to be less active or directive; wanting to be more active or directive; other thoughts related to treatment, such as expecting a good session, recalling an earlier session, or shrinking one's treatment goals; uncertainty about treatment; and making assumptions about the client. For example, as a result of countertransference dynamics, two therapists decided to end therapy sooner than they had originally planned. Another therapist, who had issues around clients' dependence, felt the urge to be more directive and provide quick resolution to the problems experienced by her dependent client.

Relations Among Origins, Triggers, and Manifestations

We examined the data to locate pairs of categories from different domains that were identified in a single interview for at least four of the eight cases. That is, across cases we observed the frequency with which different categories of (a) origins occurred with triggers, (b) origins occurred with manifestations, and (c) triggers occurred with manifestations. If categories coexisted in at least one session in half or more of the cases, a pattern was said to exist. For example, 6 of the therapists had unresolved issues related to their families of origin. When 4 of these 6 therapists remarked that issues related to their families of origin had been aroused in session, they also mentioned identifying with clients during that session. Thus, a pattern was identified in that unresolved issues from therapists' families of origins were associated with a particular manifestation (i.e., identifying with the client) in at least half the cases.

Using this system, several patterns were identified (see Table 2). First, in terms of the relation between origins and triggers, when clients discussed family of origin concerns, therapists' issues pertaining to their families of origin were frequently elicited; when therapists had negative perceptions of the client, therapists' other needs and values (e.g., need for approval) were evoked; and when termination was approaching or occurring, therapists' termination issues often were aroused. Second, in terms of the relationship between countertransference origins and manifestations, two patterns were detected. When therapists' issues around their families of origin were touched on, therapists tended to experience an identification with clients. In addition, when therapists' grandiosity and narcissism were evoked, therapists frequently felt anxious. Finally, in terms of the relationship between countertransference triggers and manifestations, three additional patterns were identified. When countertransference was triggered by clients discussing their families of origin, therapists often responded with compassionate understanding. Second, when the therapist's or client's emotional arousal triggered countertransference, therapists frequently experienced subsequent negative feelings. Third, when therapists perceived clients negatively, common reactions included anxiety, nurturance, distancing from the client, and other thoughts about treatment (e.g., planning to end therapy early, recalling previous session with client).

Case Summaries

Brief summaries of each of the eight cases will be presented to illuminate countertransference themes within

Table 2
Patterns Among Countertransference Origins, Triggers, and Manifestations

Origins	Triggers	Manifestations
Family of origin issues →	Family of origin content	
Other needs and values →	Negative perception of client	
Termination issues →	Termination	
Family of origin issues →	→	Identification with client
Grandiosity and narcissism →	→	Anxiety
	Family of origin content →	Compassionate understanding
	Emotions →	Negative feelings
	Negative perception of client →	Nurturance
	Negative perception of client →	Distancing self from client
	Negative perception of client →	Anxiety
	Negative perception of client →	Other thoughts about treatment

Note. The arrows in the table connect categories that occurred together in at least one session in four or more of the eight cases.

these dyads. Therapist 1 seemed aware of many countertransference issues, such as his needs to be important, powerful, right, helpful, liked, and in control. The therapist perceived some of these issues to be related to his socialization as a male. Furthermore, the therapist openly discussed in the postsession interviews how these issues were triggered by a client who was similar in appearance to, and had the same occupation as, his ex-wife. The therapist also perceived the client to be like himself in terms of having a strong need for control. As a result, countertransference manifestations were identified in 17 of the 20 sessions of therapy that he conducted. Common manifestations included anger, anxiety, and difficulties confronting the client.

Therapist 2 described three countertransference origins in her 17 postsession interviews: needs to nurture, perform well, and be a good parent. The therapist used her countertransference reactions to deepen her understanding of the client, remain patient, and nurture the client. In fact, approximately half of her countertransference manifestations were classified as approach responses that increased closeness with her client.

Therapist 3 described himself as having a strong need for control, and the first few therapy sessions were marked by a power struggle between the client and therapist. After the initial phase of therapy, the therapist seemed able to identify with the client, who was nearly 20 years older than the therapist and who reminded the therapist of his overcontrolled mother. In the second half of the 17 postsession interviews, the therapist openly discussed numerous countertransference issues, including disappointment and frustration with the slow progress of therapy, distancing himself from the client's dependency, and discomfort with termination, though no particular theme dominated.

