

Countertransference and Intersubjectivity: Golden Opportunities in Clinical Supervision

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Countertransference and intersubjectivity are concepts emerging from contemporary psychoanalytic practice and transtheoretical psychotherapy that represent golden opportunities for strengthening clinical supervision. Examination of countertransference within the intersubjective matrix of client, therapist, and supervisor promises to improve clinical supervision and professional practice. Case studies addressing unresolved shame and addictive family dynamics demonstrate the clinical benefits of careful examination of parallel processes in the client-therapist and therapist-supervisor dyads. Historical antecedents and recent literature indicate directions for research and training.

Countertransference and intersubjectivity are concepts arising from psychoanalysis and receiving increasing attention in transtheoretical psychotherapy. This paper explores facets of countertransference that inform treatment of sexual addiction, sexual trauma, and shame-based addictive family systems. After addressing the origins of the concepts and historical antecedents for intersubjective analysis, attunement in clinical supervision is described. Next, we address how countertransference reactions can be worked through in attuned clinical supervision based on exploration of intersubjectivity. The review concludes with explication of a complex case of addiction in a family system. The case studies present intersubjective analyses of child and parental problems concluding in observations regarding pacing and sequencing individual, couple, and family therapies for shame, sexual abuse trauma, and sexual addiction. Some implications for future research and training are offered, as well.

The concept of countertransference is familiar to most clinicians and supervisors from graduate coursework in psychotherapy theory and process.

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For the purposes of the present review, *countertransference* refers to the unconscious needs, feelings, and wishes that the therapist or counselor projects onto the object of the client (Brenner, 1985; Heimann, 1950; Reich, 1951). The *transference* of the client represents the concurrent projections of the client upon the object of the therapist and the clinical experiences they share in psychotherapy and counseling (Deutsch, 1953; Racker, 1968). *Intersubjectivity* in clinical supervision involves the subjective reactions of the client, therapist, and supervisor to one another, reflecting the unfinished business and personality of each member of the triad (Brown & Miller, 2002). The intersubjective perspective is emerging as a contemporary model for understanding the co-participatory nature of psychotherapy, as well as the reciprocal mutual influence processes of supervision (Fiscalini, 2004; Frie & Reis, 2005).

The therapist and client co-create a psychotherapeutic object relationship in which the interplay of transference and countertransference contributes to conflictual progress (Smith, 1998). Countertransference can move beyond empathy through identification toward distortion as the therapist becomes lost in the intimate relationship of therapy. The individual and communal contributions of the client and therapist are balanced through the creation of an “intersubjectively generated experience of the analytic pair,” which is accessible to the therapist through reflection on his or her feelings and fantasies about the client and their emerging relationship (Ogden, 1994, p. 3). Supervision affords a golden opportunity for examining these feelings and fantasies and making meaning of the intersubjectively determined experiences of the client and therapist who are immersed in the process of psychotherapy. The therapist is responsible for harnessing the power of countertransference to facilitate the healthy integration of intrapsychic and interpersonal realms.

COUNTERTRANSFERENCE

Examination of countertransference is central to contemporary practice in psychoanalysis (Coburn, 1997; Levy & Parnell, 2001; Schneider, 1992; Smith, 1998). Addressing the countertransference reactions of therapists or trainees in supervision is encountered in many clinical disciplines, including social work (Bonosky, 1995; Sehl, 1998; Streat, 2000; Walsh, 2002), psychiatry (Book, 1987; Bridges, 1998), psychology (Anderson & Williams-Rice, 1996; Friedman & Gelso, 2000), and professional counseling (Brockett & Gleckman, 1991; DeLucia-Waack, 1999; Levitov, Fall, & Jennings, 1999; Watkins, 1985). Some authors noted that examination of countertransference is required to address ethical dilemmas inherent in the supervision process (Dickey, Dooley, & Guest, 1993; Kurpius & Gibson, 1991; Pearson, 2000; Upchurch, 1985).

Hayes and colleagues articulated a useful model for examining countertransference in counseling and psychotherapy (Hayes & Gelso, 1993; Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998; Rosenberger & Hayes, 2002a, 2002b). Their evolving model is transtheoretical, applying beyond the boundaries of psychoanalysis, and research-based (Hayes, 2004). Hayes (2002) discussed the clinical epistemology involved in dealing with countertransference. He emphasized that the self of the therapist is an important construct even among clinicians who are cognitively and behaviorally oriented and generally reject psychodynamics.

The helping relationship and therapy process can be facilitated or impeded by the health of the clinician's self, which sets limits on the accuracy of empathy (Hayes, 2002). Research on countertransference indicated that personal qualities such as self insight and self-integration (i.e., coherence in personality structure) reduce negative consequences of countertransference, strengthen the working alliance, and promote positive outcomes (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes, Riker & Ingram, 1997; Rosenberger & Hayes, 2002a).

Hayes' (1995) original model of countertransference identified five factors: origins, triggers, manifestations, effects, and management. *Origins* referred to therapists' unresolved issues (i.e., intrapsychic conflicts) while *triggers* related to therapy events that instigated or elicited the issues (Hayes et al., 1998, p. 469). *Manifestations* included therapist thoughts, feelings, and actions resulting from instigation of the issues. *Effects* represented impacts upon therapy process and outcome. *Management factors* included conceptual and anxiety reduction skills, as well as insight and self care (Hayes et al., 1998, pp. 469–470).

Using the original model, the authors established that experienced counselors and therapists identified countertransference phenomena in 80% of their sessions (Hayes et al., 1998, p. 477). Origins emerged when addressing particular problems (e.g., trauma) and cultural issues (e.g., sexual orientation). Client presentation and remarks, as well as changes in therapy structure or process were associated with triggers. Manifestations included approach, avoidance, negative feelings, and difficulty in treatment planning. Although Hayes and colleagues examined relations among origins, triggers, and manifestations (Hayes et al., 1998, p. 475) and overall patterns (pp. 478–479), their qualitative research focused primarily on countertransference in the therapy relationship.

