We are never truly "neutral" observers and interpreters. In every word and comment we implicitly convey something of our own life experience, our standards and beliefs, something we feel about the patient as a human being. How could it be otherwise?

—Emanuel Peterfreund (1983, p. 108)

Psychotherapeutic work, no matter its theoretical perspective, involves human engagement and understanding. These complementary abilities—to relate to the other and to know the other—draw on a backdrop of countless interpersonal experiences for their performance. In addition to formal clinical training, such personal experiences shape the foundation of interpersonal competencies used in professional practice and influence in subtle and, at times, dramatic ways the therapist's ability to relate with empathy to the client and to fully participate in and effectively facilitate the therapeutic process. Clinical supervision provides one crucial entry point by which the supervisee will come to appreciate the intersection of personal and professional factors, internalize professional attitudes, and develop approaches to more effectively bring the 'person' of the therapist as an ally into the service of the treatment. We open this discussion emphasizing the normative and ever-present contributions of personal factors to clinical practice, and we reserve the term countertransference for more carefully delineated phenomena that require more pointed examination within supervision and management within the therapeutic relationship. We further discriminate objective countertransference (reactions of the psychotherapist induced by the client's maladaptive perceptions, affects, and behavior, which are consistent with the
THEORETICAL OVERVIEW

Clinical supervision provides a setting for novice clinicians to explore the nature of their personal reactions and the impact such reactions have on the therapeutic process. Integral to this supervisory task is the use of a theoretical framework in which the influence of personal factors, subjective and objective countertransference reactions, and mutually constructed enactments can be understood.

Personal Factors

Each of us, as psychologists, well before we ever entered graduate school or met our first client, formed fundamental ways of relating to others. We assimilated family and culture-bound styles of interpersonal relating, formed attitudes and beliefs about human nature, and absorbed the worldviews and mores of the ethnic, social, political, cultural, intellectual, gendered, economic, and spiritual communities in which we inhabit. These inescapable frameworks of identity, forged out of interaction with our surroundings, establish fundamental assumptions about self and others, instill ethical values, and furnish a feeling or sense of being at home in the world. Not solely products of internalization, our personal identities reflect dynamic, emergent sources of meaning and motivation, which result in continuity of self-experience and self-agency over time. As we assimilate new experience into our inherited social reality, we may question (or even reject) aspects originating in our given multicultural identities; however, the imprint of these seminal influences remains. Personal perspectives, commitments, and loyalties emerge out of the dialectic between freely authoring our lives and our historical and cultural embeddedness. These personal factors influence professional work, as clinical understanding inevitably draws from the multicultural sources shaping our identities.

Our perspectives are not only shaped by forces of individual psychology but are influenced by the loyalties we hold to the particular social worlds that contributed to the formation of our identities. Fowers (2001) suggested “being loyal is inherently exclusionary and discriminatory” (p. 269) and leads to partiality:

It [loyalty] emphasizes our embeddedness in family, culture, and nation and that we are unavoidably partial to these groups. Our attachment to
these groups and the way of life in which we have been socialized is
deeper than abstract reason and more compelling than most calculations
of consequences. (p. 279)

Such loyalties engender notions of difference and may delimit our ability to
fully understand and to empathize with others’ worlds of experience. For
example, internalized homophobia (Gelso, Fassinger, Gomez, & Latts, 1995;
Hayes & Gelso, 1993) may influence our ability to understand the other and
may perpetuate expressions of prejudice.

Supervision provides a context to develop appreciation for the personal
factors that inform clinical understanding and engagement with clients. Cen-
tral to this task is demonstrating in practice that our understanding is always
perspectival and bears the “inescapable influence of personal interests, com-
mitments, and the cultures out of which personal meaning is constructed”
(Falender & Shafranske, 2004, p. 83). In addition to affecting one’s under-
standing of another’s experience, influences of history and culture impact
styles of interpersonal relating, particularly in respect to the expression of
emotion and mores regarding interpersonal conduct. Through careful exam-
ination of points of subjective conjunction (when the supervisee believes to be
in sync with the worldview of the client) and subjective disjunction (when the
supervisee experiences confusion, disbelief, or disagreement about the client’s
perspective), the role of personal factors can be elucidated, because it is in
self-perceived moments of heightened empathy or disconnection when the
contributions of the therapist’s implicit meaning system are most apparent.
The intention of bringing into awareness the persistent influence of personal
factors is consistent with the multicultural guidelines of the American Psy-
chological Association (APA; 2003) which recognize that as cultural beings,
psychologists (supervisees and their supervisors) may hold attitudes and
beliefs that can detrimentally influence their perceptions of interactions with
individuals who are different from themselves (p. 19). Differences in behav-
ioral expectations based on cultural norms for interpersonal conduct, for
example, accepting a gift or exchanging an embrace, contribute as well to the
therapeutic relationship. In our view, personal factors derived from one’s
familial and multicultural identities continuously influence the therapeutic
and supervisory processes.