Therapist 4 possessed strong values related to independence and strength that she identified as potential sources of countertransference. The client with whom she worked for 12 sessions looked frequently to the therapist for guidance and advice, generating recurrent frustration in the therapist. Furthermore, the therapist seemed to experience difficulty identifying with the client, stating in one postsession interview, "I have never, ever, ever" been as dependent as the client. A second theme for this dyad involved death. The client's mother was in the process of dying and the therapist's mother had died within the previous year. The therapist felt some connection with the client around death but found from her own experience that it was not helpful "to get lost in the grieving." Because the therapist found information about death and dying to be helpful in her recovery process, she assumed the client would benefit from the same. Consequently, the therapist was predominantly didactic and intellectual in addressing the client's concerns about her mother's impending death.

Therapist 5 struggled for control throughout his work with a female client who looked to him for guidance and rescuing but who angrily rejected his advice because she saw it as controlling. This tapped into the therapist's countertransference issues of needing to gratify and help others and caused him to feel overly responsible for the client. The therapist struggled throughout their 17 sessions with how directive he should be, and he vacillated between empathizing with the client and distancing himself from her.

Therapist 6 was reminded by his client's anxious and driven personality of his parents who possessed similar traits. During the 20 sessions with his client, the therapist was actively involved in his parents' lives in that his father's health was failing, precipitating a series of crises in his mother who relied on him, the therapist, for help. As a result of the therapist's countertransference issues regarding his family of origin, he seemed able to identify with his client's experience of losing her father, though he also admitted to being overwhelmed at times by the client's presentation and multiplicity of issues. Furthermore, the client discussed issues related to marital discord and difficulties raising her stepson, both of which were issues the therapist had wrestled with in his own life. When the client discussed these topics, the therapist responded by alternatively empathizing and distancing himself.

Therapist 7 was engaged to be married, and the client with whom she worked for 12 sessions was experiencing problems with self-confidence, assertiveness, and her marriage. The therapist identified common countertransference reactions of guardedness (e.g., against being hostile) and distancing herself from the client, whom the therapist perceived as dependent and needy. In addition, when the client initiated

discussion about her marital strife, the therapist tended to focus on how the client could improve her communication with her husband and often gave advice to the client about how she needed to accept her husband more fully.

Therapist 8 had several unresolved conflicts that were triggered by her client's issues during their 12 sessions together. For instance, the therapist was conflicted about her decision not to leave her husband, and the client had divorced her husband. In addition, the therapist had unresolved issues about being childless, and the client frequently discussed concerns around raising her three children. The therapist felt envious of the client as both a mother and a divorcée. The therapist also described feeling bored when the client would discuss child-rearing issues. Furthermore, the therapist's father had died when she was an infant, and the client's father tried to commit suicide and eventually died when she was a young girl. The therapist seemed able to draw from her experience of losing her father to connect and identify with the client, though she did not disclose her father's death to the client. On the whole, the therapist spoke more sparingly about countertransference issues than any of the other therapists in the study. It was unclear whether the therapist was unaware of the influence of countertransference on the work or if she was simply reticent to discuss personal issues in the postsession interviews.

Narrative Summary

Countertransference frequently originated in therapists' unresolved conflicts related to family issues, needs and values, therapy-specific areas such as termination and performance issues, and cultural issues. Countertransference was triggered by a variety of stimuli, including what the client talked about, the therapist's comparing the client with others, changes in therapy procedures, the therapist's assessment of therapy progress, the therapist's perceptions of the client, and the therapist's or client's emotional arousal. In terms of manifestations, countertransference tended to draw the therapist closer to the client (e.g., identifying with or nurturing the client) or push the therapist away from the client (e.g., by way of blocked understanding or distancing from the client). However, some negative countertransference feelings affected the distance between therapist and client in unpredictable or inconsistent ways. Countertransference also caused therapists to reflect on and make decisions about the therapy process.