Gelso and colleagues investigated interactions of client and therapist attachment styles, anticipating the intersubjective nature of client, therapist-trainee, and supervisor perceptions of initial counseling or psychotherapy sessions (Mohr, Gelso, & Hill, 2005). Countertransference was highest when the client had a preoccupied attachment pattern and the trainee had a fearful or dismissing attachment pattern (Mohr et al., 2005, pp. 305–306). Interestingly, the authors found patterns of bias in supervisor ratings of trainee

behavior suggesting “. . . the importance of gaining more knowledge on possible sources of bias in supervisors’ perceptions of countertransference behavior” (Mohr et al., 2005, p. 306). Potential effects of the supervisor’s countertransference upon clinician (or trainee) countertransference highlight the importance of intersubjectivity in addressing these issues.

Most supervisors have little or no experience in dealing with their own countertransference issues (Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000). Longer term supervisory relationships with trainees, license candidates, and professional peers increase the relevancy of examining countertransference and parallel processes in supervision (Pearson, 2000). Countertransference may even affect validity and trustworthiness in qualitative research (Halbrook & Ginsberg, 1997). While supervisor (or researcher) countertransference likely functions in an analogous manner to therapist countertransference, there are some particular components of interest.

Similar to therapist countertransference, supervisor countertransference consisted of affective, cognitive, and behavioral components (Ladany et al., 2000). In a qualitative investigation, sources of supervisor countertransference included supervisee’s interpersonal style and supervisor’s unresolved personal issues, as well as interactions of the client-supervisee and supervisee-supervisor dyads (Ladany et al., 2000). Their results indicated that both the supervisee (intern) and supervisor also interact with the training environment. Obviously, countertransference is a complex, multifaceted issue, relevant to clinical work across theoretical orientations and within clinical supervision.

Examination of countertransference reactions within the intersubjective matrix of client, therapist, and supervisor promises not only to maintain ethical standards in supervision, but also to improve professional practice. The purpose of this literature review was to investigate the roles of countertransference and intersubjectivity reactions in clinical supervision. After reviewing the constructs in their historical context, applications and recommendations for contemporary clinical education and supervision are provided. While this review article is offered to a diverse group of clinicians and supervisors, traditional terminology (i.e., “therapist” or “analyst” refers to the clinician and “patient” indicates a client) for clinical supervision is employed when discussing historical antecedents in psychoanalytic practice.

HISTORICAL ANTECEDENTS

After introducing the term, Freud (1910, 1912, 1915) actually had little to say about the subject. His seminal writings indicated that he viewed countertransference as a type of interference in the analyst’s understanding of the patient based upon the patient’s arousal of unconscious conflicts in the analyst. Similar to other constructs in psychodynamic therapy, Freud’s followers

expanded the definition of countertransference to account for the active participatory role of the analyst in contemporary psychoanalysis.

The “narrow view” of countertransference was articulated by Reich (1951).

...the effects of the analyst's own unconscious needs and conflicts on his understanding or technique. In such cases the patient represents for the analyst an object of the past onto whom the analyst's past feelings and wishes are projected, just as it happens in the patient's transference situation with the analyst (p. 26).

The broad view of countertransference arose from the work of Melanie Klein (1984) and the British school of psychoanalysis. Heimann (1950, p. 81) defined countertransference as “all of the feelings which the analyst experiences toward the patient.” This broad view of the phenomenon contributed to the constructive use of countertransference by the analyst in understanding parts of the patient's personality and the resulting defense mechanisms.

An object relations view of countertransference takes into account both that part of the experience evoked by the patient's transference reactions and the role of the analyst's object relations projected onto the patient (Brenner, 1985). Elaborating upon the term, “complementary identification,” borrowed from Helene Deutsch (1953), Racker (1968, pp. 134–137), observed that the patient treats the analyst like an internal object, with which the analyst identifies and acts accordingly. The experience of countertransference ranges from empathy to neurosis depending upon the extent of conscious awareness of the powerful thoughts and feelings (Smith, 1998, pp. 100–103).

Smith (1998) described psychoanalysis as a type of intimate relationship under the influence of the object relations of both patient and analyst. In this manner, the patient and analyst “co-create” the analytic object relationship in which countertransference contributes to both interference and progress by means of “conflictual listening.” The analyst is responsible for listening at different levels and detecting the extent and impact of emotional involvement. Countertransference moves from empathy through identification toward neurosis. The contributions of the patient and analyst are balanced through the creation of an “analytic third” or the “intersubjectively generated experience of the analytic pair,” which is accessible to the analyst through reflection on his or her feelings and fantasies about the patient and their emerging relationship (Ogden, 1994, p. 3).

The analyst's experience of intersubjectivity is similar to the willing suspension of disbelief experienced in reading a novel or watching a film (Beres & Arlow, 1974). In listening to a patient, the analyst shifts moment-to-moment from observation to immersion in the process. Extended states of immersion and identification occur when countertransference is being used productively. When the analyst is open to examining carefully the experience of countertransference, the treatment relationship will move toward beneficial

outcomes for the patient. If the analyst is consumed by the countertransference experience, then neurotic re-enactments occur with the potential for harm (Smith, 1998). Clinical supervision, especially in the psychodynamic tradition, has been used to analyze the countertransference experience with the goal of supporting the treatment process.