Countertransference

Drawing on Kiesler (2001), we consider countertransference to be a
class of clinical phenomena, unique among the personal factors experienced
by psychotherapists, which refers to “distinctly different, unusual, or idio-
syncratic acts or patterns of therapist experience and/or actions toward a client
[that constitute] deviations from baselines [in the therapist’s usual practice]”
Similar to all personal factors, countertransference influences the conduct of therapy; however, unique to these phenomena is their potential to heighten emotional reactivity in the therapist, prompting not only intense affective states but also resulting in nonreflective and, at times, unintended actions. Such actions, when in the extreme, may threaten the therapeutic alliance and imperil the treatment. Whereas the interplay of personal factors in the usual course of treatment allows for discussion, correction, and reinterpretation of misunderstandings and misattunements, the therapeutic dyad under the influence of countertransference (often related to transference) holds the possibility of rapid acceleration of forms of engagement or enactments, which further strains the alliance and foreclose meaningful therapeutic collaboration. This is particularly the case when working with clients who present histories of severely compromised interpersonal relationships and difficulties in maintaining self-regulation. Norcross (2001) observed that

Most theoretical orientations place considerable emphasis on the inner work of the therapist—how to constructively harness the intense, conflictual, and often painful reactions of working with difficult people—even if they do not invoke the term (Safran & Muran, 2000). All theoretical traditions, moreover, recognize the therapist’s contribution to the treatment process and the need for therapist self-care when experiencing the looming despair, sudden rage, or boundary confusion that is all part of countertransference. (p. 981)

Although agreement might be obtained among clinicians with respect to describing the behavioral manifestations and phenomenology of countertransference, controversy has swirled around its origins, nature, and value. Countertransference has been broadly applied to refer to the personal reactions of the psychotherapist; however, originally it was more narrowly defined. Freud (1910/1957) conceived of countertransference as “a result of the patient’s influence on [the physician’s] unconscious feelings” (p. 144) and concluded, “no psychoanalyst goes further than his own complexes and internal resistances permit” (p. 145). From this perspective, countertransference was seen as a manifestation of the therapist’s transference in response to the client and an obstacle to be overcome (p. 144). Freud later added to his conceptualization the notion that the doctor may use his or her unconscious mind to understand the patient’s unconscious mind. Like a double helix, the notions of countertransference as a hindrance to treatment and as a vehicle for understanding have been intertwined throughout the development of the concept (Epstein & Feiner, 1979, p. 490). Although a comprehensive review of the use and meaning of the term is beyond the scope of this chapter, the following summary presents major theoretical perspectives appearing in the clinical literature, which offer hypothetical models to employ within supervision.
Freud's (1910/1957) original emphasis on the activation of the therapist’s transference remains a salient perspective (Brenner, 2006). For example, Luborsky and Barrett (2006), following their review of the literature, proposed the therapist’s responses to the patient were based on significant patterns of relating in the therapist’s life. Similarly, Gelso and Hayes (2007) conceptualized these dynamics in terms of the countertransference interaction hypothesis in which “countertransference results from the interaction of particular patient actions or triggers (words, intimations, characteristics, behaviors) with particular therapist conflicts and vulnerabilities” (pp. 131–132). This perspective emphasizes the role of subjective countertransference (Spotnitz, 1969), in which the unresolved conflicts in the therapist are seen to contribute to inappropriate and defensive reactions on the part of the therapist manifested by avoidance.

An alternative perspective was presented in Heimann’s (1950) pivotal article, which expanded countertransference to “cover all of the feelings” (p. 81) the therapist has toward the client and provided an important tool to understand the client’s unconscious. In this totalistic perspective, countertransference originated in the client and reflected unconscious pressure exerted into the therapist by way of projection identification, thus stimulating heightened emotional reactions in the clinician. Although controversy remains as to the relative contributions of the client and the therapist in the production of such mental contents in the therapist (Gabbard, 1995; Jacobs, 1999), “most contemporary Kleinians now accept the notion that the therapist’s countertransference may reflect the patient’s attempt to evoke feelings in the therapist that the patient cannot tolerate” (Gabbard, 2001, p. 285; see also role-responsiveness theory [Sandler, 1976]). Relevant to this perspective is Winnicott’s (1949) notion of objective countertransference, in which the therapist’s reactions are seen to be responses to “the actual personality and behavior of the patient based on objective observation” (p. 45) and reflect reactions generally evoked in others by the client’s maladaptive behavior (Hafkenscheid, 2003; Kiesler, 2001). Important to our discussion, the totalistic or comprehensive perspective encourages the exploration of countertransference and places emphasis on its beneficial aspects in gaining awareness of the client’s intrapsychic life as well as the interpersonal impacts and pressures enacted within the therapeutic relationship.

An intersubjective perspective, which considers experience to be socially constructed, imports a postmodern sensitivity that emphasizes the contributions of both the client and the therapist to shape each other’s responses. Countertransference (and transference) may be viewed as “an inexplicably intertwined mixture of the clinical participants’ subjective reactions to one another” (Dunn, 1995, p. 723), and clear distinctions between the psychotherapist’s countertransference and the client’s transference become blurred. Rather than conceiving of reactions as the products of isolated minds, an intersubjective
perspective recognizes an individual’s reactions to be the products of the interaction, influenced by self-experience and contextual factors. Drawing on social constructivism from a psychoanalytic relational point of view (Hoffman, 1983, 1991) and the model of the “analytic third” from a contemporary neo-Kleinian–Bionian perspective (Ogden, 1994, 2005), countertransference is seen as a mutually constructed phenomenon emanating out of the intrapsychic and interpersonal interactions within the therapeutic encounter. An emphasis within supervision, drawing on this approach, would view the emotional reactions and behaviors of the supervisee to be important data reflecting not only the dynamic interactions between the client and therapist but also involving the contributions of the supervisor (Corpuz, Falender, & Shafranske, 2006).