Discussion

Countertransference was ubiquitous among the therapists who participated in this study. Despite using a strict and, by some accounts, narrow definition of countertransference, we found that therapists identified countertransference phenomena in fully 80% of their sessions. We would submit that this is likely an underestimate of the prevalence of countertransference in these cases, as countertransference that was unconscious and not detected by the interviewers was not available for our scrutiny. That the therapists were highly experienced and considered experts by their peers makes the incidence of countertransference perhaps more notable. At a minimum, our findings undermine the professional myth that good therapists do not experience countertransference (Spence, 1987). To the contrary, it may be that highly reputable therapists are acutely aware of their countertransference dynamics, and more so than other therapists (see Van Wagoner et al., 1991).

Origins

That family issues were identified as countertransference origins by all 8 therapists suggests that family matters may engender countertransference in a large number, if not a majority, of therapists (cf. Liaboe & Guy, 1987; Racusin, Abramowitz, & Winter, 1981). Therapists' needs also were a common source of countertransference (e.g., need to be needed, to control, to be right, for approval, to be a good therapist, for gratification, to be important), raising the practical and important question of what causes therapists to place their own needs ahead of clients' needs. According to the clinical literature, therapists may be particularly prone to meet their own needs at the expense of a client when therapists lose sight of the "relational nature of therapy" (Brown, 1994, p. 37) and when therapists' needs are unfulfilled in their personal lives (Flapan & Fenchel, 1984).

Another common source of countertransference were issues specific to the role of therapist, such as performing well and dealing with termination. Therapists' attention to their personal conflicts in these areas seems especially important, because therapy inevitably requires that therapists both perform and face separation. The final category of origins, cultural issues, was identified by only two therapists, although the politically sensitive nature of this topic may have contributed to other therapists not discussing culture-based countertransference. Furthermore, that only two types of cultural issues (gender and race) were described by therapists suggests that this is likely an incomplete category of origins that may include other, yet-to-be-identified subcategories (e.g., sexual orientation, social class, religion). In fact, homophobia has been found to be a significant predictor of countertransference behavior with gay and lesbian clients (Gelso et al., 1995; Hayes & Gelso, 1993). Taken as a group, the origins we identified may help to normalize these various sources of countertransference, thereby facilitating therapists' awareness of and openness about their unresolved issues in these areas.

One might inquire about the "origins of the origins" we identified. That is, what causes a therapist to possess specific countertransference origins and not others? Whereas there are multiple layers of influence involved in countertransference, our research was necessarily bound by what therapists were able and willing to reveal. Even when therapists were highly self-aware and trusted the interviewer, limits existed as to therapists' ability to explain phenomena that are, to some degree, unconscious (Hill et al., 1997).

Triggers

Our findings indicate that a host of stimuli can provoke countertransference reactions. For example, consistent with

Cutler's (1958) research, we found that the content of clients' material frequently elicited countertransference reactions. Whereas some triggers can be considered objective and factual (e.g., the client discussed death, therapy was interrupted for several weeks), most triggers were the result of the therapists' subjective perceptions. For example, countertransference was stimulated by the therapists' phenomenological evaluations of the progress of therapy, appraisals of the client, comparisons of the client to others, or perceptions of a certain level of emotional arousal in the client or therapist. Thus, the lenses through which therapists saw the world largely dictated whether and when countertransference was stimulated. We recommend that therapists check their lenses continually to both heighten their self-awareness and enhance their ability to recognize stimuli that are likely to trigger countertransference. In fact, research indicates that therapists' awareness is inversely related to countertransference behavior and is critical to managing countertransference (Friedinger, 1987; Hayes et al., 1991; Latts & Gelso, 1995; Latts, Gelso, Gomez, & Fassinger, 1998; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Van Wagoner et al., 1991).

Manifestations

Other than the fairly cognitive manifestations involved in treatment planning, it appears that most countertransference reactions affect the emotional distance between therapist and client. Some reactions predictably draw the therapist and client closer together (e.g., identifying or empathizing with the client), whereas other reactions push the therapist and client further apart (e.g., blocked understanding, boredom). However, negative feelings seem to be unpredictable in their effect on the distance between therapist and client. For example, some therapists may react to their anxiety by withdrawing from the client (cf. Hayes & Gelso, 1991), whereas others may respond by increasing their involvement with the client (see Gelso et al., 1995). Thus, countertransference apparently contributes to the constant dance that occurs between client and therapist of drawing nearer or moving apart, of "joining and disjoining" (Perls, 1947, p. 22), of "merging with and separating from" one another (Gorkin, 1987, p. 80).