COUNTERTRANSFERENCE AND INTERSUBJECTIVITY IN ATTUNED SUPERVISION

Countertransference may represent the crucible of counseling and psychotherapy in that it creates golden opportunities for deeply understanding the patient and imposes limits to the productivity of the helping relationship. Freud (1910) emphasized the limitations implicit in countertransference to establish the need for a training analysis conducted by a professional mentor.

... we are almost inclined to insist that he shall recognize this countertransference in himself and overcome it. Now that a considerable number of people are practicing psychoanalysis and exchanging their observations with one another, we have noticed that no psychoanalyst goes further than his own complexes and internal resistances permit; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his own observations on his patients. Any one who fails to produce results in self-analysis of this kind may at once give up any idea of being able to treat patients by analysis (Freud, 1910, pp. 144–145).

Freud's position, though narrow and rigid, introduced the necessity of clinical supervision to make countertransference productive.

Smith (1998) broadened the construct of countertransference to account for particulars in the therapy process and expressed a useful model of intersubjectivity as a means by which conflict is resolved. In Smith's formulation, countertransference is a normal facet of object relations in intimate relationships. Countertransference cannot be avoided and should not be overcome. Rather, the therapist's reactions to the patient's disclosures become fertile ground for professional helping. The therapist's thoughts, feelings, and fantasies provide insight into the inner world of the patient and the true nature of the problem. The "countertransference readiness" of the therapist mediates between the patient's transference and the clinician's "reflexive acceptance of the role which the patient is forcing on him" (Sandler, 1976, p. 46). Countertransference readiness and other opportunities for therapist understanding emerge from the intersubjectivity of the supervision process.

Intersubjectivity in clinical supervision involves the subjective reactions of the client, therapist, and supervisor to one another, reflecting the unfinished business and personality of each member of the triad (Brown & Miller, 2002). Intersubjectivity permits the supervisor to reflect on her or his countertransference experiences in order to understand the emerging client-therapist relationship. Countertransference reactions of the therapist represent tools for understanding the patient. Countertransference reactions increase with the extent of “empathic strain” (Lindy & Wilson, 1994; Wilson, Lindy, & Raphael, 1994) in the helping relationship, intensifying the need for supervision. The intersubjective nature of counseling and psychotherapy produces parallel processes in the client-therapist and therapist-supervisor dyads (Grey & Fiscalini, 1987). Facilitating and examining the intersubjectivity provide opportunities for addressing undisclosed material and working through emotional hurts and conflicts (Dass-Brailsford, 2003).

Intersubjectivity consists in the client’s largely unconscious observations of the therapist’s functioning, communicated by the client’s disclosures. The clinician’s selective consideration of the patient’s material in supervision reveals the therapist’s issues and the transference reactions of the client. The supervisor’s thoughts and feelings, as well as fantasies and fears, regarding the therapist, client, and their relationship provide the limits to the intersubjective matrix for the working through of countertransference in supervision (Beres & Arlow, 1974; Brown & Miller, 2002).

Inexperienced counselors are afraid to be vulnerable in supervision. They are susceptible to unrecognized countertransference reactions that interfere with therapy. Experienced therapists may become overly confident, bold or controlling, reflecting technical proficiency, yet lack of self awareness. Working through countertransference requires attunement in supervision to the needs of the clinician or supervisee (Auerbach & Blatt, 2001; Martino, 2001; Sedlak, 2003).

Attunement involves constructing supervision as a “holding environment” (Ginot, 2001; Winnicott, 1965) that is safe enough for genuine therapist self-disclosure. The supervisor maintains and strengthens the working alliance by providing warmth and confrontation, as needed. The balance of support and accountability (or limit setting) advances the working through of therapist countertransference. Yet, the success of supervision is dependent upon the establishment of vulnerability at the core of the relationship. Therapy heals the damaged object relations of the client while supervision heals the damaged object relations of the therapist.

Attuned supervision invites the therapist or trainee to be vulnerable enough to open up the intersubjective matrix, become immersed in the process, and manage productively the countertransference reactions (Auerbach & Blatt, 2001; Brown & Miller, 2002; Martino, 2001; Ricci, 1995). Attuned supervision is both personal and technical, facilitated by self-disclosure, and guided by the insights of the supervisor. By maintaining the focus on

beneficial outcomes for the client, the supervisor sets limits on the supervisory relationship. While the intersubjectivity makes the relationship intensely personal, supervision is not the same as personal counseling for the therapist. An attuned supervisor is perhaps in the best position to identify the unfinished business of the clinician, recommending personal counseling for the therapist and making referral when appropriate. However, the holding environment of supervision makes it possible to harness the productive potential of strong emotions without the necessity of personal therapy for supervisees.

WORKING THROUGH COUNTERTRANSFERENCE REACTIONS IN SUPERVISION

In order to understand the working through of countertransference, it is useful to focus on the extreme case. Counselors and therapists who work with trauma survivors experience profound empathic strain and present predictable countertransference reactions (Wilson, Lindy, & Raphael, 1994). These reactions may occur in any therapy or counseling relationship, but they are highly probable given the emotional upheaval of trauma work and the strains experienced by the empathic clinician (Danieli, 1994). Exploration of countertransference reactions of clinicians engaged in treating life trauma makes it possible to see clearly the components of working through countertransference in any counseling or therapy relationship.

According to the model of countertransference in therapy with trauma survivors (Lindy & Wilson, 1994; Wilson & Lindy, 1994; Wilson, Lindy, & Raphael, 1994), reactions occur in therapists who experience empathic strain in addressing pain and shame in the life stories or narrative accounts of victims of rape, terrorism, torture, and other overwhelming experiences. Countertransference reactions emerge in sustained inquiry over time depending upon the severity of stressors in the trauma story, factors in the client's personality and coping, factors in the therapist (including one's own life experiences) and factors in the institutional or organizational context (Wilson & Lindy, 1994, 19–24). The most extreme countertransference reactions would be anticipated in a therapy relationship involving a narrative account of severe trauma (e.g., torture) by a survivor presenting borderline personality and dual diagnosis (typically PTSD and chemical dependence); an empathic therapist who has some history of trauma and family chemical dependence; and an unsupportive or oppositional organizational setting with lack of supervision and a peer network (Cramer, 2002; Danieli, 1994; Wilson & Lindy, 1994).