Countertransference may be viewed globally to include all of the personal reactions of the therapist to the client, as products of their interpersonal interactions. Such reactions may also be understood to reflect the therapist’s unconscious transference to the client, or alternatively, as the contents of the client’s mental life that have been projected onto and contained by the therapist. No matter the specific interpretative stance taken, countertransference is an important area for exploration within clinical supervision and management within psychotherapy training.

THE SUPERVISORY PROCESS

The process of supervision bears the responsibility of ensuring the highest level of patient care, while simultaneously affording the supervisee with an opportunity to practice, leading to development of clinical competence. The task of learning psychotherapy is difficult on many levels because of its complexity and the unique interpersonal and psychological demands placed on the therapist. Psychotherapy is often stressful, despite what is usually conveyed in clinical texts, and this is particularly the case for the novice clinician. The experienced psychotherapist, on the one hand, develops over time skills at living with “the pressure of person on person, with its attendant anxieties, satisfactions, cautions, and effort” (L. Friedman, 1988, p. 6). The supervisee, on the other hand, faces every session with a degree of doubt in himself or herself and uncertainty as to what to expect in the clinical interaction. Supervision provides a vehicle to process the wide range of personal reactions that are stimulated in the consulting room, to foresee and correct any possible mishandling of the case, and to provide support to the supervisee in developing abilities to understand and to engage the client in a meaningful therapeutic process. Whereas deficits in knowledge and technical skill may be readily addressed through additional training, shortcomings in fundamental interpersonal skills; conflicts arising from unresolved psychological issues;
unproductive reactions when working with difficult patients; or biases, inflexibility, and prejudice pose particular challenges. In our view, a supervisory working alliance must be in place and a modicum of trust developed to address personal factors and countertransference with the supervisee. We also suggest that a preparatory phase can be initiated that will assist in establishing a strong foundation on which personal factors can be addressed. Included within this preparation are the following:

- **Alliance**: Through the mutual identification of training goals and objectives and consensus on the means to achieve the goals, a respectful, cordial, and collaborative relationship is initiated.

- **Supervisory contract**: The expectation that personal factors and countertransference will be addressed in supervision is discussed and incorporated into the supervisory contract. The development of self-awareness of personal factors affecting the therapeutic process, the ability to use consultation effectively, and the ability to manage countertransference reactions are explicitly identified as professional competencies to be developed in clinical training and supervision.

- **Explicit orientation to personal factors**: The supervisor introduces the conceptual framework for understanding the role of personal factors in the conduct of psychotherapy as well as in supervision. Emphasis is placed on the normative nature of the confluence of personal and professional factors in psychological practice. Exposure to selected theoretical and empirical literature as well as personal supervisor discussion and personal disclosure encourage openness to this dimension of practice.

- **Modeling**: The supervisor models appropriate disclosure in briefly sharing how aspects of his or her own multicultural identities contribute to clinical practice.

- **Initial exploration of personal factors and strengths**: In training activities and in individual supervision, the supervisee and supervisor initiate exploration of personal factors and signature strengths that contribute positively to the supervisee's competence.

Following this opening phase, it is important that exploration of personal factors be consistently addressed within supervision, or the message will be communicated that issues related to multicultural diversity and individual differences do not really matter. Of particular importance is the development of the understanding that everyone is located within multiple cultural locations and that attention to multicultural issues is not only
a matter of clinical relevance, it is a professional responsibility (APA, 2003). Powers (2001) wrote the following:

This attachment to culture is an unavoidable part of being human and
the ambiguities, tensions, and conflicts of being a participant in culture
are just as present among mainstream Americans as among members of
minority groups. Matters of culture are important whether we are work-
ing with a member of another cultural group or someone who shares
much of our own cultural background. . . . Culture is not about people
from other groups; it is a powerful part of all of our identities. (p. 277)

In our view, it is important to place emphasis on the multiple cultures
in which we are embedded, for instance, gender, religion or spirituality, age,
ability, economic status, and so on, and to consider individual differences
not as static entities but rather as dynamic dimensions, which have meaning
between individuals. Such a process of exploration is not about categoriza-
tion but is rather about thoughtful reflection about the dynamic contexts in
which these cultures interact, particularly with the clinical setting.