Unfortunately, it was not possible to determine from our data what effects the countertransference manifestations had on therapy outcome. Although some manifestations probably had effects on outcome that easily could be classified as facilitative (e.g., empathy) or hindering (e.g., blocked understanding), it is difficult to make accurate generalizations about the effects of most countertransference reactions. For example, whereas identifying with a client generally is helpful, doing so may be detrimental when the client and therapist have diffuse boundaries and are enmeshed. Distancing from the client may be more therapeutic in such situations. Furthermore, therapists' countertransferential anger may be used either constructively (e.g., to help the therapist confront the client) or destructively (e.g., to punish the client; see Sharkin, 1989; Sharkin & Gelso, 1993). What determines whether countertransference reactions will facilitate rather than hinder therapy? It could be that the more resolved an intrapsychic conflict is for a therapist, the greater the likelihood that the therapist will be able to use his or her countertransference therapeutically (e.g., to deepen one's understanding of the client). Conversely, the less resolved a conflict is, the more likely it may be that countertransference will lead to problematic consequences. For example, Therapist 4 appeared too engrossed in her countertransference issues of valuing strength and independence to connect with her dependent client and help the client work through her problems. This case illustrates the oft-expressed position that:

> Therapists who have difficulty accepting certain feelings and experiences in themselves will have difficulty empathizing with these experiences in their patients. . . . For example, therapists who have difficulty accepting their own needs for nurturance and support will find it hard to empathize with and enter into the phenomenological world of dependent patients. . . . Such therapists will tend to pressure the patient *not* to be where he or she is or *not* to experience what he or she is fully experiencing, rather than trying to understand and empathize with the patient's current experience. (Safran & Segal, 1990, p. 84)

In contrast, Therapist 2 seemed able to utilize her countertransference issues of needing to nurture and be a good parent by supporting and being patient with her client.

Overall Patterns

The patterns we observed among categories of countertransference origins, triggers, and manifestations give rise to a variety of hypotheses that could be tested empirically. Table 2, for instance, contains data on the co-occurrence of categories that could engender a host of possible hypotheses, such as:

> Therapists' unresolved issues pertaining to their needs and values will be stimulated when they perceive clients negatively; or When therapists' grandiosity and narcissism are evoked by clients, therapists will tend to feel anxious; or When therapists' countertransference is triggered by clients' discussion of family of origin issues, therapists will generally respond with compassionate understanding.

Furthermore, the patterns in Table 2 raise questions about variables that might moderate the relationships we observed. For instance, negative perceptions of the client were associated with a host of manifestations. It seems crucial to ascertain the factors that distinguish when a therapist's negative perceptions of a client will lead to, for example, nurturing feelings rather than distancing from the client. We suspect that the more well-developed the therapist's countertransference management skills, the better able the therapist will be to examine the roots of his or her negative perceptions, to tease out reality-based ways in which the client contributes to these perceptions, and to recognize and take responsibility for the influence of the therapist's unresolved issues on his or her perceptions. Two hypotheses follow from this line of reasoning:

> Therapists with better countertransference management abilities will demonstrate fewer manifestations that negatively affect therapy process and outcome; and Countertransference

> management factors will moderate the relationship between manifestations and effects such that when manifestations are exhibited that negatively affect therapy, therapists with better management abilities will subsequently make better use of these manifestations (e.g., by repairing ruptures in the alliance or deriving insight into the therapy relationship).

Although some research has been conducted on factors related to, and specific constituents of, countertransference management (e.g., Latts & Gelso, 1995; Robbins & Jolkovski, 1987; Van Wagoner et al., 1991), the field currently lacks adequate ways of measuring what therapists actually do in a session or between sessions to effectively manage their countertransference. We see this as a critical avenue to pursue in future research.