There are two basic types of countertransference reactions: *Type I*, including avoidance, counterphobia, distancing and detachment; and *Type II*, including overidentification, overridealization, enmeshment, and excessive advocacy (Wilson, Lindy & Raphael, 1994). The first type of countertransference reactions varies along a continuum from denial and

minimization, through distortion and avoidance, to detachment and withdrawal. The second type varies from dependency and enmeshment, through overcommitment and overidealization, to overidentification and excessive preoccupation. In a sense, the two types of countertransference reactions reflect the two poles of PTSD: avoidance, withdrawal and blunting versus intrusion, preoccupation, and overinvolvement (American Psychiatric Association, 2000, pp. 463–468).

Therapists and counselors who have experienced considerable life trauma and upheaval are predisposed to empathic repression (Type I) or empathic enmeshment (Type II) reactions (Wilson, Lindy, & Raphael, 1994, pp. 41–42). In empathic repression, the clinician colludes with the survivor to avoid trauma issues in order to reduce loss and grief. Identifying the repression is the major task of working through the countertransference in supervision. Working through may also involve recommending personal counseling for the supervisee. In empathic enmeshment, the clinician rescues the client and takes excessive responsibility for the survivor's recovery. Supervision is needed to strengthen boundaries in the therapy relationship and reduce dependency. Working through enmeshment may require additional education regarding the centrality of exposure to strong affect in healing from trauma-related disorders.

Clinicians who have been spared personal catastrophes during their development are predisposed to experiencing empathic withdrawal (Type I) or empathic disequilibrium (Type II) reactions (Wilson, Lindy, & Raphael, 1994, pp. 40–42). In empathic withdrawal, the therapist engages typical mechanisms for avoiding the reality of the trauma narrative by disbelief, minimization, and intellectualization. Major goals of supervision are education about trauma and acceptance of the life stories of survivors. Working through involves exploration of naïve beliefs and worldviews and expanding openness to unpleasant affect. In empathic disequilibrium, the clinician, similar to the survivor, is overwhelmed by the horror of trauma. Overcome by pain and shame, the therapist has difficulty modulating affect and placing events in context. Supervision for empathic disequilibrium emphasizes self-care and stress management in order to avoid contact traumatization, subclinical depression, and burnout. Working through this countertransference reaction involves pacing and boundary setting to maintain a balance of vulnerability and confidence.

In general, the Type I countertransference reactions indicate a need for supervision that addresses the personhood or self of the therapist. The Type II reactions indicate supervisory needs for education and technique. The supervisor encourages counselors and trainees experiencing Type I reactions to venture forth and take risks. Clinicians evidencing Type II reactions benefit from boundary and limit setting. Venturing forth and responding productively to limits are characteristic of healthy object relations and personal growth (Horner, 1979).

Clinicians who are experiencing Type I reactions are inclined to premature termination of treatment or unnecessary or inappropriate referral, especially for medication management (Wilson, Lindy, & Raphael, 1994, p. 49). Type I therapists also tend to get stuck or fixated with a client within an early phase of recovery or a particular area of functioning. Therapists working with Type II reactions may unintentionally intensify trauma-specific transference, induce regression, or encourage acting out behavior (Wilson, Lindy, & Raphael, 1994, p. 50). In the extreme cases of Type II countertransference reactions, the therapist and client may experience pathological bonding and re-enact salient aspects of unresolved trauma. In this manner, the client and clinician are captive to a neurotic pair-bond that stifles growth or introduces harm. Inappropriate relational and sexual boundaries between client and therapist, as well as the resulting ethical violations, may be associated with inadequate supervision of Type II countertransference reactions, especially in cases involving presentation of sexual material.

Clinical supervision affords opportunities for therapists to explore the true nature of trauma, overcome obstacles to growth, and make meaning from profound life experiences. Counselors and trainees who work with trauma survivors are confronted directly by the reality of countertransference reactions. Supervision assists the therapist in harnessing his or her idiosyncratic countertransference reaction in order to move the helping relationship toward a beneficial conclusion.

USES OF INTERSUBJECTIVITY IN CLINICAL SUPERVISION

Returning to the topic of clinical supervision, it is possible to apply the insights gained in the explication of countertransference reactions of counselors who treat trauma survivors. What is predictably encountered in trauma work provides some guidelines for examining the intersubjective nature of supervision in all types of counseling and therapy.

Supervisors set the limits in the supervisory process through examination of the intersubjective matrix (Auerbach & Blatt, 2001; Brown & Miller, 2002). Examination of parallel processes in client-therapist and therapist-supervisor dyads is a basic model in intersubjective analysis. Client disclosures provide information about the clinician's current level of functioning. The therapist's formulation of the case reveals the transference issues of the client and the countertransference reactions of the counselor. The experiences of the supervisor enable him or her to observe parallel processes in the therapy and supervisory dyads. Exploration of parallel processes identifies recurrent patterns of behavior, which may reflect re-enactments of unfinished business or themes that interfere with the growth process (Brown & Miller, 2002; Caplan & Caplan, 1999; Grey & Fiscalini, 1987; Ricci, 1995).