Management of Countertransference

Exploration and management of countertransference are best accom-
plished on the foundation of a well-established supervisory alliance in which
consideration of personal factors has been routinely encouraged. Such a foun-
dation can be further enhanced by supervisor modeling in which supervisors
disclose examples of the countertransference pressures they have faced when
conducting psychotherapy. It is important for the supervisor at the beginning
of the rotation to assess the supervisee’s familiarity with the countertransference
literature and to enhance understanding about the intersection of personal fac-
tors, multicultural identities, and countertransference; the ubiquitous nature
of countertransference; the nature of enactments; the clinical contexts in
which countertransference often is aroused; and the expectation to bring
countertransference material into the supervision. Failure to address counter-
transference may lead to alliance ruptures in the therapeutic relationship and
potentially in the supervisory relationship as well. The following points may
be helpful reminders in establishing a context to process countertransference
within supervision:

- Countertransference is a particular kind of personal factor that
  originates in a variety of clinical contexts; efforts to identify and
to understand its nature and impact on the treatment is a clin-
ical competency and is to be addressed in clinical supervision.
- Clinical competence includes the awareness of personal factors,
  which influence the therapeutic process, as well as skills in effec-
tively bringing countertransference reactions into the service of
the treatment.

- Countertransference may elicit positive and/or negative responses
  in the therapist and take the forms of distinctly unusual, idiosyn-
  cratic, or uncharacteristic acts or patterns of therapist experience
  and/or actions toward a client, which may include enactments
  and parallel processes involving the supervisory relationship.

- Countertransference is an informer of the therapeutic process
  and can provide important insights into the client's relational
  world, the therapist's relational world, and the schemas or
  internal object relations affecting the clinical relationship.
  Both objective and subjective forms of countertransference
  may occur in the therapeutic process, which require differen-
  tiation and management.

- The supervisory alliance must be established before counter-
  transference can be meaningfully addressed and managed.

- It is critical to maintain the boundary between supervision and
  psychotherapy when addressing countertransference reactions.
  Any exploration of supervisee personal factors must be specifi-
  cally related to the conduct of the treatment provided by the
  supervisee.

- How supervisees address and manage countertransference reac-
  tions is more important than the fact that such reactions occur.
  Countertransference reactions may involve either avoidance or
  inappropriate overinvolvement, which serve self-protective
  and defensive functions.

Clinical supervision plays a crucial role in the management of counter-
transference by providing the supervisee a supportive and safe environment to
identify and explore his or her personal reactions and to use clinical theories
to organize understanding and to reinstate a productive therapeutic relation-
ship. In many instances, supervisees will freely bring their countertransference
reactions into supervision. Others are less likely to do so, because of inade-
quate understanding of countertransference, limited self-awareness, defen-
siveness, or lack of trust and safety in the alliance, among other reasons.
Supervisors need to inquire into the supervisee's experience when departures
from usual clinical conduct occur, when the supervisee reports or the super-
visor observes distinctively unusual subjective states (boredom, confusion, irri-
tation, excitement, fascination, arousal), or when treatment is not progressing.
Gelso and Hayes (2002) identified five factors, personal and professional com-
petencies, which are associated with the management of countertransference
(see Table 5.1); each plays a crucial role in supporting the exploration and
management of countertransference in supervision.
TABLE 5.1
Five Factors in Countertransference Management

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-insight</td>
<td>The extent to which the therapist is aware of his or her own feelings, including countertransference feelings, and understands their basis.</td>
</tr>
<tr>
<td>Self-integration</td>
<td>The therapist's possession of an intact, basically healthy character structure. In the therapy interaction, such self-integration manifests itself as a recognition of ego boundaries or an ability to differentiate self from other.</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Refers to the therapist's ability to allow himself or herself to experience anxiety as well as management the internal skill to control and to understand anxiety so that it does not bleed over into their responses to patients.</td>
</tr>
<tr>
<td>Empathy</td>
<td>The ability to partially identify with and put one's self in the other's shoes; permits the therapist to focus on the patient's needs despite the difficulties the therapist may experience in the work. Also, empathic ability may be part of sensitivity to one's own feelings, including countertransference feelings, which in turn ought to prevent the acting out of countertransference.</td>
</tr>
<tr>
<td>Conceptualizing</td>
<td>The therapist's ability to draw on theory in the work and grasp ability theoretically the patient's dynamics in terms of the therapeutic relationship.</td>
</tr>
</tbody>
</table>


The exploration and management of countertransference may be accomplished through a collaborative process in supervision that involves identification of the indicators of countertransference, facilitation of self-reflective functions, elaboration of the possible origins and meanings of countertransference through the inclusion of theory, and development of meta-communication strategies to manage the countertransference.

A Process Model for Addressing Countertransference

Countertransference has been considered in the totalistic view to be an ongoing, pervasive influence within the therapeutic relationship. The spontaneous and disciplined responses of the psychotherapist originate from both personal and professional sources. Although theoretically these influences can be discriminated and their origins isolated, in practice these factors interpenetrate and are expressed globally as organizing principles. Even in instances in which discrete memories reveal specific dynamic starting points, mental contents immediately are associated within existing webs of meaning; as such, clear lines between personal and professional influence are difficult to identify. The psychologist will be in different states of mind in respect to countertransference at various points in the therapeutic process. That is not to imply that there are moments in which the clinician is either influenced or not by
countertransference. In our view, it is more accurate to assume that personal factors are always in play, and from the totalistic perspective, countertransference is always present.