Finally, the patterns we observed could generate hypotheses about potential underlying causal variables. For example, as suggested in Table 2, therapists may be prone to respond with compassionate understanding when clients discuss family of origin matters. Why? Perhaps therapists can empathize with clients around family of origin concerns because dealing with families is an issue necessarily shared by therapists and clients alike. Of course, simply having the same issue as one's client does not guarantee that a therapist will respond empathically; in fact, just the opposite may be true (Cutler, 1958). However, when a client's issues are similar to the therapist's, the therapist at least has the opportunity to use his or her own conflicts as a deepened source of understanding of the client, provided the therapist's issues are sufficiently resolved. In other words, it is possible for therapists to convert their own experiences of suffering and working through personal conflict into sources of healing for clients. Based on the foregoing discussion, we offer the following hypothesis for future empirical scrutiny:

> When a client stimulates an area of unresolved conflict in a therapist, the degree to which the conflict is resolved within the therapist will relate directly to the extent to which the therapist uses her or his countertransference therapeutically.

Implications for Practice and Research

When considered together, the domains of countertransference origins, triggers, and manifestations provide a framework that may be beneficial to therapists, supervisors, and educators. Therapists can use the framework to review their work with clients, looking for evidence of countertransference. It may be most helpful for therapists to work backwards through the model, starting with a scrutiny of their overt behaviors and internal reactions to clients (manifestations), paying particular attention to changes in their feelings of connection to the client (approach, avoidance). Therapists can then try to identify the events that provoked their reactions (triggers) and begin looking within themselves for unresolved issues (origins) that may have been touched on. However, it may be easier for some therapists to start elsewhere in the model (e.g., by reflecting on a specific client behavior that may have triggered countertransference). Regardless of where a therapist "enters" the model, the key is to maintain a mindset of being alert for signs of countertransference. Supervisors and counselor educators may find the model similarly helpful in teaching trainees how to identify countertransference and use the self as a therapeutic instrument (May, 1939; Tauber, 1954; Williams, Judge, Hill, & Hoffman, 1997).

The findings from this study also may be useful in shaping future measurement of countertransference. Research on countertransference has been hampered by difficulties in operationalizing and measuring this nebulous and multifaceted construct (Fauth, 1998; Gelso & Hayes, 1998). Existing measures of countertransference typically have restricted their focus to manifestations such as inaccurate recall of information (Hayes & Gelso, 1993; Gelso et al., 1995), anxiety (Hayes & Gelso, 1991; Gelso et al., 1995), and under- and overinvolvement in client material (Bandura et al., 1960; Gelso et al., 1995; Hayes & Gelso, 1991; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Although our manifestations support the continued operationalization of countertransference along these cognitive, affective, and behavioral dimensions, we also detected manifestations that have not been used to operationalize countertransference in prior research (e.g., boredom, uncertainty, inadequacy, disappointment with the client). Some of these reactions, it might be noted, have been identified in the theoretical literature as possible manifestations of countertransference (e.g., see Flannery, 1995, for a discussion of how countertransference may give rise to boredom). Based on the manifestations identified in this study, one could develop a "checklist" inventory of countertransference behaviors, feelings, and thoughts, similar to Multon, Patton, and Kivlighan's (1996) measure of transference. Alternatively, the manifestations found in this study could be used to inform and refine existing instruments, such as Friedman and Gelso's (1997) measure of countertransference behaviors with positive and negative valences.

Limitations

One of the dimensions along which qualitative research can be evaluated is the extent to which the findings are comprehensive (Rennie et al., 1988). This criterion raises the question of how inclusive our data are of all potential countertransference origins, triggers, and manifestations. Because we analyzed preexisting data from a fixed and small number of cases, the results surely do not encompass all possible origins, triggers, and manifestations, nor even all countertransference domains (e.g., management factors and effects were not examined). Indeed, each of the cases contributed to the formation of new categories, suggesting that additional cases would give rise to further categories. Replication of this study would provide information about the relative stability of our findings (Hill et al., 1997).

Along the lines of replicability, the scope of our findings may be limited not only by a fixed and small number of cases but also by characteristics of the researchers, therapists, and clients. Because data vary in salience for different researchers, discrepancies exist in data that are viewed as *figure* and *ground.* Whereas we are confident that our results are grounded in the data (another of Rennie et al.'s [1988] criteria for qualitative research), we cannot rule out the possibility that other findings might be discerned and

emphasized by different researchers. In this study, the three domains we identified in the data (origins, triggers, and manifestations) were consistent with a theory of countertransference previously postulated by the first author (Hayes, 1995). Depending on one's vantage point, then, we have either provided evidence to support and elaborate upon Hayes' existing theory or simply confirmed our prestudy expectancies. A critical issue in this regard concerns the extent to which our preconceptions about countertransference were permeable (Stiles, 1993, 1997). The fact that Hayes' model was furnished with detailed categories and subcategories indicates that our prestudy mindsets were permeable; that the domains of origins, triggers, and manifestations were not modified suggests otherwise. Ultimately, it is up to the reader to decide to what extent our study is trustworthy (Hill et al., 1997).