After examining the parallel processes and particular themes in supervision, it is helpful to explore countertransference reactions. Depending on the life experiences of the therapist and the clinical experiences of both counselor and supervisor, the reactions can range from lack of conscious awareness to readiness to disclose and reflect. Life trauma experiences, including profound neglect and abuse, are most likely to elicit strong, resistant countertransference reactions. However, the “normal neuroses” of everyday life (Horney, 1994) present clinician issues associated with gaps in object relations and psychosexual development; limitations in capacity for intimacy; and fears regarding loss, rejection, or judgment. Many supervisors and therapists also struggle with angry feelings and needs for power or control (i.e., moving against).

The identified parallel processes, themes, and issues converge on some structural characteristics of the therapy and supervisory relationships. With the Type I countertransference reactions, there is the tendency to withdraw (i.e., move away from). Examination of Type I reactions can begin by addressing the negative aspects of the therapy relationship and any repulsion or avoidance. Type II countertransference reactions involve the tendency to move toward the client too quickly or too closely. An empathic supervisor who is able to hold strong feelings will be able to assist the therapist in containing and making meaning from overinvolvement and idealization. In the safe holding environment of clinical supervision, the clinician will produce disclosures related to both love and hatred, attraction and repulsion projected upon selected clients.

The supervisor may employ certain techniques or approaches to facilitate the resolution of countertransference. Imagery, dreamwork, word association and creative arts are useful in exploring the unconscious wishes and themes of the supervisee (Calisch, 1994; Danieli, 1994; Swift & Wonderlich, 1993). Danieli (1994) described a structured process for working through countertransference reactions in group supervision.

Working with countertransference reactions of therapists or trainees in group supervision intensifies the examination of intersubjectivity (Danieli, 1994). Initially, there is an instigation or focusing upon a personal experience associated with trauma, guilt, or humiliation. Then, the supervisor encourages supervisees to draw, associate words and affects, and reflect on the experience. The supervisee bridges from affects associated with the focal experience to early memories and choices. Next, the supervisory process involves sharing with others in the group. The period of sharing contributes to discussions of secrets, self-knowledge, and ongoing disclosure. Finally, each group member receives help related to identifying specific training needs, insights and strengths, and current personal and professional issues. Groupwork is especially helpful in addressing countertransference in multi-level supervision (Laveman, 1994). Individual and group supervision processes contribute to bonding, boundary setting, and meaning making.

An attuned supervisor can help the supervisee hold the empathic bond and accept the limits of professional practice. The supervisor provides support and education, offering a deep, meaningful relationship, as well as useful techniques or approaches for working through the countertransference. The intersubjective nature of supervision affords rich clinical material for exploration.

Through attunement in the supervisory process, the supervisor is able to "...turn his own unconscious like a receptive organ toward the transmitting unconscious of the patient" (Freud, 1912, p. 115) and the therapist. The empathic supervisor is able to examine her or his own countertransference to identify unspoken material and obstacles in the ongoing relationship of the clinician and client. Attunement in supervision helps the therapist to integrate the many facets of the helping relationship and move from empathy toward depth of understanding needed to heal damaged object relations (Ginot, 2001; Martino, 2001). In this manner, the genuine intimacy experienced in supervision and therapy affords opportunities for all participants to hold vulnerable feelings, experience healthy bonding, and receive encouragement to venture forth.

IMPLICATIONS FOR CLINICAL SUPERVISION: ADDICTIVE FAMILY CASE STUDIES

The intersubjective nature of the relationships inherent in supervision demands personal and professional reflection. When therapy or supervision becomes too "technique-oriented," this probably reflects some avoidance of feelings and issues that could be explored in a healthy professional relationship. On the other hand, preoccupation with feelings, patterns of behavior, and complex psychodynamics may reflect some impairment in the therapy or supervisory relationships. Effective clinical supervision involves a balance of personal and professional issues, reflection and action, insight and behavior change.

An example of attuned supervision in which the intersubjective matrix is explored may be helpful in identifying implications for counselor supervision. Consider the hypothetical scenario of the intersubjective matrix: Marcy Smith (licensed professional counselor), John Stevens (supervisor), and Jane P. (a 10-year-old client). Added to this cast of characters are Cynthia P. and Michael P., the child's parents. Marcy Smith, M.S. has chosen to specialize in treating children, the majority presenting obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder or both. She is highly regarded by referral sources for her work with such children. Dr. John Stevens is a clinical supervisor who works with the agency in which Ms. Smith is employed.

Jane P. is a 10-year-old 5th grader who makes As in the private school she attends. She has few friends and no extracurricular activities. Jane prefers

the company of her mother, with whom she sleeps several nights a week. She presents a complex clinical portrait including anxiety, rumination, sorting and counting rituals, hoarding, sleep disturbance (insomnia), perfectionism, and temper tantrums (especially around her mother). She was initially referred for evaluation by her pediatrician whom the mother consulted after an incident at school. The teacher reported that Jane became frustrated when required to work on a group task, yelled at her peers, and slapped a girl. The pediatrician asked Marcy Smith to teach the child some relaxation techniques and otherwise help her with compulsive behavior. He placed the child on paroxetine (*Paxil*) and scheduled a follow-up visit in a month.

Ms. Smith established good rapport with Jane, initiating relaxation training in the context of play therapy. She initially consulted with the child's mother and confirmed the diagnosis of obsessive compulsive disorder (OCD). After the collateral contact with Cynthia P., Ms. Smith did little to involve the mother in the counseling process. The mother requested to be included in the sessions, but Ms. Smith explained that she preferred to strengthen the therapeutic relationship through individual counseling.