In our view, the more narrow definition of countertransference is more useful in clinical supervision, when monitoring supervisee behavior, particularly when considering Kiesler's (2001) criteria: "distinctly different, unusual, or idiosyncratic acts or patterns of therapist experience and/or actions toward a client [that constitute] deviations from baselines" [in the therapist's usual practice] (pp. 1061–1062). The impact on supervisee therapeutic behavior and on the therapeutic process may be of greater or lesser influence, depending on the extent to which the content evokes conflict in the psychologist. The development of a countertransference conceptual model to identify and to describe the states of mind or mental activities likely to occur under such influence contributes to the examination of the role of personal factors in psychological treatment. Bouchard, Normandin, and Séguin (1995) provide useful categories to classify such mental states or activities, based in part on an empirical research approach, the Countertransference Rating System developed by Normandin and Bouchard (1993). Although this approach is anchored in psychoanalytic terminology, we find that the phenomena that are described and the metacognitive process can be applied across theoretical perspectives. This model includes specific stages of processing and requires different interventions on the part of the supervisor.

The Objective–Rational State

In the objective–rational state, the clinician is participating in what is regarded (by the psychotherapist) as an objective observation of another's subjectivity. For example, Intern A is conducting an interview with a new client. As the client describes her long-standing depression and the chaos in her life, the trainee feels empathically moved and, in the moment, she feels that she has fully grasped her client's suffering. She reports to her supervisor with absolute certainty that she "gets this client" and believes that her perceptions are sound and that her understanding is objective. Bouchard et al. (1995), drawing on Buber (1970), characterized this as an "I–it mode" (p. 740), in which the clinician is mentally oriented toward observing from the outside rather than from the inside as a subject. Understanding the client is enhanced by the systematic observation of cognitions and behaviors, through the vicarious introspection of subjective experience, or through the analysis of one's identifications, in which the client may have projected disowned aspects of self onto the therapist through projective identification and other aspects of countertransference. Although the term objective is used in the title, we suggest that perception is never purely objective (the intern's perceptions are shaped by her subjective experience of empathy as well as by her developing
skill in making clinical observations). The label of objective refers to the clinician's subjective experience of obtaining objective understanding. This is a state in which personal factors, although silently influencing the therapist, are not resulting in distinctive shifts in state of mind or in behavioral changes and remain almost invisibly in the background.

The Reactive State

The reactive state is one in which the psychologist is organizing experience primarily under the influence of countertransference. This state corresponds to the more narrow view of countertransference, which poses a hindrance to objectivity and results in distinctive, idiosyncratic states of mind and therapist behavior—states and behaviors that are out of the ordinary. In this state of mind, the capacity for objective—rational observation is suspended. It is a state primarily motivated by influences derived from personal, rather than professional, sources. Bouchard et al. (1995) suggested, from a psychoanalytic object relations perspective, that the manifestations of this state may result in impulsive, defensive—rational, or retrospective—defensive—rational reactions. These are states in which the clinician is under pressure to act or to defend against acting under the influence of the countertransference. In the dialogue from the case illustration, presented subsequently, the supervisee is in a heightened state of agitation, which limited her ability to bring into meaningful dialogue the client's behaviors; she was in a highly reactive state, feeling overwhelmed and angry.

The objective—rational state cannot be reentered under the state of countertransference without first recognizing the reactive state of mind and then processing within the reflective state, described in more detail below. The process of recognition commences when the clinician (or with the help of the supervisor in supervision) observes the discrepancy between his or her reactions in contrast to more usual forms of emotional, ideational, and behavioral responding. For example, if the therapist is in a unique state of agitation for which there is seemingly no external precipitant and only with a given client, this alerts the therapist that something unusual is going on. This awareness leads to a break in the immediacy of the enactment, and the clinician decenters from a reactive state and enters into a mode of reflection.

The Reflective State

This state is based on the ability of the clinician to make his or her own personal subjectivity the object of observation. In our view, this includes intentionality, curiosity, psychological-mindedness, nondefensiveness, and open-endedness, as well as other personal and professional capacities. The supervisee must have the capacity to maintain an awareness of the reactive
state to examine the contents of the countertransference and to obtain a clinically useful understanding of the enactment. The supervisor assists by explicating and by encouraging the supervisee to nondefensively reengage in the state of mind that he or she was feeling during the session. The state comprises four distinct processes: emergence, immersion, elaboration, and interpretation.

Emergence. This subphase commences at the moment in which the psychotherapist gains a glimmer of awareness of countertransference responses. This awareness may reveal a shift in his or her emotions, thoughts, and behavior and sometimes is characterized by the recognition of being in an unusual state of mind, for instance, confusion, boredom, or fear. Essentially, emergence is a state in which the therapist is able to pause and think about his or her immediate experience. As the clinician is able to stay engaged with the experience (rather than avoiding or acting out of the state of mind), emergence of conscious self-awareness is supported. Supervision assists the novice clinician to pay attention to these glimmers of self-awareness, to contain emotional overarousal, and to examine the meaning of the atypical states of mind or behavior they are experiencing in the therapeutic (or supervisory) relationship.

Immersion. This subphase concerns the intentional expansion of associations to the experience. By encouraging the supervisee to reflect on the salient moments in the session (as is facilitated in interpersonal process recall [Kagan, 1980]), associations such as memories, fantasies, and identifications, can be meaningfully brought into awareness.