In terms of therapist characteristics, the external validity of our findings is limited in that 7 of the 8 therapists described their theoretical orientations as primarily psychodynamic, all were highly experienced and reputable, and all were current or previous university employees (half were academicians; Hill, 1989). Thus, the sample of therapists is not representative of most practitioners, and our findings may not generalize to therapists who are less experienced, perceived to be less excellent, or who work in different settings. In addition, therapists' comfort in discussing countertransference seemed to vary, and their discomfort may have attenuated the depth of responses to the interview questions. Finally, all the clients were women who presented with depression and anxiety. Establishing the generalizability of our results requires replication with different dyads, particularly with therapists who are not psychodynamic and with male clients. Replication studies would shed light on how representative and comprehensive our findings are.

An additional criterion for evaluating qualitative studies is that the resulting theory should be credible (Hill et al., 1997; Rennie et al., 1988). A credible theory requires the interviewee's conscious awareness of the phenomenon under investigation (Hill et al., 1997; Nisbett & Wilson, 1977). This is a tenuous assumption with regard to countertransference, which often operates on an unconscious level. Perhaps we have generated a theory not so much of countertransference but of therapists' awareness of countertransference immediately following their sessions. Of course, even this awareness is subject to distortion, and our findings must be interpreted with this possibility in mind. Although interviewers observed sessions and occasionally probed about countertransference dynamics that may have been outside therapists' awareness, the interviewers were not focused explicitly and solely on countertransference. The perspective of an actively involved, highly focused third person (e.g., a supervisor) may be needed to more fully capture countertransference phenomena that are unconscious (Hayes et al., 1997; Singer & Luborsky, 1977). As another alternative, therapists may be better able to identify and discuss countertransference issues if they are interviewed some time other than immediately following sessions, as was the case in this study. We should note that, because of the time that elapsed between data collection and data analysis, we did not ask therapists to review and provide feedback on our findings. Thus, the study is lacking in testimonial validity (Hill et al., 1997; Lincoln & Guba, 1985; Stiles, 1993).

Finally, although we often presented and discussed countertransference domains and categories separately, it is important to remember that the origins, triggers, and manifestations occurred together and interacted and influenced one another. Therapeutic reality is not nearly so neat as our categories suggest. For example, therapists' countertransference reactions to a single trigger often included a mix of approach and avoidance reactions.

Limitations notwithstanding, the present study extends existing countertransference research by classifying categories of countertransference origins, triggers, and manifestations, and identifying patterns among categories. The data also gave rise to several hypotheses that can be tested empirically. Consequently, the present study provides a basis for future research that will help refine these hypotheses and deepen understanding of countertransference.

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Call for Nominations: *Emotion*

The premiere issue of **Emotion**, the newest journal from APA, will be published in 2001. The Publications and Communications (P&C) Board has opened nominations for the editorship for the period from September 1999 through December 2006.

Candidates should be members of APA and should be available to start receiving manuscripts in the fall of 1999. The successful candidate will assist the APA P&C Board in refining the scope of coverage for **Emotion**; it is anticipated that this will be a broad-based multidisciplinary journal that includes

- articles focused on emotion representing neuroscience, developmental, clinical, social, and cultural approaches

and

- articles focused on emotion dealing with not only the psychological, social, and biological aspects of emotion, but also neuropsychological and developmental studies.

Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominees are also encouraged.

To nominate candidates, prepare a statement of one page or less in support of each candidate. The members of the search committee are Janet Shibley Hyde, PhD (search chair); Joseph J. Campos, PhD; Richard J. Davidson, PhD; Hazel R. Markus, PhD; and Klaus R. Scherer, PhD.

Address all nominations to:

Janet Shibley Hyde, PhD, **Emotion** Search Chair
c/o Karen Sellman, P&C Board Search Liaison
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American Psychological Association
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The first review of nominations will begin December 7, 1998.