During a regular staffing held at the agency, Dr. Stevens asked Ms. Smith to present to the group the case of Jane P. She did an excellent job of introducing her client and detailing progress to date. Several professional peers asked why Ms. Smith had not shifted to family counseling, focusing on the enmeshment of Jane and Cynthia. Ms. Smith became angry and questioned the validity of the group's feedback. The counselor explained she was bothered by the mother's "intrusion" into the individual counseling. She described the mother as demanding and controlling. Ms. Smith said she wanted to "insulate" (i.e., protect) the vulnerable child from potential harm in overly intense family sessions. Dr. Stevens expressed some concerns that the father, Michael P., had not been invited to sessions. Ms. Smith explained that he was not involved in family life. Instead, Mr. P spent most of his time on the computer. Ms. Smith said that Cynthia complained about his lack of involvement generally and lack of marital intimacy in particular. The group supervision session ended with Ms. Smith appearing to be rather defensive and entrenched in the individual counseling decision. She rejected the suggestions of her professional peers and resolved to defend her clinical judgment by referring to the pediatrician's referral directives in upcoming supervision.

Later, Dr. Stevens conducted individual supervision with Ms. Smith. Practicing attuned supervision, Dr. Stevens decided to create a safe haven for exploring countertransference by first engaging in self-disclosure. He prepared himself for the supervision session by examining his own unfinished business with an alcoholic, unavailable father. Dr. Stevens recognized his yearning for a father as the source for his feedback to Ms. Smith. The supervisor disclosed, "Marcy, my lack of fathering when I was a child made me aware that Mr. P is being excluded from the counseling process." He continued, "Have you considered scheduling a collateral contact with him?"

Ms. Smith responded by superficially agreeing to contact the parents. Then, she launched into an agitated defense of individual counseling, using contacts with the referring physician as her rationale. Dr. Stevens empathized with Ms. Smith's desire to help the child and agreed that progress was being made through relaxation exercises. He praised the counselor's ability to work with the physician and suggested that Ms. Smith could use her relational skills in addressing issues regarding the "closeness" of mother and child.

The counselor disclosed that Cynthia P. reminded Ms. Smith of her own overly adequate, perfectionistic, and controlling mother. The counselor's mother had focused her attention on her child when she learned that her husband had been involved in a series of extramarital affairs. Marcy Smith spontaneously recalled avoiding her mother in order to insulate aspects of her life from excessive scrutiny (i.e., intrusion). During the ongoing supervision session, Ms. Smith shared personal details regarding how well psychotropic medication worked in treating her own depression and anxiety. She said that she enjoyed working with physicians because she viewed most problems with anxiety as essentially biological in origin.

The attuned supervisor respected Ms. Smith's vulnerability and willingness to engage in reflection. He praised her self-disclosure and focused on technical aspects of the ongoing play therapy. Dr. Stevens paced himself over the next individual supervision sessions. He helped Ms. Smith to see how parallel processes were established in that the counselor's anger in group supervision was very similar to her client's rage at peers. He encouraged the counselor to engage in dream recording and journal writing. Ms. Smith gained insight that she was avoiding her mother, as well as family shame associated with her father's affairs, by attempting to exclude the parents from family therapy. The counselor realized that she had been empathizing excessively with her client (i.e., Type II countertransference reaction) due to unfinished business with her mother in the family of origin. She now could perceive the enmeshment of mother and child to be a symptom of lack of marital bonding. The child's anxious and compulsive symptoms represented her efforts to distract attention away from marital problems by taking care of her mother. Marcy realized that the child also engaged in symptomatic behavior to avoid anticipated intimidation by her unhappy mother. Therefore, she decided to schedule a conjoint session with the parents to explore potentials for family therapy in the future.

During the conjoint session with Jane's parents, Marcy realized that she had not identified several interrelated problems in the family system. The mother tried to comfort herself and exert control in a threatening family situation by focusing her emotional energy on the child. Her overinvolvement in the parent-child relationship camouflaged marital dysfunction associated with her husband's addiction to Internet pornography. The couple had withdrawn from one another and experienced a sexless marriage. His underinvolvement in the marriage and parenting reflected his progressive cybersex addiction

(see Manning, 2006). Overinvolvement in one dyad and underinvolvement in another is characteristic of triangulation in dysfunctional addictive family systems (Bowen, 1978). The child's anxious and compulsive symptoms represented her contribution to maintaining balance in the family system by distracting her mother, camouflaging her father's sexual addiction, and holding her parents' marriage together.

Marcy Smith's participation in attuned supervision enabled her to recognize the underlying complexity of this case, which initially seemed to involve only medication management and relaxation therapy for the symptomatic child. After the conjoint session in which each parent was brave enough to make essential disclosures, Ms. Smith indicated that she would like to refer the couple to an experienced counselor in the agency. The marriage counselor subsequently helped in clarifying their problems with intimacy and sexuality. Mr. P became involved in a community-based sexual addiction treatment group. Eventually, Mrs. P revealed that she had survived sexual abuse perpetrated by an uncle. She decided to pursue a course of individual therapy for sexual abuse issues while continuing the marital counseling. Ms. Smith continued to provide supportive counseling to Jane until the parents were ready to join them in family counseling.

There were layers of meaning in the intersubjectivity presented by the hypothetical clinical supervision. In the absence of attuned supervision, Ms. Smith could have felt misunderstood or "victimized" by her peers. She may have remained entrenched in her technical mastery within individual counseling and lost opportunities to reflect and grow as a professional counselor. The supervisor instigated analysis of intersubjectivity by examining his countertransference. While searching for the "lost fathering," he seemed to know intuitively there was undisclosed addiction in the family system. Frequently, clinical supervisors have much to offer when they reflect on what is missing in a case presentation.