Elaboration. Elaboration involves what Bouchard et al. (1995) referred to as “integrative elaboration” (p. 742). As the term implies, this subphase brings the supervisee’s associations together within the context of clinical theory, which brings meaning to the experience of the countertransference and provides a means to understand the impacts on the therapeutic process.

Interpretation. This is the endpoint of the process of reflection and involves the development of a provisional understanding of the meaning and origins of the clinician’s countertransference reactions. In supervision, the supervisor facilitates growth in the supervisee’s self-reflective capacity and assists the novice psychotherapist to consider ways in which his or her reactions can be usefully brought into the service of the treatment.

Enhancing Self-Awareness and Clinical Use of Countertransference

Although initially developed for a psychoanalytic audience, the countertransference conceptual model provides a useful starting point for consideration of therapist competencies important to the management of countertransference, such as self-insight and self-integration (Hayes, Gelso, Van Wagoner, & Diemer, 1991; Van Wagoner, Gelso, Hayes, & Diemer, 1991). The components of the reflective state may be integrated into a heuristic, although not necessarily psychodynamic, process in supervision. The subphases of immersion
and elaboration depict an approach to working with countertransference and personal factors that may be facilitated in supervision. Exploration of personal factors in supervision may be augmented by further study of the theoretical and research literature on countertransference (Friedman & Gelso, 2000; Hayes, 2004; Singer, Sincoff, & Kolligan, 1989) and clinical resources (Pope, Sonne, & Greene, 2006).

Following this process, supervision focuses on identifying strategies to address any difficulties arising from the countertransference. This may include judicious use of self-disclosure and engagement in metacommunication interventions, with the client focusing on repair of alliance strains or ruptures (see chap. 7, this volume, for a detailed discussion and chap. 5 of Falender & Shafranske [2004]).

AN EXAMPLE OF THE APPROACH

The following excerpt presents an important phase in a clinical case in which countertransference was significantly impacting the therapeutic process and illustrates the use of the countertransference conceptual model within supervision (which will be highlighted in the process commentary included in the brackets at the ends of narrative lines). As depicted in the transcript, the client, a Caucasian woman in her early 30s with depression with borderline features, related to the supervisee, a Caucasian female clinical psychology doctoral student in her mid-20s, in a highly dismissive tone, often criticizing or ignoring what seemed to be fairly empathic, supportive comments and symptom-focused interventions. In this phase of the treatment, the supervisee was aware that she was experiencing distinctive and idiosyncratic states of mind and was becoming aware that she was behaving in unusual ways during session, for instance, being curt in her tone, repeatedly glancing at the clock, and so on. The transcript begins with the supervisee in an agitated state of mind, immediately following a session with her client. In terms of the stages in the process model, the supervisee was in the emergent subphase (having already achieved a measure of self-awareness) and was beginning to process her reactions. The initial supervisor interventions were intended to facilitate immersion into the experience and entry into the subsequent elaboration subphase.

Supervisee: I am just so angry. I am fed up... I can't take this from her...

Supervisor: What are you experiencing right now, what's coming to mind, as you think of Shauna and your work with her? [This intervention aims to encourage immersion by facilitating self-reflection and directing attention to her associations.]

Supervisee: I hate it, what she does to me over and over...
Supervisor: Over and over?

Supervisee: Whatever I say, she rejects ... when she was crying, I reflected, “You’re feeling sad” and she says, “No, I’m not sad, I’m ah, somewhat sad, um unhappy”; then I confirm that, and she says, “No, I’m not really unhappy, I’m frustrated.” Whatever I do, it’s the same ... I can’t do anything ... do anything right ... earlier when we tried a CogB approach, she would just say, “Nothing helps” and not follow through; she was marginally compliant, and then she’d almost smile at me and say, “My problems are important ... these baby steps don’t help. I’m not like most people you see.” Then I’d inquire and try to be empathic with her experience, and all I get back is, “I don’t know,” or “How is thinking about this going to help?” ... [crying]

Supervisor: You feel you can’t do anything right ... [This focuses attention on her cognition and encourages exploration of her affective experience—both of which contribute to the generation of countertransference reactions.]

Supervisee: She makes me feel utterly powerless, empty, furious ... what am I doing? ... I should be feeling good, I passed preliminary orals, my boyfriend’s moving out here, my other cases are going well, but it’s too much, too much pressure, she makes me feel like ... crying ... I could be like her ... I don’t want to be in her state of powerlessness ... empty, pathetic ... my family was like hers, fractured, dysfunctional ... it was like this with my brother, no matter what anyone did for him, he would reject it, he just f***d up over and over and no matter how much we loved him, he’d just ... 

Supervisor: Just ... ? [This was a decision point for the supervisor: whether to encourage further immersion, which was leading to disclosure of personal material (associated to her countertransference reactions) or to shift the focus to how these emergent feelings were influencing her clinical functioning. This would shift the focus from personal exploration of the nature and origins of the countertransference to consideration of the clinical interaction. The decision was to encourage for the moment further immersion and elaboration; however, it was important to maintain attention on how personal factors were specifically influencing the therapeutic process.]

Supervisee: He’d just fail and fail and drink, none of us could succeed without feeling guilty about working hard ... he’d reject whatever any of us tried to do to help ... Jesus, where is all of this coming from, why am I thinking about this ...
Supervisor: The transactions in the relationship with Shauna are triggering these reactions in you, including personal associations...you are really stirred up.

Supervisee: Right...it's like when I'm in the session, I freeze; I don't know what to do...

Supervisor: Perhaps we could look at what occurred in the last session more closely...you are finding yourself in a reactive mode...you're reacting. [The supervisor makes an attempt to redirect to the impact on clinical functioning and behavior in the session.]

Supervisee: She had been telling me about how her job was boring, beneath her, but she believed that all jobs, working for someone else would be that way...I had just reflected back what she had just said to me about feeling stuck, and I tried to empathize with her that she felt disappointed and stuck when she found that her job hadn't met her expectations...she goes on about all her talents [she is quite bright, multiple graduate degrees], but then she laments that nothing ever meets her expectations, nothing ever lives up to her ideas of how it should be...careers, husbands, men, friends...they all leave her...she had to go to [prestigious West coast university] and then back East to grad school and...

Supervisor: You're talking about her and moving away from your affects...I wonder if we could turn back to a specific moment in the last session...

Supervisee: Maybe, I don't want to think about it...to get back into that state...

Supervisor: Perhaps you and she are having a difficult time looking at the process that is transpiring between you and arousing reactions in you? [The supervisor alludes to a potential parallel in their modes of processing affect, including avoidance at looking at the material, which is characteristic of countertransference.]

Supervisee: I just am so frustrated.

Supervisor: I can sense your frustration. It's as if whatever you offer is rejected, spit out and you are...

Supervisee: Exactly, she just...it was the moment when she corrected me again, that she wasn't "sad"...she was "somewhat sad," I felt overwhelmed...I started asking questions, making suggestions; time was almost up, I just knew I was blowing it, and I suggested that she pay attention to her thoughts during the week and perhaps use her journal, and we could
review the thoughts that were triggering her feelings and she says, “OK, but I don’t think that’ll help.”

Supervisor: And . . .

Supervisee: I just wanted the session to end . . . I felt furious and powerless, and I just wanted to get out of there . . . like her friends, no wonder they bail on her, they can’t stand her whining . . .

Supervisor: You’re back in touch with your feelings, having reactions, which you don’t usually have when you are conducting therapy, even with other challenging cases [I enumerate]; so there is a powerful dynamic or enactment that you may be caught up in, which can help us to understand the dynamics in the case. [The supervisor is attempting to facilitate further movement from immersion (and reactivity) to elaboration. In the elaboration phase, the raw material of the clinician’s associations is brought into a meaningful theory—and, in our view, science-derived context.]

Supervisee: You’re right; I know I’m so caught up in this.

Supervisor: Are you at a point where we can look at that together?

Supervisee: Yes, thanks, I feel better just being able to vent, to dump.

Supervisor: Like her?

Supervisee: Oh, like I just did to you, what she does to me . . . that’s right, sometimes it’s like she isn’t even thinking in the session just dumping . . . she doesn’t want to think . . . but I want her to think about what’s going on [Parallel process emerges.]

Supervisor: Well, let’s go back to a particular moment in the session, when you felt yourself becoming caught up in her process . . .

Supervisee: It’s when she rejects my interest or any of my attempts to engage her in self-reflection . . . I get frustrated by her unwillingness to look at her behavior . . . her passivity, and I start feeling like I have to do something, like I have to fix her . . . but whatever I do, she spits out.

Supervisor: You are describing a repetitive pattern, a CCRT [Core Conflictual Relationship Theme (Luborsky, 1984)]; let’s look at . . .

Supervisee: Then I get confused, and that’s when the material from my family begins to . . . gets in the way . . . I can feel these intense feelings emerging . . . when my brother would fight with my father and lie about what he was doing or not doing, the whole family was in a turmoil . . .
Supervisor: Another memory gets activated ... let's look at those experiences for a moment, how might they connect in actuality with your client and her way of relating to you and others? [Supervisee becomes reactive, and the supervisor redirects her associations to the case. This reflects the overlap between processes of immersion and elaboration, which are demarked in theory, but are less purely differentiated in practice.]

Supervisee: I think I can understand why all of her friends get tired and abandon her: They get fed up with all of the complaints.

Supervisor: You are getting fed up with ... what is she feeding you?

Supervisee: A lot of crap ... but really, as I think about it, it's her frustration, her feeling that no matter what she does it doesn't work out ... then I feel powerless.

Supervisor: Perhaps, you are experiencing the intensity of her powerlessness, which she wants you to get, to understand, and contain. [Projective identification comes to mind.]

Supervisee: That's right ... and I got confused in that session between her powerlessness, mine as a therapist, and in those past moments ... 

Supervisor: How do you feel right now about Shauna?

Supervisee: I feel empathy for her feelings of powerlessness ... I think that's how she really feels, but I feel frustrated ... it's like I can't stay with the feelings of frustration ... I want her to do something about it.

Supervisor: So, how might you describe what happens in those moments of intensity ... ?