The counselor responded to her supervisor's empathy and self-disclosure. She felt supported, rather than attacked. If the supervisor had focused on technical issues or pushed the counselor toward the family counseling conceptualization, the supervision process would have reiterated the control and intrusion of the counselor's mothering. In addition, the therapy relationship would suffer because it served as a cover for the addictive dynamics in the marriage and the shame in the counselor's family of origin. By examining parallel processes and engaging in self-reflection, countertransference issues were worked through in the safe haven of supervision. Although the choice of individual counseling remained the same, the process by which the counselor exercised clinical judgment and made effective referral was a meaningful outcome of the golden opportunity afforded by attuned supervision.

The interlocking needs of Cynthia and Michael P. in their intimacy-avoiding, sexless marriage afford another glimpse into the power of

intersubjective inquiry. While the child's individual treatment camouflaged the couple's intimacy dysfunction, marital therapy can hide or obscure underlying trauma and addiction. Some relational therapists would minimize the significance of Mr. P's sexual addiction or severity of Mrs. P's sexual abuse trauma by holding the couple in conjoint therapy for intimacy issues. If the marital therapist experienced the Type I countertransference reaction of minimization or avoidance, then there could be an unconscious attempt to push the couple toward increasing prematurely physical intimacy and sexual outlet. Were this to happen, an experienced family therapist would predict an exacerbation of the child's presenting problem. Fortunately, the couple's therapist in this case presented healthy object relations, willingness to explore countertransference issues, and capacity to use the marital therapy as a holding environment while tolerating the separate therapies of Mr. and Mrs. P.

The treatments of Cynthia and Michael P. present additional challenges. Attempts to involve Mrs. P in long-term, overly protective individual therapy for sexual trauma could reflect a Type II countertransference in the therapist who avoids her own life trauma issues by overidentification with the client and cultivation of dependency. As Mrs. P becomes increasingly debilitated by trauma treatment, Mr. P may be encouraged to act out his sexual addiction. When he relapses through compulsive masturbation to Internet pornography, Mr. P draws attention away from Mrs. P's stuckness since he is so obviously "the problem." Similarly, the therapist leading Mr. P's sexual addiction group could manifest a countertransference distortion by attributing all individual and intimacy problems to addiction dynamics. Some addiction therapists justify overly reductionistic, confrontational and intrusive forms of therapy because they require harsh overcontrol of their own addictive urges. Either Cynthia or Michael could become trapped in therapies unconsciously devoted to managing their therapists' issues.

Intersubjective inquiry facilitates balance in complex cases of shame based, addictive family systems. Change efforts that are directed at only one person in the family system tend to reflect unhealthy countertransference reactions of the therapists who become involved in providing care. It is possible to use countertransference reflections to embrace the complexities in cases of addiction: balancing individual and communal, intrapsychic and interpersonal issues in a meaningful nexus of individual, dyadic, group, and family therapy modalities. Clinical supervision is needed to determine helpful pacing, sequencing, and transitioning between levels of treatment. Ideally, each case involving sexual addiction or sexual trauma within an addictive family system will be organized by an effective case manager whose fount of wisdom arises from experience with countertransference reflection.

The clinical supervisor works with the case manager and therapists treating individual family members to mind what is missing or obscured and to maintain the balance in the family system. In complex clinical situations, such

as the aforementioned case studies, it is beneficial generally to treat the family within a group practice or clinic. Otherwise, it will be essential to maintain close communications among treatment team members through the efforts of a case manager. Lack of awareness of intersubjectivity with resulting struggles between a treatment team and a client family system can contribute to premature termination (e.g., leaving a treatment program against medical advice) or produce iatrogenic effects. Therefore, the value of an attuned clinical supervisor, who is able to use intersubjective inquiry for the benefit of clients and therapists, cannot be overemphasized. Treatment for complex cases of sexual addiction and life trauma should be informed by individual and group supervision. The author has served as a consulting clinical supervisor across treatment teams and services, connecting and balancing the contributions in complex addictive systems through intersubjective inquiry.

Examination of intersubjectivity and countertransference represents a valuable resource to clinical supervisors. Rather than being outdated or objectionable, given the psychoanalytic origins of the perspective, attuned supervision affords enhanced meaning making in contemporary supervision. By focusing on the multifaceted relationships of the intersubjective triad of client, therapist, and supervisor, attuned supervision can improve the case formulation and resulting helping relationship. Future research and training should address the nature of countertransference and characteristics of intersubjectivity in clinical supervision.

IMPLICATIONS FOR RESEARCH AND TRAINING

Much of the recent research on countertransference issues has employed qualitative rather than quantitative research designs (Hayes, 2002; Hayes et al., 1998; Ladany et al., 2000; Mohr et al., 2005). The qualitative approach seems to best fit the complexity of the data, as well as to explore the implicit meanings associated with this important aspect of clinical supervision. There are some promising approaches to defining and measuring important aspects of the constructs of intersubjectivity and countertransference.

Hayes (2002, p. 72) firmly established the definition of countertransference within the ancient archetype of the helper using his or her wounds in service to the healing of others. In this view, countertransference is essential to an integrative psychotherapy process. There are central epistemological and contextual issues underlying the constructs of countertransference and intersubjectivity that should be addressed before dismantling the components of the helping process.

Marcus and Buffington-Vollum (2005) found in a search of the last ten years of *PsycINFO* over 6,000 countertransference citations, most of which were published outside psychoanalytic journals. The authors applied the social relations model (Kenny, 1994) from social psychology to investigate the

transtheoretical nature of countertransference and related interpersonal processes. Marcus and Buffington-Vollum deconstructed the concept of countertransference to *dyadic reciprocity* in interpersonal perception consisting of four components: the person being perceived (i.e., the target), the perceiver, the unique relationship between the perceiver and target, and the error in perception (pp. 255–258). The authors asserted that consensus seeking among ongoing ratings of client and therapist and their relationship would best measure countertransference. Marcus and Buffington-Vollum proposed that application of the theoretically neutral term, *dyadic reciprocity*, would advance practice and research in psychotherapy integration.