Supervisee: I think the pattern is that she comes in feeling depressed and looking to me to do something to fix her situation; when I empathize with her feelings, she rejects it because it doesn't really change her situation; I feel frustrated and shift into inquiry leading to problem solving, and she minimizes my attempts or puts me down ... and I feel like her, misunderstood and ... oh, I hadn't thought of that before ... misunderstood, but I do understand.

Supervisor: Tell me more. [Elaboration phase, moving toward the interpretive phase, which is characterized by integration of theory leading to consideration of future behavior.]

Supervisee: I think I don't stay with her frustration for long, I shift to problem solving ... And then she becomes rejecting, and then I really feel frustrated, out of control, ineffective ...
Is this like projective identification ... that in specific moments I experience what underlies her experience ...?

**Supervisor:** The intensity may suggest, among possibilities, that you are feeling in the moment, constructed in the moment out of both of your experiences, the intensity of trying hard and feeling that nothing works ... that she isn't obtaining what she wants and she is overwhelmed with fear that her needs will never be met ... you could think of this in terms of projective identification or consider that in these moments there is an enactment drawing from each of your experiences and being intersubjectively constructed.

**Supervisee:** That feels right ... actually, as I think of that, she fears that no one will understand how desperate she feels, since she feels she'll never be able to get it right.

**Supervisor:** And with you ...

**Supervisee:** I don't let her become desperate ... I counter it with suggestions that she rejects ...

**Supervisor:** Perhaps, the intensity of her experience has not found a place in the therapy?

**Supervisee:** Only in her rejecting my suggestions ... I don't want to feel her desperation ...

**Supervisor:** So, she makes you feel desperate ... rather than ...

**Supervisee:** Yes, I move out of empathizing with her and become like others in her life ... demanding that she just change ... it's hard to be with her frustration ... she does try, but if she doesn't get immediate success, she falls back into her depressive passivity ... I haven't really seen it so clearly before ... I guess it triggers my own stuff ... [The supervisee is able to discuss her reactions specific to the clinical material as formal aspects of countertransference. In the beginning of the session, she was primarily in a reactive state of mind; now, she is able to reflect on the impact of her personal reactions on the therapeutic process.]

**Supervisor:** How do you feel now, when you hold these thoughts in your mind?

**Supervisee:** Clear, I think I understand better, I'm not so mad, actually I feel some empathy for her ... I think I've been contributing to this pattern.

**Supervisor:** How so?

**Supervisee:** Feelings get triggered in me, when I sense her desperateness, and I think I react out of countertransference and shift to
problem solving, putting it all back on her and the cycle of relating gets started.

Supervisor: Using the psychoanalytic model for a moment, how might you understand this? [This intervention is aiming at explicit integration of the theoretical and empirical literature into the discussion.]

Supervisee: This is an enactment and countertransference.

Supervisor: How do you understand countertransference . . . ?

Supervisee: Well, the countertransference part relates to my own personal experiences . . .

Supervisor: Might you also consider some of your responses as being outside of countertransference?

Supervisee: Well, realistically, I think most student therapists would feel frustrated.

Supervisor: Maybe even seasoned clinicians . . . It reminds me of Winnicott's [1949] paper "Hate in the Countertransference," in which the idea of objective countertransference is introduced; you might want to read that paper.

Supervisee: It's been unclear whether I'm frustrated 'cause of past issues, or whether it's because this is a hard case and I'm new to this.

Supervisor: Let's look at how you can use the perspective you are taking to help Shauna.

Supervisee: Well, for one thing I'm not so mad, I feel like I've got my bearings.

Supervisor: How might that be expressed when you meet her next week?

Supervisee: Well, I'm going to try to really stay with where she is, rather than shifting quickly to problem solving, which I guess is a demand on her to get out of the feelings . . . Even just being able to think about this may help, what do you think?

Supervisor: I think you are right; it does help to be able to think and keep your bearings in session. What I hear you saying is that you will try to stay with her experience. It might be helpful to try to reinstate a measure of curiosity as well as empathy about the experience of her rejecting what you say; if you can be curious about the dynamic meaning and function, perhaps, it'll lead to her becoming increasingly curious about how she relates to you.
Following this supervision session, the supervisee was able in the next session with the client to be increasingly empathic and curious and to engage rather than withdraw when the client criticized her. She sought out additional reading and began to be even more interested in understanding this client’s experience. They were able to continue to work with increased therapeutic effectiveness. The process model was effective in systematically leading the supervisor and supervisee through a process of metacognition, integrating direct experience and theory and leading to greater therapeutic effectiveness. Central to this work was the foundation of the supervisory alliance, which supported the exploration of the supervisee’s countertransference. The countertransference conceptual model provided a systematic approach to process the emergence of the countertransference.

CONCLUSION

Clinical supervision provides a process and a relationship to enhance competence in psychotherapy. The development of self-awareness of the role of personal factors and the management of countertransference is essential. Supervisors assist in this development by setting clear expectations, modeling reflection-in-action, and facilitating processes that incorporate knowledge (theoretical and empirical literature), skills (through practice in session, cotherapy, process model, metacognition, etc.), and values (self-awareness and integrity).

REFERENCES