Shahar (2004) also applied a meta-theoretical approach to explicate the political roles of transference-countertransference in the psychotherapy integration movement. Shahar addressed the constructs within the context of action theory (see Lerner, 1982). According to this perspective, client, therapist, and supervisor attempt to impose their perceptual realities upon one another through the exercise of interpersonal power. Shahar observed that in the context of transference-countertransference exchanges techniques may be empowering or oppressive. Addressing transference-countertransference realities may be essential to beneficial outcome and ethical use of power.

Hayes' (1995, 2004) evolving transtheoretical model identified five factors in the countertransference experience: origins, triggers, manifestations, effects, and management. In this linear model of the process, there is movement from unfinished business or family-of-origin issues, through contextual triggers and responses toward therapy and self-care. Hayes' model is best researched and lends itself to sensitive evaluation of therapy process and outcome. Being linear and molecular, the model components can be applied and tested by means of qualitative and quantitative designs. Rosenberger and Hayes (2002) innovated in the operationalizing of constructs. One measure of countertransference was the discrepancy of therapist self-ratings and peer ratings on the Adjective Check List (Gough & Helbrun, 1983), identifying therapist *blind spots* (p. 222). They also employed interview data, session ratings, and psychometric measures to investigate the influences of countertransference on working alliance and session impact.

An early measure of countertransference was the Countertransference Factors Inventory (CFI) (Hayes, Gelso, Van Wagoner & Diemer, 1991). The CFI evaluated five aspects of countertransference management: insight, self-integration, conceptualizing ability, empathy, and anxiety management. CFI total score and subscale scores on Anxiety Management and Conceptualizing Skills were positively related to trainee and supervisor ratings of outcome (Gelso, Latts, Gomez, & Fassinger, 2002, pp. 865–866). Scores on the Self-Integration subscale were related only to trainee ratings.

Friedman and Gelso (2000) developed the Inventory of Countertransference Behavior (ICB) with the goal of exploring the dimensions of underinvolvement and overinvolvement. The results of their factor analysis of

supervisory ratings of supervisee counseling sessions confirmed the existence of two central components: Negative Countertransference and Positive Countertransference (pp. 1226–1229). Their conceptualization of the involvement dimension was similar to the construct of countertransference reaction, proposed by Wilson, Lindy and Raphael (1994). However, Friedman and Gelso failed to confirm underinvolvement and overinvolvement. Instead, their results were consistent with the classic global view on countertransference that asserted it can have negative or positive impacts on the working alliance and counseling outcome. Recently, the ICB was modified to investigate the effects of counselor and client attachment styles upon selected aspects of countertransference behavior (Mohr, Gelso, & Hill, 2005).

Future research on countertransference in therapy and clinical supervision should embrace a mixed design, incorporating quantitative and qualitative methods. Ideally, objective tests, such as the CFI and ICB, can be used or adapted to measure countertransference management and impacts on the working alliance. However, it will remain essential to explore the political and interpersonal processes implicit in the transference-countertransference process. The construct of dyadic reciprocity may prove useful in addressing the subjective and uniquely personal qualities of therapy interactions.

Qualitative research is needed to address the complex issue of intersubjectivity, which does not readily submit to objective measurement. The supervisor's awareness of countertransference reactions and parallel processes in the client-therapist and therapist-supervisor dyads should be investigated to assess intersubjectivity. In addition, omissions and distortions in case formulation and presentation may provide access to data on intersubjectivity. Overall, Hayes' model components (origins, triggers, manifestations, effects, and management) afford a structure for continuing the explication of multi-level, transtheoretical countertransference phenomena.

Training should be provided to supervisors and clinical educators in countertransference phenomena and intersubjectivity. The transtheoretical models of countertransference can be incorporated in Master's degree and, especially doctoral-level coursework in supervision. Ideally, such courses would include a historical overview of the constructs and some attention to object relations or attachment theories of clinical supervision (Mohr, Gelso, & Hill, 2005). The best means for learning about intersubjectivity may be group supervision since the intersubjective matrix, including supervisor countertransference, is accessible to all participants. Recently, group psychoanalysis has addressed specifically the promises and pitfalls of intersubjectivity (Scanlon, 2000; Schulte, 2000; Urlic, 2005). Intersubjectivity is emerging as a core concept in the exploration of multicultural countertransference (Coelho & Figueiredo, 2003; La Roche, 1999). Training in intersubjectivity may be infused in coursework concerned with group counseling and multicultural counseling. Countertransference and intersubjectivity have been addressed in the marriage and family counseling specialization (Glickauf-Hughes &

Cummings, 1995; Solomon & Siegel, 1997). Training in countertransference management is routine in marriage and family counseling, primarily through exploration of family-of-origin issues in the contexts of coursework, internship, and supervision (Kane, 1995; Kern, Riordan, & Gay, 1995).

Countertransference and intersubjectivity are emerging as core constructs in marriage and family counseling, multicultural counseling, group-work, internship and clinical supervision. The transtheoretical nature of the phenomena invites professional educators and researchers from diverse clinical orientations to join their psychoanalytic colleagues in advancing training and research. Ongoing exploration of the constructs will facilitate knowledge development and deepening of the supervisory relationships. Countertransference and intersubjectivity present golden opportunities for clinical education and supervision, particularly in the emotionally charged, complex cases of sexual addiction and life trauma. Shame bound dynamics in addictive family systems elicit countertransference reactions in therapists and trainees that can interfere with therapy outcomes. Attuned supervision involving intersubjective inquiry and analysis affords opportunities for therapist-trainee reflections and movement toward healthy object relations among all participants in the healing process.

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